



NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	NO PA REQUIRED PREFERRED
Central Nervous System (CNS) Agents: Anticonvulsants	Clobazam (Generic of Onfi)
Central Nervous System (CNS) Agents: Multiple Sclerosis	Aubagio
Endocrine Agents: Osteoporosis-Bone Ossification Enhancers	Forteo
Gastrointestinal Agents: Anti-Emetics	Bonjesta
Genitourinary Agents: Benign Prostatic Hyperplasia	Alfuzosin (Generic of Uroxatral) Dutasteride (Generic of Avodart)
Genitourinary Agents: Electrolyte Depletter Agents	Sevelamer (Generic of Renagel and Renvela)
Infectious Disease Agents: Antibiotics-Macrolides	Eryped
Infectious Disease Agents: Antivirals-HIV	Atazanavir Sulfate Oral Powder (Generic of Reyataz) Tivicay PD
Infectious Disease Agents: Antibiotics-Tetracyclines	Vibramycin Suspension (no PA Required for age 12 or under)
Ophthalmic Agents: Antibiotics and Antibiotic -Steroid Combination Drops and Ointments	Neomycin/Polymyxin/Bacitracin/Hydrocortisone Ointment
Ophthalmic Agents: Glaucoma Agents	Dorzolamide/Timolol (Generic of Cosopt PF)

NEW CLINICAL PA REQUIRED "PREFERRED" DRUGS	
THERAPEUTIC CLASS	CLINICAL PA REQUIRED PREFERRED
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors	Corifact
Immunomodulator Agents for Systemic Inflammatory Disease	Taltz
Immunomodulator Agents for Systemic Inflammatory Disease	Xeljanz 5mg

NEW STEP THERAPY REQUIRED "PREFERRED"	
THERAPEUTIC CLASS	STEP THERAPY REQUIRED "PREFERRED"
Central nervous System (CNS) Agents: Anti-Migraine, Prophylaxis Treatment	Aimovig Ajovy
Endocrine Agents: Diabetes - Non-Insulin	Farxiga Invokana Invokamet Miglitol (Generic of Glyset)



NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED
Central Nervous System (CNS) Agents: Multiple Sclerosis	Zeposia
Central Nervous System (CNS) Agents: Parkinson's Agents	Kynmobi
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	Dayvigo
Endocrine Agents: Diabetes-Insulin	Lyumjev
Gastrointestinal Agents: Anti-Emetics	Doxylamine and Pyridoxine (generic of Diclegis)
Immunomodulator Agents for Systemic Inflammatory Disease	Cosentyx
Infectious Disease Agents: Antibiotics-Tetracyclines	Vibramycin Suspension (PA Required for age over 12) Doxycycline (generic of Doryx)
Ophthalmic Agents: Antihistamines and Mast Cell Stabilizers	Pazeo Drops

CHANGES IN CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
Central Nervous System (CNS) Agents: Anti-Migraine, Prophylaxis	<p><u>STEP THERAPY REQUIRED PREFERRED MEDICATION:</u> For a drug requiring step therapy, there must have been inadequate clinical response to a trial of at least 30 days each to at least 3 controller migraine medications or has experienced contraindications or intolerance to them (i.e., beta-blockers, anticonvulsants, tricyclic antidepressants, and/or serotonin-norepinephrine reuptake inhibitors).</p> <p><u>NON-PREFERRED MEDICATION:</u> For a non-preferred medication drug requiring step therapy, there must have been inadequate clinical response to a trial of at least 30 days each to at least 3 controller migraine medications or has experienced contraindications or intolerance to them (i.e., beta-blockers, anticonvulsants, tricyclic antidepressants, and/or serotonin-norepinephrine reuptake inhibitors) AND an inadequate clinical response to a trial of at least 30 days of one step therapy required preferred medication</p> <p><u>ADDITIONAL CRITERIA FOR MIGRAINE PROPHYLAXIS:</u></p> <ol style="list-style-type: none"> 1. Patient must have one of the following diagnoses: <ol style="list-style-type: none"> a. Episodic migraine with the following frequencies of migraine: 4-15 headaches per 30 days measured over 90 consecutive days and headache duration of longer than 4 hours per day or longer during an attack on average. b. Chronic migraine with the following frequencies of migraine: 15 or more headaches per 30 days measured over 90 consecutive days and headache duration of longer than 4 hours per day or longer during an attack on average



