| 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons:<br>1) Chart notes were not sent to us to show your response to this drug.<br>Please note: Chart notes sent to us were cut off.<br>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. | | |
| 12455912 | JASON SCOTT REICHENBERG MD | Dermatology | SKYRIZI PEN | TARGETED IMMUNOMODULATORS | L40.0 | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval).<br>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. | | |
| 12604917 | DAVID WARREN BROWN MD | Psychiatry | FETZIMA | ANTIDEPRESSANTS | F33.9 - MDD | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are bupropion - TRIED, one serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g. desvenlafaxine extended release (ER) (Pristiq equiv), venlafaxine - TRIED, duloxetine), and two selective serotonin reuptake inhibitors (SSRIs) (e.g. citalopram, escitalopram, fluoxetine, paroxetine, or sertraline).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. | | |
| 12638815 | CODY PAULINE SEEL PA | Physician Assistant | 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.<br>1) Records showing this drug is working well have not been received.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND<br>2) Dupixent will NOT be used in combination with another targeted immunomodulator product.<br>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. | | |
| 12644984 | PAMELA JAYNE HOWARD MD | Neurology | QULIPTA | MIGRAINE PRODUCTS | G43.909 - Migraine, unspecified, not intractable, without status migrainosus | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Aimovig (TRIED), Ajovy, and Emgality.<br>Prior authorization may be required, quantity limits may apply.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. | | |
| 12645250 | PAMELA JAYNE HOWARD MD | Neurology | NURTEC | MIGRAINE PRODUCTS | G43.909 - Migraine, unspecified, not intractable, without status migrainosus | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy (tried). Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 12653176 | AUGUSTIN ROGER BATLLE MD | Internal Medicine | LINZESS | GASTROINTESTINAL AGENTS - MISC. | B96.81 - Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) The drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without any known cause), OR for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation).<br>2) Records did not show that one (1) of the following types of drugs for at least one (1) month did not work for you: stimulant laxatives (bisacodyl, sennosides), PEG 3350 (MIRALAX, GLYCOLAX), or bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). These drugs are available over-the-counter (OTC) without a prescription. Your pharmacy benefit may not cover these OTC drugs.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND<br>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).<br>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. |
| 12660068 | TODD EGAN CRUMP MD | Family Practice | OZEMPIC | ANTIDIABETICS | obesity | Plan Exclusion | This request cannot be approved because this drug is being used for obesity. 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. |
| 12661501 | LAURA ELLEN PURDY MD | Family Practice | MOUNJARO | ANTIDIABETICS | R73.03 - Prediabetes | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNJARO was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 12665896 | DANIEL ANTHONY CARRASCO MD | Dermatology | RINVOQ | TARGETED IMMUNOMODULATORS | atopic dermatitis | Criteria Not Met | Our prior authorization criteria for upadacitinib (Rinvoq) have not been met. From the records that we have received, Rinvoq was denied for these reasons:<br>1) Records did not show a medium to very high potency topical steroid, such as betamethasone or halobetasol cream, did not work for you.<br>2) Records did not show a topical calcineurin inhibitor, such as tacrolimus ointment, did not work for you.<br>3) Records did not show that immunosuppressant drugs, such as azathioprine, cyclosporine, methotrexate, mycophenolate mofetil, or a biologic drug, such as Dupixent, did not work for you. Prior authorization and quantity limits may apply.<br>4) Chart notes showing how much of your body is affected, previous treatments that have been tried, and other details of your health issue were not received.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for upadacitinib (Rinvoq) have not been met. From the information we have received, the member does not meet number(s) 4, 5, and 6 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member is 12 years of age or older; AND<br>2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND<br>3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema) at baseline; AND<br>4) Indicate ONE (1) of the following: (A) Greater than or equal to 10% body surface area (BSA) affected and percent BSA is provided OR BSA affected is less than 10%, but member has involvement of sensitive areas (documentation required to be submitted for an approval); AND<br>5) A medium to very high potency topical steroid AND a topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required to be submitted for an approval); AND<br>6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentation is required to be submitted for an approval); AND<br>7) Rinvoq will NOT be used in combination with another targeted immunomodulator product.<br>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. |
| 12697302 | MANUEL JOSEPH MARTIN MD | Family Practice | TRULICITY | ANTIDIABETICS | obesity | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, TRULICITY INJ 1.5/0.5 was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 12700465 | SHERWIN SHAOYU YEN | Endocrinology, Diabetes & Metabolism | MOUNJARO | ANTIDIABETICS | Z68.44 - Body mass index [BMI] 60.0-69.9, adult | 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. |
| 12708042 | COREY JAY ZELLER MD | Family Practice | MOUNJARO | ANTIDIABETICS | E66.9 - Obesity, unspecified | 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. |
| 12708765 | DANIEL ANTHONY CARRASCO MD | Dermatology | RINVOQ | TARGETED IMMUNOMODULATORS | L20.89 - Other atopic dermatitis | Criteria Not Met | Our prior authorization criteria for upadacitinib (Rinvoq) have not been met. From the records that we have received, Rinvoq was denied for these reasons:<br>1) Records did not show a topical calcineurin inhibitor, such as tacrolimus ointment, did not work for you.<br>2) Records did not show that immunosuppressant drugs, such as azathioprine, cyclosporine, methotrexate, mycophenolate mofetil, or a biologic drug, such as Dupixent, did not work for you. Prior authorization and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for upadacitinib (Rinvoq) have not been met. From the information we have received, the member does not meet number(s) 5 and 6 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member is 12 years of age or older; AND<br>2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND<br>3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema) at baseline; AND<br>4) Indicate ONE (1) of the following: (A) Greater than or equal to 10% body surface area (BSA) affected and percent BSA is provided OR BSA affected is less than 10%, but member has involvement of sensitive areas (documentation required to be submitted for an approval); AND<br>5) A medium to very high potency topical steroid AND a topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required to be submitted for an approval); AND<br>6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentation is required to be submitted for an approval); AND<br>7) Rinvoq will NOT be used in combination with another targeted immunomodulator product.<br>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. |
| 12711564 | CODY PAULINE SEEL PA | Physician Assistant | TRETINOIN | DERMATOLOGICALS | L82.1 - Other seborrheic keratosis | Plan Exclusion | This request cannot be approved because this drug is being used for seborrheic keratosis. 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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are quetiapine OR 2 formulary antipsychotic agents( risperidone, aripiprazole, olanzapine, ziprasidone and others).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. |
| 12712956 | KERRY ALLISON RAMON APN | Nurse Practitioner | VRAYLAR | ANTIPSYCHOTICS/ANTIMANIC AGENTS | bipolar depression | Not Covered | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 12733566 | SHERWIN SHAOYU YEN | Endocrinology, Diabetes & Metabolism | WEGOVY | ANTI-OBESITY/ANOREXIANTS | Z68.32 - Body mass index [BMI] 32.0-32.9, adult | 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. |
| 12738476 | MARC EDWARD ZOOK MD | Family Practice | OZEMPIC | ANTIDIABETICS | Personal history of other diseases of the female genital tract | 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. |
| 12739768 | TRAVIS MICHAEL AVERITT DO | Family Practice | MOUNJARO | ANTIDIABETICS | E66.01 - Morbid (severe) obesity due to excess calories | 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. |
| 12743965 | KRISTY MICHELLE MARKELL PA | Physician Assistant | HYDROCODONE BITARTRATE/AC | ANALGESICS - OPIOID | G89.4 - Chronic pain syndrome | Criteria Not Met | We have received a request for 90 tablets for a 30 day supply for hydrocodone/acetaminophen. 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:<br>1) Records show that you have recent use of an opioid pain reliever; OR<br>2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.<br>Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. |
| 12745999 | LAURA ELLEN PURDY MD | Family Practice | SAXENDA | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | 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. |
| 12761830 | LAURENCE CHU MD | Otolaryngology | DUPIXENT | DERMATOLOGICALS | J33.9 | Criteria Not Met | Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons:<br>1) The drug is not being used for chronic rhinosinusitis with nasal polyposis that has lasted at least 12 weeks.<br>2) Records do not show the diagnosis was confirmed with a computed tomography (CT) scan.<br>3) Oral steroids (e.g. prednisone) have not been tried and failed.<br>4) Records do not show moderate to severe symptoms of nasal congestion, blockage or obstruction (e.g. loss of smell, rhinorrhea, or facial pain).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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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(s) 3, 4, 5, and 7 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member is 18 years of age or older; AND<br>2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Otolaryngologist; AND<br>3) Member has a diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks; AND<br>4) Bilateral nasal polyposis confirmed with sinus computed tomography (CT) scan; AND<br>5) A trial of an oral corticosteroid was ineffective, contraindicated, or not tolerated; AND<br>6) A trial of a nasal corticosteroid spray was ineffective, contraindicated, or not tolerated; AND<br>7) Documentation of moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain) is provided with the request (documentation is required to be submitted).<br>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. |
