Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Denial Reason	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
11044086	ALINA MILIAN RAMOS MD	Internal Medicine	FREESTYLE LIBRE 14 DAY/RE	MEDICAL DEVICES	DM2	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of Freestyle Libre. 1) Records do not show that you meet one of these: (a) You still have trouble feeling when your blood sugar is low, OR (b) Low blood sugar may put your safety at risk when working, OR (c) Your doctor believes your blood sugar will not be controlled without a Continuous Glucose Monitor (CGM), OR (d) You have done well with CGM use and are likely to continue to benefit. 2) Records do not show you have done well with your blood sugar control with a Continuous Glucose Monitor (CGM) or that you have had less problems with low blood sugars. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Freestyle Libre (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member meets one (1) of the following: (A) Member continues to demonstrate hypoglycemia unawareness; OR (B) Undetected hypoglycemia continues to pose an occupational safety risk; OR (C) Member would be expected to have suboptimal diabetes control without Continuous Glucose Monitor (CGM) use and meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member is unlikely to test with sufficient frequency; OR (D) Member has experienced considerable benefit from CGM use and would be expected to continue to benefit from ongoing use; AND 2) Member has experienced considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
11047703	AUDREY S KUANG MD	Internal Medicine	SOFOSBUVIR/VELPATASVIR	ANTIVIRALS	hep C	Criteria Not Met	Our prior authorization criteria for sofosbuvir/velpatasvir (EPCLUSA equiv) have not been met. From the records that we have received, sofosbuvir/velpatasvir was denied for these reasons: 1) The drug is not prescribed by, or together with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist. 2) Documentation (such as chart notes or lab reports) of a recent viral level was not sent to us. This must be from within the past 3 months. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for sofosbuvir/velpatasvir (EPCLUSA equiv) have not been met. From the information we have received, the member does not meet number 1 and 4 of our prior authorization criteria for sofosbuvir/velpatasvir. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Member has a diagnosis of chronic Hepatitis C Virus (HCV); AND 3) HCV Genotype is provided; AND 4) Current viral level (HCV-RNA titer and date) is provided and must be from within the past 3 months (documentation is required for an approval); AND 5) Records indicate if member does or does not have cirrhosis (must be indicated); AND If member has decompensated cirrhosis (Child-Pugh B or C), weight-based ribavirin will be coadministered; AND 6) Duration of therapy will be 12 weeks; AND 7) Member is treatment naïve, OR If member has been previously treated, records of prior therapies used is provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
11081004	SONIA SHARON DURAIRAJ MD	Internal Medicine	BRIVIACT	ANTICONVULSANTS	R56.9 - Unspecified convulsions	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are levetiracetam and 4 preferred anticonvulsants (examples: carbamazepine, gabapentin, lamotrigine, topiramate, zonisamide, Vimpat(tried), phenytoin, divalproex, Onfi). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
11109069	KEVIN VICTOR HACKSHAW MD	Rheumatology	ACETAMINOPHEN/CODEINE	ANALGESICS - OPIOID	M05.9 - Rheumatoid arthritis with rheumatoid factor, unspecified	Not Covered	We have received a request for 90 tablets for a 30 day supply for APAP/CODEINE TABLET 300-30MG. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a 7 days for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. For members who do not show recent use of an opioid pain reliever, more than a 7 day supply for this first fill can be approved if records are sent in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.		
11128784	ALINA MILIAN RAMOS MD	Internal Medicine	FREESTYLE LIBRE 14 DAY/RE	MEDICAL DEVICES	E11.9	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of FREESTYLE LIBRE. 1) Records do not show that you meet one of these: (a) You still have trouble feeling when your blood sugar is low, OR (b) Low blood sugar may put your safety at risk when working, OR (c) Your doctor believes your blood sugar will not be controlled without a Continuous Glucose Monitor (CGM), OR (d) You have done well with CGM use and are likely to continue to benefit. 2) Records do not show you have done well with your blood sugar control with a Continuous Glucose Monitor (CGM) or that you have had less problems with low blood sugars. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for FREESTYLE LIBRE (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member meets one (1) of the following: (A) Member continues to demonstrate hypoglycemia unawareness; OR (B) Undetected hypoglycemia continues to pose an occupational safety risk; OR (C) Member would be expected to have suboptimal diabetes control without Continuous Glucose Monitor (CGM) use and meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member is unlikely to test with sufficient frequency; OR (D) Member has experienced considerable benefit from CGM use and would be expected to continue to benefit from ongoing use; AND 2) Member has experienced considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
11144063	AMANDEEP KAUR MD	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS -	N52.9 - Male erectile dysfunction,	Plan Exclusion	This request cannot be approved because your plan has chosen this drug to be excluded from coverage. Other drugs for your health issue may be covered by your plan. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this drug from coverage.		