CHANGES IN CRITERIA			
THERAPEUTIC CLASS	SUMMARY OF CHANGE		
Central Nervous System (CNS) Agents: Anticonvulsants	<p><u>ADDITIONAL CRITERIA FOR CANNABINOID</u></p> <p>Patient has a diagnosis of Lennox-Gastaut syndrome, Dravet syndrome or tuberous sclerosis complex</p> <p>Maximum daily dose (QL) not to exceed 20 mg/kg/day (titration based on response/tolerability) for Lennox-Gastaut syndrome or Dravet syndrome and not to exceed 25 mg/kg/day (titration based on response/tolerability) for tuberous sclerosis complex</p>		
Central Nervous System (CNS) Agents: Parkinson’s Agents	<p><u>ADDITIONAL INFORMATION</u></p> <p>Requests for Apokyn, Inbrija, Kynmobi and Nourianz must have documentation of a trial of at least one other medication for the treatment of “off episodes” (dopamine agonist, COMT inhibitor, or MAO-B inhibitor).</p>		
Cardiovascular Agents: Lipotropics	<p><u>TRIAL PERIOD</u></p> <p>30 days for HMG-CoA Reductase Inhibitors, Niacin derivatives, ezetimibe (Zetia), 90 days for Fibrates, 12 weeks for PCSK9 Inhibitors and 12 weeks for ATP Citrate Lyase (ACL) Inhibitors</p> <p><u>ADDITIONAL CRITERIA FOR ATP Citrate Lyase (ACL) Inhibitor:</u></p> <p>A trial and failure with one PCSK9 inhibitor</p>		
Endocrine Agents: Diabetes-Non-Insulin	<p><u>STEP THERAPY</u></p> <p>1. For a drug requiring step therapy, there must have been inadequate clinical response to metformin products (either single-ingredient or in a sulfonylurea/ metformin or TZD/metformin combination), including a trial of no less than 60 days of at least one preferred metformin product</p> <p>2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including metformin and a trial of no less than 60 days of at least one preferred or step therapy product.</p> <p>Note: Inadequate clinical response after at least 60 days of recommended therapeutic dose with documented adherence to the regimen</p> <p>DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR</p> <table border="1" data-bbox="558 1444 972 1591"> <tr> <td style="text-align: center;">STEP THERAPY REQUIRED “PREFERRED”</td> </tr> <tr> <td>Farxiga (dapagliflozin)* Invokana (canagliflozin)</td> </tr> </table> <p>*Step Therapy Requirements are waived for members with a diagnosis of Heart Failure, Chronic Kidney Disease, Cardiovascular Disease or with multiple Cardiovascular Disease risk factors</p>	STEP THERAPY REQUIRED “PREFERRED”	Farxiga (dapagliflozin)* Invokana (canagliflozin)
STEP THERAPY REQUIRED “PREFERRED”			
Farxiga (dapagliflozin)* Invokana (canagliflozin)			
Endocrine Agents: Osteoporosis-Bone Ossification Enhancers	<p><u>ADDITIONAL INFORMATION</u></p> <p>The requested medication may be approved if there has been a therapeutic failure to no less than a 90-day trial of at least one preferred medication within the same class of the requested medication</p>		



CHANGES IN CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
Genitourinary Agents: Electrolyte Depleter Agents	<u>NON-PREFERRED AGENT</u> For a non-preferred agent, there must have been an inadequate clinical response during a trial of no less than <u>7 days</u> of at least <u>two</u> preferred medications
Genitourinary Agents: Urinary Antispasmodics	<u>ADDITIONAL INFORMATION</u> The requested non-preferred medication may be approved if there has been a therapeutic failure to a trial of no less than <u>30 days</u> of at least <u>two preferred medications</u> with different active ingredients not requiring a prior authorization
Topical Agents: Immunomodulators	Elidel and Protopic 0.03% are indicated in patients 2 years old or older. Protopic 0.1% is indicated in adults only
Immunomodulator Agents for Systemic Inflammatory Disease	<u>ADDITIONAL INFORMATION</u> If there has been a therapeutic failure to no less than a 90-day trial of at least two preferred medications
Infectious Disease Agents: Antivirals-Hepatitis C	<u>ADDITIONAL CRITERIA FOR DAAs</u> Please see the Hepatitis C Direct Acting Antiviral Prior Authorization Form for criteria and the most recent regimens recommended by the American Association for the Study of Liver Diseases (AASLD)

NEW THERAPEUTIC CATEGORIES
Central Nervous System (CNS) Agents: Movement Disorders
Endocrine Agents: Diabetes – Hypoglycemia Treatments
Endocrine Agents: Endometriosis
Endocrine Agents: Uterine Fibroids
Ophthalmic Agents: Ophthalmic Steroids
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE (Self-Administered)

Central Nervous System (CNS) Agents: Movement Disorders

LENGTH OF AUTHORIZATIONS: 365 Days

ADDITIONAL CRITERIA FOR THE TREATMENT OF TARDIVE DYSKINESIA:

Prescribed by a Neurologist or Psychiatrist
Ingrezza is ONLY indicated for the treatment of Tardive Dyskinesia

ADDITIONAL CRITERIA FOR AUSTEDO FOR THE TREATMENT OF HUNTINGTON'S DISEASE:

The member must have a failure to respond to maximally tolerated dose of tetrabenazine



MOVEMENT DISORDERS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AUSTEDO (deutetrabenazine)† INGREZZA (valbenazine) TETRABENAZINE (generic of Xenazine)	

† Quantity limit of 4 tablets per day

Endocrine Agents: Diabetes – Hypoglycemia Treatments

LENGTH OF AUTHORIZATIONS: 365 DAYS

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

PA REQUIRED NON-PREFERRED:

A non-preferred medication will be approved after a trial with a preferred medication or the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion.