| 12768539 | MARIA EZIAFA CHIEJINA MD | Internal Medicine | DEXLANSOPRAZOLE | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS | Other gastritis without bleeding | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are esomeprazole cap (NEXIUM equiv), lansoprazole cap (PREVACID equiv), omeprazole DR cap (PRILOSEC equiv), pantoprazole EC tab (PROTONIX equiv), rabeprazole EC tab (ACIPHEX equiv), and others.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 12769440 | CARSON PAUL HIGGS MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.09 | 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. |
| 12775037 | LAURA ELLEN PURDY MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.9 | 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. |
| 12776541 | LAURA ELLEN PURDY MD | Family Practice | RYBELSUS | ANTIDIABETICS | E66.9 | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, Rybelsus tablet was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 12779494 | LETICIA R PEREZ PA | Physician Assistant | DESCOVY | ANTIVIRALS | Z77.21 | Criteria Not Met | Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons:<br>1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada.<br>2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR<br>2) Prescribed for pre-exposure prophylaxis of HIV infection; AND<br>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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).<br>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 |
| 12781932 | ALBERTO GLENDALYZ MD | Geriatric Medicine | RYBELSUS | ANTIDIABETICS | R73.09 | Not Covered | Our Diagnosis Restricted criteria have not been met. From the records that we have received, Rybelsus was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 12793927 | CHRISTOPHER RIDDELL JONES JR MD | Dermatology | COSENTYX SENSOREADY PEN | TARGETED IMMUNOMODULATORS | PSORIASIS VULGARIS | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Enbrel (tried), Humira (tried), Taltz, Tremfya, Cimzia, Otezla, Skyrizi, Stelara (tried).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 12796699 | MICHAEL ANDREW MUSGROVE MD | Psychiatry | ADDERALL XR | ADHD/ANTI-NARCOLEPSY | F90.0-ADHD | 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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) The generic version of this drug, called amphetamine/dextroamphetamine er, has not been tried and failed.<br>2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, Vyvanse.<br>3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.<br>Please look at the formulary to see what drugs are covered.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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, 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The generic form of the drug has been tried and failed; AND<br>2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND<br>3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.<br>Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs. |
| 12799547 | JOHN SANG HEE KIM MD | Family Practice | EMGALITY | MIGRAINE PRODUCTS | migraine | Criteria Not Met | Our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the records that we have received, Emgality 120mg was denied for these reasons:<br>1) Records did not show that you have had at least 4 migraine days per month for the last 3 months or longer.<br>2) Records did not show you have tried and failed (after using for at least 3 months) other drugs from at least ONE of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.).<br>3) More information is needed to know if this drug will be used together with Botox. If Emgality will be used together with Botox, records must also show you have had at least a three (3) month trial of Emgality alone AND a three (3) month trial of Botox alone.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the information we have received, the member does not meet number(s) 2, 3, 4 OR 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the prevention of migraine; AND<br>2) Member has four (4) or more migraine days per month for at least the previous three (3) months; AND<br>3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.); AND<br>4) Emgality will NOT be used concomitantly with onabotulinumtoxinA (BOTOX) injections for chronic migraine; OR<br>5) Emgality will be used concomitantly with onabotulinumtoxinA (BOTOX) injections for chronic migraine AND both of the following are met: (A) Member has failed at least three (3) months of individual therapy with Emgality, AND (B) Member has failed at least three (3) months of individual therapy with onabotulinumtoxinA (BOTOX).<br>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 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 12799726 | HAYS LAVASHIOUS ARNOLD III | Gastroenterology | HUMIRA PEN | TARGETED IMMUNOMODULATORS | K51.90 | Criteria Not Met | Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons:<br>1) Chart notes that were sent to us are over 1 year old. More recent documentation must be sent to us to show your response to this drug.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira for Ulcerative Colitis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Gastroenterology Specialist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval).<br>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. |
| 12805150 | JESUS NAJIB SAHAD MD | Pulmonary Disease | ALBUTEROL SULFATE HFA | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | J45.20-asthma | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are albuterol HFA inhaler (PROAIR, PROVENTIL equiv), VENTOLIN HFA INHALER.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 12810412 | FRANK ANTHONY BETANSKI III MD | Family Practice | OZEMPIC | ANTIDIABETICS | Z68.32 - Body mass index [BMI] 32.0-32.9, adult | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 12811285 | EVETTE CLARETTA KINGCAID MD | Family Practice | MOUNJARO | ANTIDIABETICS | E66.01 | 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. |
| 12819368 | SHWOL-HUO DANNY KIANG DO | Dermatology | OTEZLA | TARGETED IMMUNOMODULATORS | L40.0 - Psoriasis vulgaris | Criteria Not Met | Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons:<br>1) Chart notes were not sent to us to show your response to this drug.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Otezla for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval); AND<br>4) Apremilast (OTEZLA) will not be used in combination with biologic therapy.<br>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. |
| 12822085 | ROSIE AUGUSTIN-WHEELER MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | Z68.35 - Body mass index [BMI] 35.0-35.9, adult | 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. |
| 12822865 | MARGARET ELIZABETH BROWN MD | Dermatology | TRETINOIN | DERMATOLOGICALS | D23.4 - Other benign neoplasm of skin of scalp and neck | Criteria Not Met | Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin cream 0.025% was denied for these reasons:<br>1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. These are health issues of the skin.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Acne Agents have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for tretinoin cream 0.025%. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of acne vulgaris, acne rosacea, or actinic keratosis.<br>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. |
| 12828272 | CHRISTINE JOY CLAVECILLA RASUL | Nurse Practitioner | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | 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. |
| 12850779 | MARC EDWARD ZOOK MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.09 - Other obesity due to excess calories | 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. |
| 12862217 | JAMES NICHOLAS MCMULLEN PA | Physician Assistant | OZEMPIC | ANTIDIABETICS | E13.69 - Other specified diabetes mellitus with other specified complication | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 12863262 | DIANE LOISE BRINKMAN MD | Obstetrics & Gynecology | ETONOGESTREL/ETHINYL ESTR | CONTRACEPTIVES | Z30.015 - Encounter for initial prescription of vaginal ring hormonal contraceptive | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Nuvaring, annovera ring, zafemy patch (Xulane equivalent) and others.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 12874620 | CARSON PAUL HIGGS MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.09 | 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. |
| 12875025 | SAPAN PATEL MD | Internal Medicine | YUPELRI | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | J44.9 - Chronic obstructive pulmonary disease, unspecified | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Incruse and Lonhala.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 12877433 | STEVEN ENIUM RASMUSSEN MD | Dermatology | SKYRIZI PEN | TARGETED IMMUNOMODULATORS | L40.0 - Psoriasis vulgaris | Criteria Not Met | Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records we have received, Skyrizi was denied for these reasons:<br>1) Chart notes were not sent to us to show your response to this drug.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval).<br>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. |
| 12879465 | JEREMY RAYMOND SEMEIKS MD | Emergency Medicine | DESCOVY | ANTIVIRALS | Z20.6 | Criteria Not Met | Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons:<br>1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada.<br>2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada.<br>3) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR<br>2) Prescribed for pre-exposure prophylaxis of HIV infection; AND<br>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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).<br>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 |
| 12936898 | GAYLE YVONNE AYERS PHD | Psychiatry | ADDERALL XR | ADHD/ANTI-NARCOLEPSY | F90.0 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), Vyvanse .<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 12941781 | STEPHANIE SAMJI JAMES NP | Nurse Practitioner | FREESTYLE LIBRE 14 DAY/SE | MEDICAL DEVICES | E11.9 - Type 2 diabetes mellitus without complications | Criteria Not Met |
| 12948764 | MARINA LUZ SANCHEZ-ELLIG MD | Family Practice | OZEMPIC | ANTIDIABETICS | Type 1 diabetes mellitus without complications (HCC) | Criteria Not Met |
| 12956245 | LOUIS JOSEPH LUX MD | Internal Medicine | OXYMORPHONE HYDROCHLORIDE | ANALGESICS - OPIOID | c20 | Not Covered |
| 12957652 | ISELA ARRIETA WERCHAN MD | Psychiatry | VILAZODONE HYDROCHLORIDE | ANTIDEPRESSANTS | f39 | Criteria Not Met |
| 12961388 | MARIYA BOBROVNYK PA-C | Physician Assistant | VRAYLAR | ANTIPSYCHOTICS/ANTIMANIC AGENTS | f33.2 | Not Covered |
| 12963723 | MARINA LUZ SANCHEZ-ELLIG MD | Family Practice | OZEMPIC | ANTIDIABETICS | e10.9 | 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 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. 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) 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.

Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason:
1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.
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 Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. 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.
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.

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 immediate release (IR), oxycodone(tried), oxycodone/acetaminophen, hydrocodone/acetaminophen, hydromorphone(tried), tramadol.
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.

Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone.
1) This drug is not being used for major depressive disorder. This is a health issue where feelings of sadness and low mood last for a long time.
2) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafaxine)
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 vilazodone (Viibryd) 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 vilazodone. The reason for denial is explained to the member above. The criteria are listed here.
1) Member has a diagnosis of major depressive disorder; AND
2) Member is 18 years of age or older; AND
3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND
4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine).
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.

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 our Vraylar exception policy have not been met. From the records that we have received, these reasons caused the denial:
1) Records did not show that your current antidepressant treatment is not helping your health issue enough.
2) Records did not show at least TWO (2) or more antidepressant drugs did not work for you. (e.g. escitalopram, fluoxetine, sertraline, venlafaxine, or others)
3) Records did not show that another drug called quetiapine OR olanzapine used together with an antidepressant medication did not work for you.
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) 3, 4 and 5 of the Vraylar 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 prescribed for the adjunctive treatment of Major Depressive Disorder; AND
2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND
3) Member has had an inadequate response to antidepressant therapy during the current episode; AND
4) Two (2) or more antidepressant medications were ineffective or not tolerated; AND
5) A trial of quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication was ineffective or not tolerated.
Since criteria have not been met, we 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.

Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason:
1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.
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 Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. 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.
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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 12968232 JOHN SANG HEE KIM MD | Family Practice | NURTEC | MIGRAINE PRODUCTS | G43.009 - Migraine | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow and Ubrelvy.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 12976583 JOHN SANG HEE KIM MD | Family Practice | EMGALITY | MIGRAINE PRODUCTS | G43.009 - Migraine | Criteria Not Met | Our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the records that we have received, Emgality 120mg was denied for these reasons:<br>1) Records did not show that you have had at least 4 migraine days per month for the last 3 months or longer.<br>2) Records did not show you have tried and failed (after using for at least 3 months) other drugs from at least ONE of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.).<br>3) More information is needed to know if this drug will be used together with Botox. If Emgality will be used together with Botox, records must also show you have had at least a three (3) month trial of Emgality alone AND a three (3) month trial of Botox alone.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the information we have received, the member does not meet number(s) 2, 3, 4 or 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the prevention of migraine; AND<br>2) Member has four (4) or more migraine days per month for at least the previous three (3) months; AND<br>3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.); AND<br>4) Emgality will NOT be used concomitantly with onabotulinumtoxinA (BOTOX) injections for chronic migraine; OR<br>5) Emgality will be used concomitantly with onabotulinumtoxinA (BOTOX) injections for chronic migraine AND both of the following are met: (A) Member has failed at least three (3) months of individual therapy with Emgality, AND (B) Member has failed at least three (3) months of individual therapy with onabotulinumtoxinA (BOTOX).<br>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 |
| 12981214 CLAYTON WARREN ADAMS MD | Anesthesiology | HYDROCODONE BITARTRATE/AC | ANALGESICS - OPIOID | g89.4 | Not Covered | We have received a request for 110 tablets for a 30 day supply for hydrocodone/acetaminophen 10-325mg. 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:<br>1) Records show that you have recent use of an opioid pain reliever; OR<br>2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.<br>Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. |
| 12990209 MARIYA BOBROVNYK PA-C | Physician Assistant | VRAYLAR | ANTIPSYCHOTICS/ANTIMANIC AGENTS | MDD | 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 our Vraylar exception policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) Records did not show that another drug called quetiapine OR olanzapine used together with an antidepressant medication did not work for you.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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) 5 of the Vraylar exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND<br>2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND<br>3) Member has had an inadequate response to antidepressant therapy during the current episode; AND<br>4) Two (2) or more antidepressant medications were ineffective or not tolerated; AND<br>5) A trial of quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication was ineffective or not tolerated.<br>Since criteria have not been met, we 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. |
| 12990638 ROSIE AUGUSTIN-WHEELER MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | Z68.34 - Body mass index [BMI] 34.0-34.9, adult | 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.<br>Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons:<br>1) Chart notes were not sent to us to show your response to this drug..<br>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. |
| 12991442 SHWOL-HUO DANNY KIANG DO | Dermatology | OTEZLA | TARGETED IMMUNOMODULATORS | L40.0 - Psoriasis vulgaris | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Otezla for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval); AND<br>4) Apremilast (OTEZLA) will not be used in combination with biologic therapy.<br>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. |
| 13000812 BRUCE MICHAEL DOXEY MD | Family Practice | TADALAFIL | CARDIOVASCULAR AGENTS - MISC. | N40.1 - Benign prostatic hyperplasia with lower urinary tract symptoms | Formulary Alternatives Available | 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, Tadalafil was denied for these reasons:<br>1) One of these drugs has not been tried and failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, tamsulosin cap, or dustasteride/tamsulosin cap.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13002295 | GAIL CONDE CREAR MD | Internal Medicine | LINZESS | GASTROINTESTINAL AGENTS - MISC. | K59.00 - Constipation, unspecified | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) Records did not show that another drug called Trulance did not work for you. Prior authorization may be required.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND<br>2) A trial of plecanatide (TRULANCE) was ineffective, contraindicated, or not tolerated.<br>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. |
| 13021101 | MONIQUE DENISE MULVANY APN | Nurse Practitioner | XYREM | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | G47.419 - Narcolepsy without cataplexy | Criteria Not Met | Our prior authorization criteria for Xyrem have not been met. From the records that we have received, the following caused the denial of Xyrem.<br>1) Records did not show this drug is working for you to impove sudden sleep attacks or muscle weakness.<br>Since the criteria have not been met, we are not able to approve.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Xyrem have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Xyrem (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Documentation of a reduction in symptoms of excessive daytime sleepiness, symptoms of idiopathic hypersomnia, or cataplexy attacks is provided with the request (documentation is required for approval).<br>Since criteria have not been met, we are unable to approve coverage for this drug at this time. |
| 13038725 | JOHN SANG HEE KIM MD | Family Practice | ADDERALL XR | ADHD/ANTI-NARCOLEPSY | F90.2 - Attention-deficit hyperactivity disorder, combined type | 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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) The generic version of this drug, called amphetamine/dextroamphetamine ER (Adderall XR equivalent), has not been tried and failed. (We show recent paid claims. More information is needed if this does not work for you.)<br>2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, and Vyvanse.<br>3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.<br>Please look at the formulary to see what drugs are covered.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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, 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.<br>1) The generic form of the drug has been tried and failed; AND<br>2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND<br>3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.<br>Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs. |
| 13040353 | MONIQUE DENISE MULVANY APN | Nurse Practitioner | XYWAV | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | G47.11 - Idiopathic hypersomnia with long sleep time | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Xyrem, modafinil (tried), armodafinil (tried), Sunosi (tried), and Wakix.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13045212 | GAIL CONDE CREAR MD | Internal Medicine | TRULANCE | GASTROINTESTINAL AGENTS - MISC. | K59.04 - Chronic idiopathic constipation | Criteria Not Met | Our prior authorization criteria for Trulance have not been met. From the records that we have received, the following caused the denial of Trulance.<br>1) Records did not show that you have tried and failed a one (1) month trial (minimum) of one of the following Over-the-Counter (OTC) types of medications: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON).<br>Since the criteria have not been met, we are not able to approve.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trulance have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Trulance. The reason for denial is explained to the member above. The criteria are listed here.<br>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<br>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).<br>Since criteria have not been met, we are unable to approve coverage for this drug at this time. |
| 13055473 | STANLEY SUCHY WANG MD | Cardiology | TADALAFIL | CARDIOVASCULAR AGENTS - MISC. | N52.9 - Male erectile dysfunction, unspecified | Formulary Alternatives Available | 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, TADALAFIL TABLET 5MG was denied for these reasons:<br>1) One of these drugs has not been tried and failed: doxazosin tablet, prazosin capsule, terazosin capsule, dutasteride capsule, finasteride 5mg tablet, alfuzosin tablet, silodosin capsule, tamsulosin capsule, or dustasteride/tamsulosin capsule.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13066333 | MEGAN OLIVER JACOBSON PA-C | Physician Assistant | IVERMECTIN | ANTHELMINTICS | U07.1 - COVID-19 | Criteria Not Met |
| 13072977 | ELIZABETH LEIGH JAGGERS MD | Internal Medicine | MOUNJARO | ANTIDIABETICS | E78.5 | Criteria Not Met |
| 13077916 | COREY JAY ZELLER MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | Plan Exclusion |
| 13080305 | EDWARD LEWIS LAIN MD | Dermatology | DUPIXENT | DERMATOLOGICALS | L20.89 - Other atopic dermatitis | Criteria Not Met |
| 13085758 | SIMONA MARIANA SCUMPIA MD | Endocrinology, Diabetes & Metabolism | WEGOVY | ANTI-OBESITY/ANOREXIANTS | R73.02 - Impaired glucose tolerance (oral) | Plan Exclusion |
| 13089752 | GAIL CONDE CREAR MD | Internal Medicine | TRULANCE | GASTROINTESTINAL AGENTS - MISC. | E11.9 - Type 2 diabetes mellitus without complications | Criteria Not Met |
| 13092830 | PAMELA JAYNE HOWARD MD | Neurology | NURTEC | MIGRAINE PRODUCTS | G43.909-migraine | Not Covered |
| 13105442 | ELIZABETH LEIGH JAGGERS MD | Internal Medicine | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.9 | Plan Exclusion |