11149640	RAYMOND EMILE BIETRY III MD	Internal Medicine	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	elevated lipids	Criteria Not Met	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show that you have a health issue called Clinical Atherosclerotic Cardiovascular Disease (ASCVD). ASCVD is a health issue where cholesterol build-up impacts blood flow from the heart. Records must be sent in showing you meet one of these: (a) acute coronary syndromes (ACS), (b) previous heart attack, (c) ongoing chest pain (angina), (d) previous coronary or other arterial revascularization, (e) previous stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin. 2) Records were not sent to us that show your low density lipoprotein (LDL) level did not go below 95mg/dL while taking a strong dose of a statin drug. 3) Records were not sent to us that show your low density lipoprotein (LDL) level did not go below 70mg/dL while taking ezetimibe (Zetia equiv) with a strong dose of a statin drug. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Repatha have not been met. From the information we have received, the member does not meet number(s) 1 and 4 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to meet their Low-density lipoprotein (LDL) goal. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD), defined by at least one (1) of the following: (a) acute coronary syndromes (ACS), (b) history of myocardial infarction (MI), (c) ongoing angina (stable or unstable), (d) prior coronary or other arterial revascularization, (e) prior stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to meet low-density lipoprotein (LDL) goal; AND 3) Member has failed a minimum 8-week trial of one (1) of the following high-intensity statin therapies: (a) atorvastatin (dose of 40 mg per day or greater); OR (b) rosuvastatin (dose of 20mg per day or greater); AND 4) Member meets one (1) of the following: (a) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on high-intensity statin therapy; OR (b) LDL level remains greater than or equal to 70 mg/dL while on high-intensity statin therapy in combination with ezetimibe. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11158159	STEVEN CURTIS CROW MD	Family Practice	VIRAMUNE XR	ANTIVIRALS	B20 - Human immunodeficiency virus [HIV] disease	Criteria Not Met	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, VIRAMUNE XR TAB 400MG was denied for these reasons: 1) Nevirapine has not been tried and failed.. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs
11173700	WAIS ALEMI MD	Family Practice	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J44.9	Criteria Not Met	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11186574	DAVID CABELL GRAY MD	Family Practice	OXYCODONE HCL ER	ANALGESICS - OPIOID	G83.4 - Cauda equina syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended-release (ER) tablet (MS Contin equivalent), Xtampza ER capsule, Nucynta ER tablet, hydrocodone ER tablet (Hysingla equivalent) or hydrocodone ER capsule (Zohydro equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent), fentanyl patch (Duragesic equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11242448	DEVON JACK BRANVOLD MD	Internal Medicine	ACCU-CHEK GUIDE ME	MEDICAL DEVICES	None	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) We did not receive records from your doctor showing what health issue this drug is being used to treat. We tried to reach your doctor for those records. We did not get a reply. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are FreeStyle, Accu-Check (Aviva Plus, Guide Care and Nano), and Precision Xtra. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11268203	JUNE RUKMI CHATTERJEE MD	Internal Medicine	STELARA	TARGETED IMMUNOMODULATORS	K50.10	Criteria Not Met	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) This drug was not prescribed by a Gastroenterology Specialist. This is a doctor that works with health problems in the digestive system. 2) Records do not show a diagnosis of moderate to severe Crohn's Disease. This is a health issue that affects your digestive system. 3) Records do not show you have tried and failed corticosteroids, azathioprine, methotrexate, or 6-mercaptopurine. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ustekinumab (STELARA) have not been met. From the information we have received, the member does not meet number(s) 1, 2 and 3 of our prior authorization criteria for Stelara for Crohn's Disease. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has a diagnosis of moderately to severely active Crohn's Disease (CD); AND 3) Member had an inadequate response to immunosuppressants such as corticosteroids, azathioprine, methotrexate, or 6-mercaptopurine. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11295441	JOHN WEEMS MD	Internal Medicine	LYRICA	ANTICONVULSANTS	M79.606 - Pain in leg, unspecified	Not Covered	The requested amount of Lyrica is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Lyrica at 3 capsules per day for this use. The prescribed dose is 4 capsules per day. This drug comes in a 300mg strength. The same dose can be reached by taking one (1) 300mg capsule twice daily. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.
11309359	ADAM DAVIS HART MD	Ophthalmology	CYCLOSPORINE	OPHTHALMIC AGENTS	M35.01 - Sjogren syndrome with keratoconjunctivitis	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Restasis (Restricted to Ophthalmology or Optometry). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11310046	DEVIKA MARANGATTU MADHAVAN	Endocrinology, Diabetes & Metabolism	SOLIQUA 100/33	ANTIDIABETICS	E11.65 - Type 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for insulin glargine/lixisenatide (SOLIQUA) have not been met. From the records that we have received, Soliqua was denied for these reasons: 1) Records do not show current use of a long-acting (basal) insulin together with a type of diabetes drug called a glucagon-like peptide-1 (GLP-1) receptor agonist. Examples of basal insulins are Lantus, Levemir, Basaglar, Toujeo, Tresiba and others. Not all of these may be covered by your plan. Examples of GLP-1 agonists are Bydureon, Ozempic, Trulicity, Victoza, Byetta, and others. These drugs have limits on the quantity covered at a time and may not all be covered by your plan. 2) Records do not show you cannot get an A1c test result less than or equal to 7 after 3 months of using an appropriate dose of a type of diabetes drug called a glucoagon-like peptide-1 (GLP-1) receptor agonist. An A1c test is a blood test to see how well blood sugar has been controlled over the past few months. A result less than 7 usually means good blood sugar control. Examples of GLP-1 agonists are Bydureon, Ozempic, Trulicity, Victoza, Byetta, and others. These drugs have limits on the quantity covered at a time and may not all be covered by your plan. 3) Records do not show you cannot get an A1c test result less than or equal to 7 after 3 months of using at least 30 units a day of a long-acting (basal) insulin. An A1c is a blood test to see how well blood sugar has been controlled over the past few months. A result less than 7 usually means good blood sugar control. Examples of basal insulins are Lantus, Levemir, Basaglar, Toujeo, Tresiba and others. Not all of these may be covered by your plan. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for insulin glargine/lixisenatide (SOLIQUA) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Soliqua. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus; AND 2) Member meets ONE (1) of the following: a) Member is currently using a basal insulin in combination with a glucagon-like peptide-1 (GLP-1) receptor agonist; OR b) Member is unable to achieve a glycated hemoglobin (A1c) less than or equal to 7.0 after 3 months of treatment with a maximally dosed GLP-1 receptor agonist; OR c) Member is unable to achieve an A1c less than or equal to 7.0 after 3 months of treatment with a basal insulin greater than or equal to 30 units per day. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11314217	BRANDON MICHAEL PARKER MD	Internal Medicine	INVOKANA	ANTIDIABETICS	E11.51 - Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	Criteria Not Met	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Jardiance, Synjardy, or Glyxambi has not been tried and failed. Quantity limits may apply. 2) Farxiga or Xigduo/Xigduo XR has not been tried and failed. Quantity limits may apply. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Invokana have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Invokana tablets. The reason for denial is explained to the member above. The criteria are listed here. 1) Failure of empagliflozin (Jardiance, Synjardy, or Glyxambi); AND 2) Failure of dapagliflozin (Farxiga or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.