ENDOCRINE AGENTS: DIABETES – HYPOGLYCEMIA TREATMENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BAQSIMI nasal spray (glucagon) GLUCAGEN vial (glucagon, human recombinant) GLUCAGON EMERGENCY KIT (glucagon, human recombinant)	GVOKE HYPOPEN 1-PACK (glucagon) GVOKE PFS (glucagon)

Quantity limit of 2 per month

Endocrine Agents: Endometriosis

LENGTH OF AUTHORIZATIONS: 365 Days

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

STEP THERAPY:

For a drug requiring step therapy, there must have been a therapeutic failure of at least a 30-day trial with both a NSAID and an oral contraceptive

NON-PREFERRED:

There must have been a therapeutic failure of at least a 30-day trial with both a NSAID and an oral contraceptive and a trial and a therapeutic failure of no less than 3-months on at least one step therapy required "preferred"



ENDOMETRIOSIS TREATMENT

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	DANAZOL DEPO-SUBQ PROVERA 104 (medroxyprogesterone acetate) LUPANETA PACK (leuprolide acetate and norethindrone acetate) LUPRON DEPOT 3.75 MG, 11.25 MG (leuprolide acetate) ORILISSA (elagolix) ZOLADEX (goserelin acetate)	SYNAREL (nafarelin acetate)

Endocrine Agents: Uterine Fibroids

LENGTH OF AUTHORIZATIONS: 180 Days

Members who have been treated with Oriahnn® for 24 months or more are not eligible for additional authorizations

Members who have been treated with Lupron Depot for 6 months or more are not eligible for additional authorizations

The requested medication may be approved if the member has a diagnosis of uterine leiomyomas (fibroids) and has failed a 90 day or more trial with an oral contraceptive

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
LUPRON DEPOT 3.75 MG, 11.25 MG (leuprolide acetate) ORIAHNN (elagolix and estradiol and norethindrone)	

Ophthalmic Agents: Ophthalmic Steroids

LENGTH OF AUTHORIZATIONS: 30 Days

For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than 14 days each of at least two preferred products

OTHER APPROVAL CRITERIA:

- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval



OPHTHALMIC AGENTS: OPTHALMIC STEROIDS

Table with 2 columns: NO PA REQUIRED "PREFERRED" and PA REQUIRED "NON-PREFERRED". Lists various ophthalmic steroid medications like DEXAMETHASONE SODIUM PHOSPHATE, DUREZOL, etc.

Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE (Self-Administered)

LENGTH OF AUTHORIZATIONS: 365 DAYS

CLINICAL CRITERIA FOR ASTHMA

- Indicated for moderate to severe asthma if:
- Prescribed by or in consultation with an allergist/immunologist or pulmonologist
- Preferred medications will be approved for patients with uncontrolled eosinophilic asthma symptoms and/or exacerbations despite at least one-month adherence to therapy with:
 - Medium dose preferred ICS/LABA inhaler (members 6-11 years old) – Nucala only
 - Medium dose preferred ICS/LABA inhaler with tiotropium or high dose preferred ICS/LABA inhaler (members 12 years and older) – Nucala or Fasenna
- Non-preferred medications will be approved for patients with uncontrolled eosinophilic asthma symptoms and/or exacerbations despite at least three months adherence to therapy with a preferred agent

ADDITIONAL CRITERIA FOR DUPILUMAB (DUPIXENT)

- Indicated for moderate to severe atopic dermatitis if:
- Patient has minimum body surface area (BSA) involvement of at least 10%
- Prescribed by or in consultation with a dermatologist or allergist/immunologist
- Patient is 6 years of age or older
- Patient has had inadequate response or contraindication to two of the following: topical corticosteroids, topical calcineurin inhibitors [e.g. Elidel], or topical PDE-4 inhibitors [e.g. Eucrisa] unless atopic dermatitis is severe and involves greater than 25% of BSA.
- Initial authorization is limited to 112 days with re-authorization of up to 365 days granted following demonstration of improvement in patient condition with therapy (e.g. reduced BSA affected).
- Indicated for chronic rhinosinusitis with nasal polyposis if:
- Patient is 18 years of age or older
- Patient had an inadequate response, intolerance or contraindication to one oral corticosteroid
- Patient had a 30-day trial and experienced an inadequate response, intolerance or contraindication to one nasal corticosteroid spray



MONOCLONAL ANTIBODIES-ANTI-IL/ANTI-IGE (SELF-ADMINISTERED)

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
FASENRA (benralizumab) NUCALA (mepolizumab)	DUPIXENT (dupilumab)