Our prior authorization criteria for ivermectin (STROMECTOL) have not been met. From the records that we have received, Ivermectin was denied for these reasons:
1) This drug is being used for COVID-19. This is not a covered use per your pharmacy benefit criteria.
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 ivermectin (STROMECTOL) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Ivermectin. The reason for denial is explained to the member above. The criteria are listed here.
1) Prescribed for ONE (1) of the following:
(A) Treatment of intestinal strongyloidiasis due to Strongyloides stercoralis, OR
(B) Treatment of onchocerciasis due to Onchocerca volvulus, OR
(C) Treatment of ascariasis, OR
(D) Treatment of cutaneous larva migrans, OR
(E) Treatment of dermatosis due to mites, OR
(F) Treatment of enterobiasis, OR
(G) Prophylaxis against Strongyloid stercoralis in hematopoietic stem cell transplant recipients, OR
(H) Treatment of loiasis, OR
(I) Treatment of infection by Wuchereria bancrofti, OR
(J) Treatment of infection by Phthirus pubis, OR
(K) Treatment of Mansonelliasis, OR
(L) Treatment or prevention of scabies, OR
(M) Treatment of demodicosis due to Demodex folliculorum and/or Demodex brevis, OR
(N) Treatment of gnathostomiasis due to Gnathostoma spinigerum, OR
(O) Treatment of lice due to Pediculus humanus capitis or Pediculus humanus corporis, OR
(P) Treatment of trichuriasis.
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

Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNJARO was denied for this reason:
1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.
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 Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. 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.
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.

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.

Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons:
1) Records did not show that at least TWO (2) other treatments, such as topical steroids, topical calcineurin inhibitors (e.g. tacrolimus, pimecrolimus), light therapy, azathioprine, cyclosporine, methotrexate, and mycophenolate mofetil, did not work 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(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here.
1) Member is 6 months 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 moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND
4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval):
(A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND
5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.
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

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.

Our prior authorization criteria for Trulance have not been met. From the records that we have received, the following caused the denial of Trulance.
1) Records did not show that you have tried and failed a one (1) month trial (minimum) of one of the following Over-the-Counter (OTC) types of medications: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON).
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 Trulance have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Trulance. 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.

The requested amount of Nurtec 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 Nurtec at 8 tablets per 30 days for this use. The higher number of 18 tablets per 30 days is not a covered amount of this drug per your plan. Please note that your plan does not cover Nurtec when used for migraine prevention. Covered drugs that may be used for migraine prevention include anti-seizure drugs (e.g. topiramate immediate release (IR)(TRIED), valproic acid), beta-blockers (e.g. propranolol(, metoprolol(TRIED), timolol), Aimovig(recent claim seen), Ajovy(TRIED), Emgality, and others. Prior authorization may be required. Quantity limits may apply. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.

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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 13112471 | ALMA D CARTER PA-C | Physician Assistant | STELARA | TARGETED IMMUNOMODULATORS | Psoriasis | Criteria Not Met |
| 13136227 | APRIL WEST FOX MD | Surgery, Colon & Rectal | SODIUM SULFATE/POTASSIUM | LAXATIVES | Z12.11 - Encounter for screening for malignant neoplasm of colon | Not Covered |
| 13144333 | JAMES ALLEN ZACHARY MD | Infectious Diseases | LINZESS | GASTROINTESTINAL AGENTS - MISC. | R10.13 | Criteria Not Met |
| 13166977 | DAVE FITZGERALD CLARKE MD | Neurology, Pediatric | JORNAY PM | ADHD/ANTI-NARCOLEPSY | F90.9 | Not Covered |
| 13177848 | COREY JAY ZELLER MD | Family Practice | RYBELSUS | ANTIDIABETICS | E66.9 - Obesity, unspecified | Criteria Not Met |
| 13186778 | NATALIE ADRIANNE WILLIAMS MD | Family Practice | LEVALBUTEROL TARTRATE HFA | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | Mild intermittent asthma, uncomplicated | 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) 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) Chart notes were not sent to us to show the details of your health issue and how you responded to previous treatments.
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) 2 of our prior authorization criteria for Stelara 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; AND
4) If the 90mg dose is requested, member's weight is greater than (>) 100kg and is provided with the request.
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.