11317002	JACQUELINE MARIE KERR MD	Family Practice	FREESTYLE LIBRE 2/SENSOR/	MEDICAL DEVICES	E11.65	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of Freestyle Libre 2. 1) Records do not show that you are using insulin. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Freestyle Libre 2 (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (A) Member has demonstrated hypoglycemia unawareness; OR (B) Undetected hypoglycemia poses an occupational safety risk; OR (C) Member has suboptimal diabetes control and meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (CGM) use based upon a professional CGM trial; OR (E) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) Member will be instructed in use of the CGM products; AND 5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND 6) Provider believes that CGM use may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND 7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11333099	RABIN KHERADPOU	Internal Medicine	WEGOVY	ADHD/ANTI-NARCOLEPSY	Z68.38 - Body mass	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
11348459	SONIA YOUSUF III MD	Rheumatology	ORENCIA CLICKJECT	TARGETED IMMUNOMODULATORS	M05.79 - Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems invo	Criteria Not Met	Our prior authorization criteria for subcutaneous abatacept (ORENCIA SC) have not been met. From the records that we have received, Orencia was denied for these reasons: 1) You have not tried and failed two (2) of these: Enbrel, Humira (tried), Rinvoq, Xeljanz, OR Humira (tried) and Actemra. Prior authorization may be required. Quantity limits may apply. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for subcutaneous abatacept (ORENCIA SC) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Orencia for Rheumatoid Arthritis. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of rheumatoid arthritis (RA); AND 3) A trial of TWO (2) of the following was ineffective, not tolerated or ALL untried alternatives are contraindicated: (A) etanercept (ENBREL), (B) adalimumab (HUMIRA), (C) upadacitinib (RINVOQ), (D) tofacitinib (XELJANZ/XELJANZ XR); (E) tocilizumab (ACTEMRA) AND adalimumab (HUMIRA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs
11351677	MANSI PATEL	Nurse Practitioner	HUMALOG KWIKPEN	ANTIDIABETICS	E11.65 - Type 2 diabetes mellitus with hyperglycemia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Novolog, Insulin aspart, Fiasp, Apidra/insulin lispro (Step Therapy requires trial of Novolog or insulin aspart). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11388786	LAURELIN NICOLE MULLINS APN	Nurse Practitioner	VITAMIN D3	VITAMINS	E55.9 - Vitamin D deficiency, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include vitamin D 500 IU capsules. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.
11411829	VEENA AJIT PATEL	Rheumatology	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	SLE	Criteria Not Met	Our prior authorization criteria for Benlysta have not been met. From the records that we have received, the following caused the denial of Benlysta. 1) Daily use of corticosteroids are not needed. 2) Two of these have not been tried and failed: azathioprine, hydroxychloroquine(tried), methotrexate, mycophenolate mofetil. 3)More information is needed to know if you have a diagnosis of severe active central nervous system (CNS) Lupus. 4)More information is needed to know if Benlysta will be taken together with other biologics drugs. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Benlysta have not been met. From the information we have received, the member does not meet number 4, 5, 6, and 7 of our prior authorization criteria for Benlysta (initial coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of active, autoantibody-positive, systemic lupus erythematosus who is receiving standard therapy; AND 2) Prescribed by, or in consultation with, a Rheumatologist or Dermatologist; AND 3) Member meets ONE (1) of the following (Documentation required): Anti-double stranded DNA (anti-dsDNA) positive OR low complement (C3/C4 proteins); AND 4) Member requires daily use of corticosteroids, unless contraindicated, not tolerated, or previously ineffective; AND 5) TWO (2) of the following are ineffective, contraindicated or not tolerated: azathioprine, hydroxychloroquine, methotrexate, mycophenolate mofetil; AND 6) Member does NOT have severe active central nervous system (CNS) Lupus; AND 7) Benlysta will NOT be given in combination with other biologics. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11517438	RAYMOND EMILE BIETRY III	Internal Medicine	ENTRESTO	CARDIOVASCULAR AGENTS -	I50.9 - Heart failure, unspecified	Not Covered	The requested amount of Entresto 49-51mg tablet is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Entresto 49-51mg at 2 tablets per day for this use. The prescribed dose is two (2) Entresto 49-51mg tablets 2 times daily. This drug comes in a 97-103mg tablet. The same dose can be reached by taking one (1) Entresto 97-103mg tablet 2 times daily. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.
11521911	AMY ROMINGER MASON MD	Dermatology	DUPIXENT	DERMATOLOGICALS	L20.9 - Atopic dermatitis, unspecified	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records showing the minimum disease severity score for coverage have not been received. Accepted scores are: Scoring of Atopic Dermatitis (SCORAD) index with score greater than 40, OR Eczema Area Severity Index (EASI) with score greater than 21, OR documentation of continued disease severity and impaired activities of daily living on most successful treatment regimen. 2) A medium to very high potency topical steroid, such as betamethasone or halobetasol cream, has not been tried and failed. 3) A topical calcineurin inhibitor, such as tacrolimus ointment, has not been tried and failed. 4) Light therapy or an immunosuppressant, such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil, has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number 4, 5, and 6 of our prior authorization criteria for Dupixent for the treatment of Atopic Dermatitis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic, severe atopic dermatitis (eczema) at baseline with greater than or equal to 10% body surface area (BSA) affected OR BSA affected is less than 10%, but member has involvement of sensitive areas (documentation required); AND 4) Level of severity documented via ONE of the following: SCORAD score greater than 40, OR Eczema Area and Severity Index (EASI) score greater than 21, OR submission of supporting documentation of continued disease severity and impaired activities of daily living while on most successful treatment regimen (documentation required); AND 5) A medium to very high potency topical steroid AND topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required); AND 6) Member has tried Narrow Band UVB Phototherapy OR an Immunosuppressant such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil (documentation required). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to
11536093	KALEB MICHAEL	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR	Male erectile dysfunction,	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction (ED). Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

11550805	STEVEN CURTIS CROW MD	Family Practice	INVOKANA	ANTIDIABETICS	E11.65 - Type 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Jardiance, Synjardy, or Glyxambi has not been tried and failed. Quantity limits may apply. 2) Farxiga or Xigduo/Xigduo XR has not been tried and failed. Quantity limits may apply. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Invokana have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Invokana tablets. The reason for denial is explained to the member above. The criteria are listed here. 1) Failure of empagliflozin (Jardiance, Synjardy, or Glyxambi); AND 2) Failure of dapagliflozin (Farxiga or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time
11562710	AMY ROMINGER MASON MD	Dermatology	DUPIXENT	DERMATOLOGICALS	L20.9 - Atopic dermatitis, unspecified	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records showing the minimum disease severity score for coverage have not been received. Accepted scores are: Scoring of Atopic Dermatitis (SCORAD) index with score greater than 40, OR Eczema Area Severity Index (EASI) with score greater than 21, OR documentation of continued disease severity and impaired activities of daily living on most successful treatment regimen. 2) A medium to very high potency topical steroid, such as betamethasone or halobetasol cream, has not been tried and failed. 3) A topical calcineurin inhibitor, such as tacrolimus ointment, has not been tried and failed. 4) Light therapy or an immunosuppressant, such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil, has not been tried and failed. 5) Records show that you may not be able to use light therapy, azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil, but more information is needed to show why these treatments are not right for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number 4, 5, and 6 of our prior authorization criteria for Dupixent for the treatment of Atopic Dermatitis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic, severe atopic dermatitis (eczema) at baseline with greater than or equal to 10% body surface area (BSA) affected OR BSA affected is less than 10%, but member has involvement of sensitive areas (documentation required); AND 4) Level of severity documented via ONE of the following: SCORAD score greater than 40, OR Eczema Area and Severity Index (EASI) score greater than 21, OR submission of supporting documentation of continued disease severity and impaired activities of daily living while on most successful treatment regimen (documentation required); AND 5) A medium to very high potency topical steroid AND a topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required); AND 6) Member has tried Narrow Band UVB Phototherapy OR an Immunosuppressant such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil (documentation required). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11569506	DARUSH RAHMANI DO	General Practice	METHOTREXATE	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	M05.79 - Rheumatoid arthritis with rheumatoid	Not Covered	The requested amount of methotrexate 2.5mg tablet is more than 2.5 times the recommended highest daily dose for the drug. We will still cover up to 8 tablets per 7 days (or 32 tablets every 4 weeks) for this use. The higher dose of 56 tablets per 7 days is not an approved dose for your health issue. In order for the higher amount per day to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
11588627	JILL ELIZABETH HUDE PA-C	Physician Assistant	TALTZ	TARGETED IMMUNOMODULATORS	PP	Criteria Not Met	Our prior authorization criteria for ixekizumab (TALTZ) have not been met. From the records that we have received, Taltz was denied for these reasons: 1) Records did not show that 10 percent (or more) of your Body Surface Area (BSA) is affected by your health issue. 2) Records did not show that your health issue is causing significant functional disability for you. More information is needed to show how your health issue is impacting you. 3) Records did not show that you have palmoplantar psoriasis. This is a health issue where skin cells build up and form itchy, dry patches and scales on your palms of the hands and the soles of the feet. 4) At least one (1) of the following treatments has not been tried and failed: (A) 15 sessions of light therapy, OR (B) methotrexate 15mg per week, OR (C) acitretin. 5) Chart notes about your health condition were not sent to us to show disease severity, percentage of body surface area involvement and previous treatment. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ixekizumab (TALTZ) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria for Taltz for Plaque Psoriasis (Initial Coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11601630	DARUSH RAHMANI DO	General Practice	TERIPARATIDE	ENDOCRINE AND METABOLIC AGENTS - MISC.	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF MULTIPLE SITES WITHOUT ORGAN OR SYSTEMS INVOLVEMENT	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Tymlos, Forteo, raloxifene and oral bisphosphonates (i.e. alendronate tablets, risedronate tablets, ibandronate tablets)-(may not be appropriate). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11615227	JILL ELIZABETH HUDE PA-C	Physician Assistant	TALTZ	TARGETED IMMUNOMODULATORS	PP	Criteria Not Met	Our prior authorization criteria for ixekizumab (TALTZ) have not been met. From the records that we have received, Taltz was denied for these reasons: 1) At least one (1) of the following treatments has not been tried and failed: (A) 15 sessions of light therapy, OR (B) methotrexate 15mg per week, OR (C) acitretin. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ixekizumab (TALTZ) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Taltz for Plaque Psoriasis (Initial Coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11618622	RAMESH M SINGA MD	Pain Medicine	BELBUCA	ANALGESICS - OPIOID	G89.4 - Chronic pain syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent) (TRIED), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11663559	BILAL NAWAZ KHAN MD	Internal Medicine	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J47.9	Criteria Not Met	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) The drug is not being used for Chronic Obstructive Pulmonary Disease (COPD). 2) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11668292	PRAKASH SAMUEL EAPEN MD	Internal Medicine	TRAMADOL HCL	ANALGESICS - OPIOID	L40.50 - Arthropathic psoriasis, unspecified	Not Covered	We have received a request for 90 tablets for a 30 day supply for tramadol 50mg. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a 7 days for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. For members who do not show recent use of an opioid pain reliever, more than a 7 day supply for this first fill can be approved if records are sent in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.