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 Clenpiq, Gavilyte-C, Golytely, Nulytely, and Peg 3350/electrolytes.
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.

Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:
1) Records did not show that another drug called Trulance did not work for you. 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 linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.
1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND
2) A trial of plecanatide (TRULANCE) 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.

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 dexmethylphenidate extended release (ER)(TRIED), methylphenidate ER(TRIED), amphetamine/dextroamphetamine ER (Adderall XR equivalent), Vyvanse, and dextroamphetamine ER.
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.

Our Diagnosis Restricted criteria have not been met. From the records that we have received, RYBELSUS was denied for this reason:
1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.
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 Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. 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.
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 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, levalbuterol HFA inhaler was denied for these reasons:
1) Records did not show that Ventolin HFA inhaler has 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.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13206356 | MARINA LUZ SANCHEZ-ELLIG MD | Family Practice | OZEMPIC | ANTIDIABETICS | Type 1 diabetes mellitus without complications (HCC) | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 13206897 | ERICA MARIA RIVAS-RODRIGUEZ MD | Neurology | UBRELVY | MIGRAINE PRODUCTS | G43.111 | Criteria Not Met | Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, UBRELVY was denied for these reasons:<br>1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan, rizatriptan, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply.<br>2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) 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. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of migraine; AND<br>2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND<br>3) A trial of a second triptan was ineffective, contraindicated, or not tolerated.<br>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. |
| 13209698 | RANI DAS MD | Internal Medicine | DYANAVEL XR | ADHD/ANTI-NARCOLEPSY | ADHD | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), and Vyvanse.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13213117 | KALEB MICHAEL HAMILTON MD | Family Practice | SILDENAFIL CITRATE | CARDIOVASCULAR AGENTS - MISC. | Male erectile dysfunction, unspecified | 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. |
| 13224286 | COREY JAY ZELLER MD | Family Practice | OZEMPIC | ANTIDIABETICS | E66.9 - Obesity, unspecified | 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. |
| 13261041 | SAMI MOHAMAD ABOUMATAR MD | Neurology | VIMPAT | ANTICONVULSANTS | G40.911 - Epilepsy, unspecified, intractable, with status epilepticus | 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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.<br>Please look at the formulary to see what drugs are covered.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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) 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The generic form of the drug has been tried and failed; AND<br>2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND<br>3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.<br>Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs. |
| 13265510 | FRANCHELL HAMILTON MD | Surgery, General | MOUNJARO | ANTIDIABETICS | - | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNJARO was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 13272005 | FRANCHELL HAMILTON MD | Surgery, General | OZEMPIC | ANTIDIABETICS | e66.9 | 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. |
| 13278884 | MARY ANN MARTINEZ MD | Dermatology | KLISYRI | DERMATOLOGICALS | L57.0 - Actinic keratosis | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are diclofenac 3% gel (Solaraze equivalent), imiquimod 5% cream, topical fluorouracil(tried).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13291383 | JOSEMARIA JOSEMARIAP PATERNO MD | Anesthesiology | TRAMADOL HYDROCHLORIDE | ANALGESICS - OPIOID | g89.4 | Not Covered | We have received a request for 60 tablets for a 30 days day supply for tramadol. 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:<br>1) Records show that you have recent use of an opioid pain reliever; OR<br>2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.<br>Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. |
| 13304695 | RABIN KHERADPOUR MD | Internal Medicine | TRIGLIDE | ANTIHYPERLIPIDEMICS | E78.1 - Pure hyperglyceridemia | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fenofibrate capsule (LOFIBRA equiv), fenofibrate tablet(TRICOR equivalent) (TRIED), fenofibric acid Delayed Release capsule (TRILIPIX equivalent), gemfibrozil tablet (LOPID equivalent), Fenofibric tablet, Fibricor tablet, Lopid tablet, Tricor tablet.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13310196 | MARJAN ABEDI LINNELL MD | Pediatrics | ADZENYS XR-ODT | ADHD/ANTI-NARCOLEPSY | F90.9 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), Vyvanse, dextroamphetamine ER.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13313551 | MONICA RENEE SCHEPP | Physician Assistant | SKYRIZI PEN | TARGETED IMMUNOMODULATORS | L40.0 | Criteria Not Met | Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons:.<br>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.<br>2) Chart notes were not sent to us to show the details of your health issue and how you responded to previous treatments.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>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<br>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.<br>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. |
| 13325214 | CAGDAS ERNST RN | Advanced Practice Nurse | VILAZODONE HYDROCHLORIDE | ANTIDEPRESSANTS | F32.1 | Criteria Not Met | Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone.<br>1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine)<br>2) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafaxine)<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number 3 and 4 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of major depressive disorder; AND<br>2) Member is 18 years of age or older; AND<br>3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND<br>4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine).<br>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. |
| 13325965 | ANDRE SHAW CHEN MD | Family Practice | BUTALBITAL/ACETAMINOPHEN/ | ANALGESICS - NONNARCOTIC | G44.209 - Tension-type headache, unspecified, not intractable | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ibuprofen, naproxen, diclofenac tablet, and rizatriptan.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13331144 | MANUEL JOSEPH MARTIN MD | Family Practice | LINZESS | GASTROINTESTINAL AGENTS - MISC. | K58.1 - Irritable bowel syndrome with constipation | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) Records did not show that another drug called Trulance did not work for you. Prior authorization may be required.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND<br>2) A trial of plecanatide (TRULANCE) was ineffective, contraindicated, or not tolerated.<br>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. |
| 13334381 | IVAN JESUS PALACIOS PA-C | Physician Assistant | DESCOVY | ANTIVIRALS | Z20.2 | Criteria Not Met | Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons:<br>1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada.<br>2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada.<br>3) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR<br>2) Prescribed for pre-exposure prophylaxis of HIV infection; AND<br>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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).<br>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 |
| 13337470 | AFREEN KHAN MD | Family Practice | HYDROCORTISONE ACETATE | ANORECTAL AND RELATED PRODUCTS | L29.0 - Pruritus ani | 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:<br>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), lidocaine/hydrocortisone cream (ANAMANTLE equivalent), Proctofoam HC foam, and Analpram Kit.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13339424 | APRIL KATHLEEN WATKINS APN | Advanced Practice Nurse | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.01 - Morbid (severe) obesity due to excess calories | 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.<br>Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons:<br>1) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR<br>2) Prescribed for pre-exposure prophylaxis of HIV infection; AND<br>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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).<br>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 |
| 13347765 | MARIA HOOPER FNP-C | Nurse Practitioner | DESCOVY | ANTIVIRALS | Z72.51 - High risk heterosexual behavior | Criteria Not Met | |
| 13353128 | KRISHNA POKALA MD | Internal Medicine | BOTOX | NEUROMUSCULAR AGENTS | G43.709 | Plan Exclusion | This drug is not on our list of covered drugs, also known as our formulary. This drug may be covered as a medical benefit, as decided by your health plan. Please talk to Sendero Health Plans at 855-297-9191 to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.<br><br>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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Restasis.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. |