11694275	JOSEPH EDWARD GARCIA MD	Surgery, General	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K55.1 - Chronic vascular disorders of intestine	Criteria Not Met	Our prior authorization criteria for Motegrity have not been met. From the records that we have received, the following caused the denial of Motegrity. 1) The drug is not being used for chronic idiopathic constipation (CIC) in an adult. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Motegrity have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Motegrity. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of chronic idiopathic constipation (CIC) in an adult; AND 2) A trial of Trulance was ineffective, contraindicated, or not tolerated; AND 3) Member is NOT currently using opioids. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11707439	ASHLEY MICHELLE LEON	Nurse Practitioner	DRONABINOL	ANTIEMETICS	R63.0 - Anorexia	Criteria Not Met	Our prior authorization criteria for dronabinol (MARINOL) have not been met. From the records that we have received, dronabinol was denied for these reasons: 1) The drug is not being used to treat anorexia or loss of appetite in a person with acquired immune deficiency syndrome (AIDS) who has lost weight. 2) The drug is not being used for nausea and vomiting related to cancer treatments. 3) Records did not show you have tried and failed at least one other drug for nausea and vomiting related to cancer treatments. Records showing the other drug you tried were not received. Other drugs we cover that can help with nausea and vomiting are lorazepam, meclizine, promethazine, prochlorperazine, metoclopramide, trimethobenzamide, ondansetron, granisetron, and aprepitant. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dronabinol (MARINOL) have not been met. From the information we have received, the member does not meet number 1, 2 of our prior authorization criteria for dronabinol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of anorexia associated with weight loss in patients with acquired immune deficiency syndrome (AIDS); OR 2) Prescribed for nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments. Please list at least one antiemetic tried and the doses and dates of the trial. (Documentation is required for approval.) Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11713661	KEVIN VICTOR HACKSHAW MD	Rheumatology	HYDROCORTISONE VALERATE	DERMATOLOGICALS	M79.7 - Fibromyalgia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for fibromyalgia and rheumatoid arthritis. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other topical steroids that can be used are betamethasone dipropionate, fluocinolone ointment, fluticasone cream, mometasone cream, triamcinolone cream/ointment and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11717539	JOSEPH EDWARD GARCIA MD	Surgery, General	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.04 - Chronic idiopathic constipation	Criteria Not Met	Our prior authorization criteria for Motegrity have not been met. From the records that we have received, the following caused the denial of Motegrity. 1) Trulance has not been tried and failed. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Motegrity have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Motegrity. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of chronic idiopathic constipation (CIC) in an adult; AND 2) A trial of Trulance was ineffective, contraindicated, or not tolerated; AND 3) Member is NOT currently using opioids. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11719833	CHARLENE THERESA CONDOLL NP-C	Nurse Practitioner	INVOKANA	ANTIDIABETICS	E11.65 - Type 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Jardiance, Synjardy, or Glyxambi has not been tried and failed. Quantity limits may apply. 2) Farxiga or Xigduo/Xigduo XR has not been tried and failed. Quantity limits may apply. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Invokana have not been met. From the information we have received, the member does not meet number 1, 2 of our prior authorization criteria for Invokana tablets. The reason for denial is explained to the member above. The criteria are listed here. 1) Failure of empagliflozin (Jardiance, Synjardy, or Glyxambi); AND 2) Failure of dapagliflozin (Farxiga or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.