| 13356472 | YEN DANG NIEMAN | Ophthalmology | TYRVAYA | OPHTHALMIC AGENTS | H04.123 - Dry eye syndrome of bilateral lacrimal glands | Not Covered | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13361132 | CHRISTY TAYLOR RISINGER MD | Internal Medicine | OZEMPIC | ANTIDIABETICS | R73.09 | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 13361217 | MATTHEW SCOTT HILL DO | Family Practice | LINZESS | GASTROINTESTINAL AGENTS - MISC. | k59.00 | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) The drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without any known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation).<br>2) Records did not show that another drug called Trulance did not work for you. Prior authorization may be required.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND<br>2) A trial of plecanatide (TRULANCE) was ineffective, contraindicated, or not tolerated.<br>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. |
| 13367989 | MARIA EZIAFA CHIEJINA MD | Internal Medicine | DEXLANSOPRAZOLE | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS | K21.9 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole (TRIED), pantoprazole (TRIED), rabeprazole, lansoprazole (TRIED), and esomeprazole (TRIED).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13372167 | MATTHEW SCOTT HILL DO | Family Practice | LUBIPROSTONE | GASTROINTESTINAL AGENTS - MISC. | CIC-female member | Criteria Not Met | Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons:<br>1) Records did not show that taking one of the following over-the-counter (OTC) drugs for one month did not work for you: stimulants (e.g., bisacodyl, sennosides), or PEG 3350 (e.g., Miralax), or bulk-forming laxatives (e.g., Metamucil, Citrucel, Fibercon).<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR<br>2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR<br>3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND<br>4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon).<br>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 |
| 13375646 | MARIA EZIAFA CHIEJINA MD | Internal Medicine | DEXLANSOPRAZOLE | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS | K21.9, Z87.11 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole (TRIED), pantoprazole (TRIED), rabeprazole, lansoprazole (TRIED), esomeprazole (TRIED).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13375653 | MATTHEW SCOTT HILL DO | Family Practice | LINZESS | GASTROINTESTINAL AGENTS - MISC. | K59.04-CIC | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) Records did not show that another drug called plecanatide (TRULANCE) did not work for you.<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND<br>2) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated.<br>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. |
| 13400615 | NINA HORMUZDIAR NARIMAN | Physician Assistant | TRAMADOL HYDROCHLORIDE | ANALGESICS - OPIOID | M17.0 OA of knee | Not Covered | We have received a request for 90 tablets for a 30 days 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 day supply 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 days day supply for this first fill can be approved if records are sent in showing one of these:<br>1) Records show that you have recent use of an opioid pain reliever; OR<br>2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.<br>Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | 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.<br>1) Records show this drug is being used together with another biologic drug.<br>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. |
| 13408106 | ELIZABETH HAVEY MILLER MD | Dermatology | DUPIXENT | DERMATOLOGICALS | L20.9 | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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(s) 2 of our prior authorization criteria for Dupixent (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND<br>2) Dupixent will NOT be used in combination with another targeted immunomodulator product.<br>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. |
| 13410583 | KAREN JENIFER ROMERO DO | Family Practice | MOUNJARO | ANTIDIABETICS | Prediabetes | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, Mounjaro was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 13416189 | RUDXANDRA AGUIAR MD | Internal Medicine | WEGOVY | ANTI-OBESITY/ANOREXIANTS | Other obesity due to excess calories | 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. |
| 13425005 | NELLA GEMMA STOUT | Nurse Practitioner | WEGOVY | ANTI-OBESITY/ANOREXIANTS | bmi 36-36.9 | 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. |
| 13438125 | SUSAN BALITE NUNEZ MD | Endocrinology, Pediatric | BYDUREON BCISE | ANTIDIABETICS | R73.03 | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, BYDUREON BCISE was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 13445821 | STACIA CHRISTINE MILES MD | Dermatology | TRETINOIN | DERMATOLOGICALS | L81.4 - Other melanin hyperpigmentation | Plan Exclusion | This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. |
| 13449001 | STEVEN ENIUM RASMUSSEN MD | Dermatology | SKYRIZI PEN | TARGETED IMMUNOMODULATORS | L40.0 - Psoriasis vulgaris | Criteria Not Met | Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons:<br>1) Chart notes were not sent to us to show your response to this drug.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval).<br>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. |
| 13461509 | KAREN JENIFER ROMERO DO | Family Practice | MOUNJARO | ANTIDIABETICS | R73.03 | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNJARO was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 13480222 | TIMOTHY IAN HILTON NP | Advanced Practice Nurse | BELBUCA | ANALGESICS - OPIOID | 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:<br>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), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13480319 STEVEN ENIUM RASMUSSEN MD | Dermatology | SKYRIZI | TARGETED IMMUNOMODULATORS | L40.0 | Criteria Not Met | Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons:<br>1) Chart notes that were sent to us are from an office visit that took place before you restarted Skyrizi. Your health care provider must send more recent documentation (or a written statement) showing your response to this drug.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval).<br>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. |
| 13490289 KAVITHA RAJAN MD | Internal Medicine | OXYCONTIN | ANALGESICS - OPIOID | Chronic severe pain | 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:<br>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), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13491531 RUDXANDRA AGUIAR MD | Internal Medicine | LINZESS | GASTROINTESTINAL AGENTS - MISC. | k59.09 | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) Records did not show that another drug called plecanatide (TRULANCE) did not work for you.<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND<br>2) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated.<br>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. |
| 13502675 MIMI I-NAN HU MD | Endocrinology, Diabetes & Metabolism | MEKINIST | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES | - | Criteria Not Met | Our prior authorization criteria for trametinib (MEKINIST) have not been met. From the records that we have received, the following caused the denial of Mekinist.<br>1) Records did not show that this drug will be used together with another cancer drug called Tafinlar.<br>2) Records did not show that you have a specific genetic change (mutation) that is needed for this drug to work. Documentation is required for an approval.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for trametinib (MEKINIST) have not been met. From the information we have received, the member does not meet number(s) 4 and 5 of our prior authorization criteria for Mekinist. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of solid tumor; AND<br>2) Prescribed by, or in consultation with, an Oncologist; AND<br>3) Tumor is either unresectable or metastatic; AND<br>4) Request is for dabrafenib (TAFINLAR) AND trametinib (MEKINIST) combination therapy; AND<br>5) Documentation of a BRAF V600E mutation is provided with the request (documentation is required to be submitted for an approval); AND<br>6) Tumor progressed following prior treatment; AND<br>7) No satisfactory alternative treatment options are available.<br>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 |
| 13504999 JAMES ALLEN ZACHARY MD | Infectious Diseases | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | 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. |
| 13514826 STEPHANIE JILL REICH MD | Obstetrics & Gynecology | VIVJOA | ANTIFUNGALS | B37.32 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are terconazole (TRIED), miconazole, clotrimazole, fluconazole (TRIED).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13534189 | ERIC BRANDON PEREZ FNP-C | Nurse Practitioner | DESCOVY | ANTIVIRALS | Z20.6 - Contact with and (suspected) exposure to human immunodeficiency virus [HIV] | Criteria Not Met |
| 13536493 | ABHILASHA GUPTA MD | Internal Medicine | SPIRIVA HANDIHALER | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | j44.9 | Not Covered |
| 13543533 | BRIAN TERRY MILLER DO | Allergy & Immunology | NURTEC | MIGRAINE PRODUCTS | g43.101 | Not Covered |
| 13546132 | SCOTT ADAM BORUCHOW MD | Neurology | QULIPTA | MIGRAINE PRODUCTS | Migraine with aura, intractable, without status migrainosus | Not Covered |
| 13559406 | STEVEN KIRK FOSTER MD | General Practice | VRAYLAR | ANTIPSYCHOTICS/ANTIMANIC AGENTS | anxiety | Not Covered |

Our prior authorization criteria for emtricitabine/tenofovir alafenamide (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 bones got weaker while taking a drug called Truvada.
3) Records were not sent to us to show your kidneys are not working like normal based on lab tests.
4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.
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 emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
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

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 Incruse Ellipta, Anoro Ellipta, Stiolto Respimat, Lonhala Magnair (step therapy requires trial of Incruse Ellipta).
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.

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 Reyvow and Ubrelvy.
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.

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 Aimovig(tried), Ajovy and Emgality.
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.

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 anxiety. This is not an approved use.
2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buspirone, hydroxyzine, meprobamate, alprazolam, diazepam, lorazepam 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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 13560730 | MANUEL JOSEPH MARTIN MD | Family Practice | PROAIR DIGIHALER | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | J45.40 - Moderate persistent asthma, uncomplicated | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Ventolin HFA inhaler, albuterol HFA inhaler (Proair equivalent), albuterol HFA inhaler (Proventil equivalent), levalbuterol. Quantity limits may apply.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13565082 | FRANK STEWART FLOCA MD | Psychiatry | REXULTI | ANTIPSYCHOTICS/ANTIMANIC AGENTS | MDD | 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 our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) Records did not show aripiprazole (Abilify equivalent) did not work for you.<br>2) Records did not show that another drug called quetiapine OR olanzapine used with an antidepressant medication did not work for you.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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 & 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND<br>2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND<br>3) Member has had an inadequate response to antidepressant therapy during the current episode; AND<br>4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND<br>5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication.<br>Since criteria have not been met, we unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is |
| 13570238 | ALICE DIANE FRIEDMAN MD | Gastroenterology | STELARA | TARGETED IMMUNOMODULATORS | UC | Plan Limits Exceeded | The requested amount of Stelara 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 Stelara at 0.5 mL every 6 weeks for this use. The prescribed dose is 1 mL every 6 weeks. This drug comes in a 90mg syringe. The same dose can be reached by taking one (1) 90mg syringe every 6 weeks. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered. |
| 13572936 | JENELYN JOY RAMOS | Family Practice | ANUCORT-HC | ANORECTAL AGENTS | K64.9 - Unspecified hemorrhoids | 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:<br>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, lidocaine/hydrocortisone cream, Proctofoam HC, and others.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13573909 | KARA ELIZABETH SJOGREN DO | Family Practice | SAXENDA | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | Plan Exclusion | This request cannot be approved because this drug is being used for obesity (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. |
| 13580259 | UTTAM KESHAV RAO MD | Hematology & Oncology | PREVYMIS | ANTIVIRALS | AML | Criteria Not Met | Our prior authorization criteria for letermovir (Prevymis) have not been met. From the records that we have received, Prevymis was denied for these reasons:<br>1) More information is needed to know if this drug will be started within 30 days after your stem cell transplant.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for letermovir (Prevymis) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Prevymis. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by, or in consultation with, a Hematologist, Oncologist, Transplant, or Infectious Disease Specialist; AND<br>2) Member is cytomegalovirus (CMV)-seropositive; AND<br>3) Prescribed for the primary prophylaxis of CMV infection or disease after an allogeneic hematopoietic stem cell transplant; AND<br>4) Letermovir (PREVYMIS) will be initiated within 30 days after transplant; OR<br>5) Prescribed for secondary prophylaxis of CMV infection or disease following pre-emptive therapy for post-hematopoietic stem cell transplant CMV infection; AND<br>6) Prescribed therapy is limited to one tablet daily for up to 100 days without renewal.<br>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. |
| 13586674 | LUKE CONNOR JOHNSON PA-C | Physician Assistant | CLOMID | ENDOCRINE AND METABOLIC AGENTS - MISC. | E29.1 | 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:<br>1) This drug is being used for testicular hypofunction. This is not an approved use.<br>2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone cypionate injection, testosterone 1% gel (Androgel equivalent), testosterone 1.62% gel (Androgel 1.62% equivalent), testosterone topical solution (Axiron equivalent), Androderm patch.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13587727 | JORGE LUIS ARIZMENDI PA-C | Physician Assistant | OZEMPIC | ANTIDIABETICS | R73.03 - Prediabetes | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |
| 13595426 | KRISTINA TRUONG DO | Family Practice | LINZESS | GASTROINTESTINAL AGENTS - MISC. | K59.03-drug induced constipation | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without any known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation).<br>2) Records did not show that another drug called plecanatide (TRULANCE) did not work for you.<br>3) Records did not show that another drug called lubiprostone (AMITIZA) did not work for you.<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 1. 3. 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND<br>2) The member is 18 years of age or older; AND<br>3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND<br>4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR<br>5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C).<br>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. |
| 13598813 | LETICIA R PEREZ PA | Physician Assistant | DESCOVY | ANTIVIRALS | Z77.21 - Contact with and (suspected) exposure to potentially hazardous body fluids | Criteria Not Met | Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons:<br>1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada.<br>2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada.<br>3) Records were not sent to us to show your kidneys are not working like normal based on lab tests.<br>4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR<br>2) Prescribed for pre-exposure prophylaxis of HIV infection; AND<br>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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).<br>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 |
| 13610470 | LUKE CONNOR JOHNSON PA-C | Physician Assistant | WEGOVY | ANTI-OBESITY/ANOREXIANTS | Z68.41 - Body mass index [BMI] 40.0-44.9, adult | Plan Exclusion | This request cannot be approved because this drug is being used for weightloss. 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. |
| 13614593 | JORGE LUIS ARIZMENDI PA-C | Physician Assistant | ALLI | ANTI-OBESITY/ANOREXIANTS | E66.01 - Morbid (severe) obesity due to excess calories | Plan Exclusion | This request cannot be approved because this drug is being used for weightloss. 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. |
| 13631808 | UTTAM KESHAV RAO MD | Hematology & Oncology | PREVYMIS | ANTIVIRALS | B25.9 | Criteria Not Met | Our prior authorization criteria for letermovir (Prevymis) have not been met. From the records that we have received, Prevymis was denied for these reasons:<br>1) More information is needed to know if this drug will be started within 30 days after your stem cell transplant.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for letermovir (Prevymis) have not been met. From the information we have received, the member does not meet number(s) 4 and 6 of our prior authorization criteria for Prevymis. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by, or in consultation with, a Hematologist, Oncologist, Transplant, or Infectious Disease Specialist; AND<br>2) Member is cytomegalovirus (CMV)-seropositive; AND<br>3) Prescribed for the primary prophylaxis of CMV infection or disease after an allogeneic hematopoietic stem cell transplant; AND<br>4) Letermovir (PREVYMIS) will be initiated within 30 days after transplant; OR<br>5) Prescribed for secondary prophylaxis of CMV infection or disease following pre-emptive therapy for post-hematopoietic stem cell transplant CMV infection; AND<br>6) Prescribed therapy is limited to one tablet daily for up to 100 days without renewal.<br>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 |
| 13633114 | DANIEL ANTHONY CARRASCO MD | Dermatology | OPZELURA | DERMATOLOGICALS | L20.9 | Criteria Not Met | Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons:<br>1) Records did not show that a topical calcineurin inhibitor, such as pimecrolimus cream or tacrolimus ointment, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Opzelura. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by, or in consultation with, a Dermatologist; AND<br>2) Member has a diagnosis of mild to moderate atopic dermatitis (AD); AND<br>3) Trials of BOTH of the following have been ineffective, contraindicated, or not tolerated: (A) a topical corticosteroid, AND (B) a topical calcineurin inhibitor.<br>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 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13637465 | KERRY ALLISON RAMON APN | Nurse Practitioner | DAYVIGO | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS | G47.00 - Insomnia, unspecified | Not Covered |
| 13646500 | MANUEL JOSEPH MARTIN MD | Family Practice | HUMULIN 70/30 KWIKPEN | ANTIDIABETICS | E11.65 | Criteria Not Met |
| 13655957 | AMY ROMINGER MASON MD | Dermatology | OPZELURA | DERMATOLOGICALS | L20.84 - Intrinsic (allergic) eczema | Criteria Not Met |
| 13663890 | YEN DANG NIEMAN | Ophthalmology | TYRVAYA | OPHTHALMIC AGENTS | H04.123 | Not Covered |
| 13666781 | TIMOTHY IAN HILTON NP | Advanced Practice Nurse | BELBUCA | ANALGESICS - OPIOID | G89.4 | Not Covered |
| 13670819 | SERENA HON MD | Family Practice | WEGOVY | ANTI-OBESITY/ANOREXIANTS | Morbid (severe) obesity due to excess calories (HCC) | Plan Exclusion |
| 13682542 | TIMOTHY ANDRE MACK | Nurse Practitioner | SILDENAFIL CITRATE | CARDIOVASCULAR AGENTS - MISC. | N52.9 - Male erectile dysfunction, unspecified | Plan Exclusion |
| 13686345 | MICHAEL JOSEPH REGAN IV MD | Emergency Medicine | WEGOVY | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | Plan Exclusion |
| 13686447 | MICHAEL JOSEPH REGAN IV MD | Emergency Medicine | SAXENDA | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | Plan Exclusion |