11727487	SHAHBAZ ASIF MALIK MD	Internal Medicine	PREVYMIS	ANTIVIRALS	CMV reactivation prevention	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Prevymis exception policy have not been met. From the records that we have received, the following caused the denial. 1) Records do not show that an allogeneic hematopoietic stem cell transplant has been received or will be received within 30 days before starting this drug. 2) Records sent to us did not show there are high risk characteristics of developing Cytomegalovirus (CMV) disease after transplant. Please look at the formulary for a list of covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 4, 5 of the Prevymis exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Prescribed by, or in consultation with, a hematologist, oncologist, transplant, or infectious disease physician; AND 2) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 3) Member is cytomegalovirus (CMV)-seropositive; AND 4) Member has received or will receive an allogeneic hematopoietic stem cell transplant within 30 days prior to initiation of Prevymis; AND 5) Member has one of the following high-risk characteristics: cord blood transplant recipient OR prior alemtuzumab therapy OR T-cell depleted allograft OR related donor has greater than or equal to 1 HLA mismatch at HLA-A, -B, or -DR locus OR unrelated donor has greater than or equal to 1 HLA mismatch at HLA-A, -B, -C, or -DRB1 locus OR haploidentical donor OR member has graft-versus-host disease (GVHD) (grade greater than or equal to 2) requiring prednisone greater than or equal to 1 milligram per kilogram per day or equivalent; AND 6) Length of prescribed therapy is less than or equal to 100 days. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11727541	SHAHBAZ ASIF MALIK MD	Internal Medicine	PREVYMIS	ANTIVIRALS	CMV reactivation prevention	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Prevymis exception policy have not been met. From the records that we have received, the following caused the denial. 1) Records do not show that an allogeneic hematopoietic stem cell transplant has been received or will be received within 30 days before starting this drug. 2) Records sent to us did not show there are high risk characteristics of developing Cytomegalovirus (CMV) disease after transplant. Please look at the formulary for a list of covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 4, 5 of the Prevymis exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Prescribed by, or in consultation with, a hematologist, oncologist, transplant, or infectious disease physician; AND 2) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 3) Member is cytomegalovirus (CMV)-seropositive; AND 4) Member has received or will receive an allogeneic hematopoietic stem cell transplant within 30 days prior to initiation of Prevymis; AND 5) Member has one of the following high-risk characteristics: cord blood transplant recipient OR prior alemtuzumab therapy OR T-cell depleted allograft OR related donor has greater than or equal to 1 HLA mismatch at HLA-A, -B, or -DR locus OR unrelated donor has greater than or equal to 1 HLA mismatch at HLA-A, -B, -C, or -DRB1 locus OR haploidentical donor OR member has graft-versus-host disease (GVHD) (grade greater than or equal to 2) requiring prednisone greater than or equal to 1 milligram per kilogram per day or equivalent; AND 6) Length of prescribed therapy is less than or equal to 100 days. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11767459	LIGIOLA TERESA ARANAGA SANCHEZ	Advanced Practice Nurse	FYCOMPA	ANTICONVULSANTS	G40.219 - Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with c	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topiramate (TRIED) and lacosamide. Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11779809	LIGIOLA TERESA ARANAGA SANCHEZ	Advanced Practice Nurse	FYCOMPA	ANTICONVULSANTS	G40.219	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topiramate (tried) and lacosamide. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11849195	RABIN KHERADPOUR MD	Internal Medicine	CAPSAICIN HOT PATCH	DERMATOLOGICALS	N/A	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) We did not receive records from your doctor showing what health issue this drug is being used to treat. We tried to reach your doctor for those records. We did not get a reply. 2) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11852336	EMMANUEL JOHN LEE MD	Family Practice	ZYVOX	ANTI-INFECTIVE AGENTS - MISC.	L03.119 - Cellulitis of unspecified part of limb	Criteria Not Met	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, ZYVOX was denied for this reason: 1) The drug is not prescribed by a Infectious Disease Specialist. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted to Specialist prior authorization criteria have not been met. From the information we have received, the member does not meet 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The provider's specialty matches the Restricted Specialty requirements per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs
11874433	SUSAN KATHLEEN	Endocrinology, Diabetes &	SILDENAFIL CITRATE	CARDIOVASCULAR	N52.9 - Male erectile	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction (ED). Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
11890725	SAMI N ADIB MD	-	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are proctosol-HC cream (Anusol-HC equivalent), pramoxine/hydrocortisone cream kit (Analpram-HC equivalent), lidocaind/hydrocortisone cream (Anamantle equivalent), and Proctofoam-HC. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11922255	CHRISTOPHER JAY GARRISON	Physical Medicine & Rehabilitation	ENEMEEZ MINI	LAXATIVES	K59.2 - Neurogenic bowel, not	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include Enemeez Mini enema, docusate, stimulant laxatives (e.g. bisacodyl, sennosides), PEG-3350 (e.g. Miralax-TRIED), and other OTC laxative products. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.

11959941	MARY EVELYN SCHUWERK MPH	Physician Assistant	BELBUCA	ANALGESICS - OPIOID	M35.00	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended-release (ER) tablet, oxycodone ER tablet, Xtampza ER, Nucynta ER, hydrocodone ER tablet (Hysingla equivalent) or hydrocodone ER capsule (Zohydro equivalent), tramadol ER tablet, buprenorphine patch (TRIED), fentanyl patch (Duragesic equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11980886	KATHRYN CHRISTEN SIEMS PA	Physician Assistant	JUBLIA	DERMATOLOGICALS	L60.8 - Other nail disorders	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ciclopirox topical solution (Penlac equivalent), terbinafine tablet, itraconazole capsule, griseofulvin. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11988060	CHARLENE THERESA CONDOLL NP-C	Nurse Practitioner	INVOKANA	ANTIDIABETICS	E11.65 - Type 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Jardiance, Synjardy, or Glyxambi has not been tried and failed. Quantity limits may apply. 2) Farxiga or Xigduo/Xigduo XR has not been tried and failed. Quantity limits may apply. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Invokana have not been met. From the information we have received, the member does not meet number 1, 2 of our prior authorization criteria for Invokana tablets. The reason for denial is explained to the member above. The criteria are listed here. 1) Failure of empagliflozin (Jardiance, Synjardy, or Glyxambi); AND 2) Failure of dapagliflozin (Farxiga or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.
11988218	AMANDEEP KAUR MD	Family Practice	TRUE METRIX AIR BLOOD GLU	MEDICAL DEVICES	E11.9 - Type 2 diabetes mellitus without complications	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Accu-Chek test strips and Onetouch test strips. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11988257	AMANDEEP KAUR MD	Family Practice	TRUE METRIX BLOOD GLUCOSE	DIAGNOSTIC PRODUCTS	E11.9 - Type 2 diabetes mellitus without complications	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Accu-Check and One Touch test strips. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

<table>
<tr><td>11988590</td><td>MICHELLE LE MARKLEY MD</td><td>Family Practice</td><td>OLOPATADINE HCL</td><td>OPHTHALMIC AGENTS</td><td>J30.2 - Other seasonal allergic rhinitis</td><td>Not Covered</td><td>This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are covered NDCs of olopatadine 0.1% eye drops. These are 00536130840, 17478030805, 43598076507, 58602000640. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
4) Prescription drug samples were not used to establish treatment.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.</td></tr>
<tr><td>12057620</td><td>CARSON PAUL HIGGS MD</td><td>Family Practice</td><td>FREESTYLE LIBRE 2/SENSOR/</td><td>MEDICAL DEVICES</td><td>DM2</td><td>Criteria Not Met</td><td>Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of FREESTYLE LIBRE 2.
1) Records do not show you are under the care of a Diabetes care expert.
Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for FREESTYLE LIBRE 2 (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here.
1) Member with Type 1 or Type 2 Diabetes using insulin; AND
2) Member meets one of the following: (A) Member has demonstrated hypoglycemia unawareness; OR (B) Undetected hypoglycemia poses an occupational safety risk; OR (C) Member has suboptimal diabetes control and meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (CGM) use based upon a professional CGM trial; OR (E) Member is pregnant; AND
3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND
4) Member will be instructed in use of the CGM products; AND
5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND
6) Provider believes that CGM use may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND
7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.</td></tr>
<tr><td>12068564</td><td>CARSON PAUL HIGGS MD</td><td>Family Practice</td><td>FREESTYLE LIBRE 2/SENSOR/</td><td>MEDICAL DEVICES</td><td>DM2</td><td>Criteria Not Met</td><td>Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of FREESTY LIBR KIT 2 SENSOR.
1) Records do not show you are under the care of a Diabetes care expert.
Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for FREESTY LIBR KIT 2 SENSOR (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here.
1) Member with Type 1 or Type 2 Diabetes using insulin; AND
2) Member meets one of the following: (A) Member has demonstrated hypoglycemia unawareness; OR (B) Undetected hypoglycemia poses an occupational safety risk; OR (C) Member has suboptimal diabetes control and meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (CGM) use based upon a professional CGM trial; OR (E) Member is pregnant; AND
3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND
4) Member will be instructed in use of the CGM products; AND
5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND
6) Provider believes that CGM use may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND
7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.</td></tr>
<tr><td>12121290</td><td>DIANA MP STOUT FNP</td><td>Nurse Practitioner</td><td>ANDRODERM</td><td>ANDROGENS-ANABOLIC</td><td>R79.89 - Other specified abnormal findings of blood chemistry</td><td>Criteria Not Met</td><td>Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Androderm patch was denied for these reasons:
1) The drug is not being used for primary or secondary hypogonadism. This is a condition in which the body does not make enough testosterone.
2) More information is needed to know if your low levels of testosterone are age-related.
Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here.
1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND
2) Member has been established on testosterone replacement therapy; AND
3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs</td></tr>
<tr><td>12172235</td><td>AMMAR MOIN AHMED MD</td><td>Adolescent Medicine</td><td>DOXEPIN HYDROCHLORIDE</td><td>DERMATOLOGICALS</td><td>G54.8 - Other nerve root and plexus disorders</td><td>Criteria Not Met</td><td>Our prior authorization criteria for doxepin cream have not been met. From the records that we have received, the following caused the denial of doxepin cream.
1) The drug is not being used for short-term (up to 8 days) treatment of atopic dermatitis or lichen simplex. These are conditions that cause itching of the skin.
Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for doxepin cream have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for doxepin cream. The reason for denial is explained to the member above. The criteria are listed here.
1) Prescribed for the short-term management (up to 8 days) of moderate pruritis in an adult with atopic dermatitis or lichen simplex chronicus.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.</td></tr>
</table>

12181816	VARSHA SURESH BILOLIKAR MD	Family Practice	RESTASIS	OPHTHALMIC AGENTS	H04.123	Criteria Not Met	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, Restasis was denied for this reason: 1) The drug is not prescribed by an Ophthalmology or Optometry Specialist. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted to Specialist prior authorization criteria have not been met. From the information we have received, the member does not meet 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The provider's specialty matches the Restricted Specialty requirements per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs
12250229	BRETT WILLIAM	Urology	SILDENAFIL CITRATE	CARDIOVASCULAR	N52.01 - Erectile	Plan Exclusion	This request cannot be approved because this drug is being used for Erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
12251406	MARIA GABRIELLA PRUDHOMME NP	Nurse Practitioner	DUPIXENT	DERMATOLOGICALS	L20.89 - Other atopic dermatitis	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) The drug is not being used for chronic severe atopic dermatitis (eczema). 2) Records showing the minimum disease severity score for coverage have not been received. Accepted scores are: Scoring of Atopic Dermatitis (SCORAD) index with score greater than 40, OR Eczema Area Severity Index (EASI) with score greater than 21, OR documentation of continued disease severity and impaired activities of daily living on most successful treatment regimen. 3) A topical calcineurin inhibitor, such as tacrolimus ointment, has not been tried and failed. 4) An immunosuppressant, such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil, has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number 3, 4, 5, 6 of our prior authorization criteria for Dupixent for the treatment of Atopic Dermatitis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic, severe atopic dermatitis (eczema) at baseline with greater than or equal to 10% body surface area (BSA) affected OR BSA affected is less than 10%, but member has involvement of sensitive areas (documentation required); AND 4) Level of severity documented via ONE of the following: SCORAD score greater than 40, OR Eczema Area and Severity Index (EASI) score greater than 21, OR submission of supporting documentation of continued disease severity and impaired activities of daily living while on most successful treatment regimen (documentation required); AND 5) A medium to very high potency topical steroid AND a topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required); AND 6) Member has tried Narrow Band UVB Phototherapy OR an Immunosuppressant such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil (documentation required); AND 7) Dupixent will NOT be used in combination with another targeted immunomodulator product. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to
12254356	GRAHAM MILLER BLOCK	Internal Medicine	OXYCONTIN	ANALGESICS - OPIOID	D70.1 - Agranulocytosis secondary to cancer chemotherapy	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent-TRIED), Xtampza ER (TRIED), oxycodone ER (TRIED), fentanyl patch (Duragesic equivalent-TRIED), Nucynta ER (tapentadol ER-TRIED), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent-TRIED), tramadol ER tablet (Ultram ER equivalent-TRIED), buprenorphine patch (Butrans equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12354922	LISA MICHELE	Nurse Practitioner	WEGOVY	ADHD/ANTI-NARCOLEPSY	E66.9 - Obesity,	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
12414898	ANUPAMA MADABHUSHI KAPADIA MD	Internal Medicine	INVOKANA	ANTIDIABETICS	E11.9	Criteria Not Met	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Jardiance, Synjardy, or Glyxambi has not been tried and failed. Quantity limits may apply. 2) Farxiga or Xigduo/Xigduo XR has not been tried and failed. Quantity limits may apply. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Invokana have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Invokana tablets. The reason for denial is explained to the member above. The criteria are listed here. 1) Failure of empagliflozin (Jardiance, Synjardy, or Glyxambi); AND 2) Failure of dapagliflozin (Farxiga or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.
12426924	PRAVEEN KUMAR SAMPATH MD	Gastroenterology	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.09 - Other constipation	Criteria Not Met	Our prior authorization criteria for Linzess have not been met. From the records that we have received, the following caused the denial of Linzess. 1) The drug is not prescribed to treat Chronic Idiopathic Constipation (CIC) OR Irritable Bowel Syndrome with Constipation (IBS-C). Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Linzess have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of an adult with ONE (1) of the following: Chronic Idiopathic Constipation (CIC) OR Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A one-month trial (minimum) of ONE (1) of the following was ineffective, contraindicated, or not tolerated: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

12428034	RYAN STEVEN GOLDSTEIN	Internal Medicine	NITAZOXANIDE	ANTI-INFECTIVE AGENTS - MISC.	A04.8 - Other specified bacterial intestinal infections	Criteria Not Met	Our prior authorization criteria for nitazoxanide (Alinia) have not been met. From the records that we have received, the following caused the denial of Alinia. 1) Alinia was not prescribed for Giardiasis. Giardiasis is an infection in the intestines caused by the giardia parasite that causes diarrhea and upset stomach. 2) Alinia was not prescribed for Cryptosporidiosis. Cryptosporidiosis is an infection of the intestines caused by the cryptosporidium parasite that causes in diarrhea and upset stomach. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for nitazoxanide (Alinia) have not been met. From the information we have received, the member does not meet number 1 or 2 of our prior authorization criteria for Alinia. The reason for denial is explained to the member above. The criteria are listed here. 1) Alinia is prescribed for the treatment of Cryptosporidiosis; OR 2) Alinia is prescribed for the treatment of Giardiasis; AND 3) Metronidazole OR Tinidazole was ineffective, contraindicated or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12432463	GRIFFIN LOWE FULLER MD	Family Practice	DESCOVY	ANTIVIRALS	Z79.899 - Other long term (current) drug therapy	Criteria Not Met	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your kidneys are not working like normal based on lab tests. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12524075	ROBERT GLENN	Psychiatry	SILDENAFIL CITRATE	CARDIOVASCULAR	ED	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
12529647	RABIN KHERADPOUR MD	Internal Medicine	KERENDIA	ENDOCRINE AND METABOLIC AGENTS - MISC.	DM2	Criteria Not Met	Our prior authorization criteria for finerenone (Kerendia) have not been met. From the records that we have received, Kerendia was denied for these reasons: 1) Records did not show that another drug called Farxiga did not work for you. Records show a recent paid claim for Farxiga 11/18/22. More information is needed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for finerenone (Kerendia) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Kerendia. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of BOTH Type 2 Diabetes AND Chronic Kidney Disease (CKD); AND 2) A trial of dapagliflozin (Farxiga) was not tolerated or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12531062	RABIN KHERADPOUR MD	Internal Medicine	KERENDIA	ENDOCRINE AND METABOLIC AGENTS - MISC.	e11.8	Criteria Not Met	Our prior authorization criteria for finerenone (Kerendia) have not been met. From the records that we have received, Kerendia was denied for these reasons: 1) Records did not show that you have tried another drug called Farxiga. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for finerenone (Kerendia) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Kerendia. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of BOTH Type 2 Diabetes AND Chronic Kidney Disease (CKD); AND 2) A trial of dapagliflozin (Farxiga) was not tolerated or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12541014	SAGARIKA SATYAVADA	Gastroenterology	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	K59.04	Criteria Not Met	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Trulance has not been tried and failed. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Amitiza have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in a woman 18 years of age or older AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member with chronic, non-cancer pain, including a member with chronic pain related to prior cancer or its treatment who does not require frequent (e.g. weekly) opioid dosage escalation AND A trial of Movantik was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
12561569	KOONJ ASHVIN SHAH MD	Internal Medicine	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	COPD	Criteria Not Met	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records showing this drug is working well have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet 1 of our prior authorization criteria for Dupixent (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 2) Dupixent will NOT be used in combination with omalizumab (Xolair) or other interleukin-5 (IL-5) agents. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12573568	JUAN LUIS RODRIGUEZ RAMOS MD	Allergy & Immunology	DUPIXENT	DERMATOLOGICALS	J45.40	Criteria Not Met	