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 zolpidem, zaleplon, trazodone (TRIED), eszopiclone, ramelteon, and Belsomra.
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.

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, Humulin 70/30 was denied for these reasons:
1) One of these drugs has not been tried and failed: Novolin 70/30, Novolin N, or Novolin R.
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.

Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons:
1) This drug is not being used for atopic dermatitis (eczema), which is a health issue that causes dry, itchy, and/or red skin, OR for nonsegmental vitiligo, a health issue where patches of skin on both sides of the body become depigmented (or lose color). Additional criteria apply for each covered health issue.
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 ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Opzelura. The reason for denial is explained to the member above. The criteria are listed here.
1) Member has a diagnosis of atopic dermatitis (AD) OR nonsegmental vitiligo; AND
2) Additional criteria for covered diagnosis are met.
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.

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. Another drug that can be used is Restasis single use vials.
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.

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), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent)-(tried).
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.

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.

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.

This request cannot be approved because this drug is being used for weightloss . 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.

This request cannot be approved because this drug is being used for weightloss . 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.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13691406 | STEVEN ENIUM RASMUSSEN MD | Dermatology | SKYRIZI PEN | TARGETED IMMUNOMODULATORS | L40.0 | Criteria Not Met | Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons:<br>1) Chart notes were not sent to us to show your response to this drug.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has demonstrated a significant improvement in their condition; AND<br>3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval).<br>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 |
| 13712430 | COURTNEY SHEA-RAINER YAU MD | Hematology & Oncology | PROMACTA | HEMATOPOIETIC AGENTS | D69.59 - Other secondary thrombocytopenia | Criteria Not Met | Our prior authorization criteria for eltrombopag (PROMACTA) have not been met. From the records that we have received, Promacta was denied for these reasons:<br>1) Records did not show at least one other treatment for your health issue has been tried and failed.<br>2) Records do not show a platelet count less than 30,000 cells per microliter. Platelet levels less than this need treatment to prevent bleeding.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for eltrombopag (PROMACTA) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Promacta. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by, or in consultation with, a Hematology Specialist; AND<br>2) Diagnosis of Chronic Immune Thrombocytopenia (ITP), and BOTH of the following are met:<br>A) At least ONE (1) prior ITP therapy (glucocorticoids, intravenous immunoglobulin (IVIG), or splenectomy) has been tried and failed; AND<br>B) Platelet count is less than (<) 30,000/microliter; OR<br>3) Diagnosis of Hepatitis C associated thrombocytopenia, and BOTH of the following are met:<br>A) Member needs to initiate interferon-based therapy; AND<br>B) Member has a degree of thrombocytopenia that requires treatment with eltrombopag (PROMACTA) in<br>order to initiate or maintain interferon-based therapy; OR<br>4) Diagnosis of Severe Aplastic Anemia, and ONE of the following is met:<br>A) Member has had an insufficient response to immunosuppressive therapy; OR<br>B) Member will be using first-line in combination with immunosuppressant therapy.<br>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 |
| 13713026 | MICHELLE ELIZABETH MOYER DO | Psychiatry | L-METHYLFOLATE FORTE | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS | F33.1 - Major depressive disorder, recurrent, moderate | Plan Exclusion | This request cannot be approved because your plan has chosen this drug/product to be excluded from coverage. Other drugs/products for your health issue may be covered by your plan. Please look at the list of covered drugs/products, 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. |
| 13714448 | SHERI MICHELLE RAVENSCROFT MD | Developmental-Behavioral Medicine | QUILLIVANT XR | ADHD/ANTI-NARCOLEPSY | F84.0 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER (Concerta, Ritalin LA, or Metadate CD equivalent), amphetamine/dextroamphetamine ER (Adderall XR equivalent), Vyvanse chewable, dextroamphetamine ER, and others. Please note: ER capsules can be opened and sprinkled over applesauce.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13725758 | ROBERT KYLE COWAN JR MD | Obstetrics & Gynecology | ESTROGEL | ESTROGENS | N95.1 - Menopausal and female climacteric states | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol tablet, Premarin tablet, one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13741184 | BIANCA ELISA FALCON | Nurse Practitioner | BREXAFEMME | ANTIFUNGALS | B37.31 - Acute candidiasis of vulva and vagina | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fluconazole (tried), and terconazole cream or suppository.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13741289 | DAVID LAWRENCE PHILLIPS | Urology | GEMTESA | URINARY ANTISPASMODICS | - | Not Covered |
| 13746299 | RABIN KHERADPOUR MD | Internal Medicine | STELARA | TARGETED IMMUNOMODULATORS | UC | Criteria Not Met |
| 13756620 | KATHERINE DAWN KELLER DO | Family Practice | NURTEC | MIGRAINE PRODUCTS | migraine | Not Covered |
| 13763223 | JAMES COCHRAN ANDERSON IV MD | Pediatrics | JORNAY PM | ADHD/ANTI-NARCOLEPSY | f90.0 | Not Covered |
| 13772398 | CODY PAULINE SEEL PA | Physician Assistant | TRETINOIN | DERMATOLOGICALS | D23.39 - Other benign neoplasm of skin of other parts of face | Criteria Not Met |
| 13773003 | PAUL BENARD MOORE MD | Endocrinology, Diabetes & Metabolism | TADALAFIL | CARDIOVASCULAR AGENTS - MISC. | N52.9 - Male erectile dysfunction, unspecified | Formulary Alternatives Available |

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 Myrbetriq and 3 other drugs for your health issue, such as oxybutynin Extended Release, trospium, tolterodine, darifenacin, solifenacin.
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.

Our prior authorization criteria for subcutaneous ustekinumab (STELARA SC) have not been met. From the records that we have received, Stelara SC was denied for these reasons:
1) This drug was not prescribed by a Gastroenterology Specialist. This is a doctor that works with digestive system health issues.
2) Records did not show that this drug is working well 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 ustekinumab (STELARA) 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 Stelara SC. 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 Ulcerative Colitis (UC); AND
3) Member has demonstrated a significant improvement in their condition; AND
4) Documented (written explanation accepted) improvement within the past year submitted with this request (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.

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 Reyvow and Ubrelvy.
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.

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 dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), Vyvanse, dextroamphetamine ER.
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.

Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin cream was denied for these reasons:
1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. These are health issues of the skin.
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 Acne Agents have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for tretinoin cream. The reason for denial is explained to the member above. The criteria are listed here.
1) Prescribed for the treatment of acne vulgaris, acne rosacea, or actinic keratosis.
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 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, tadalafil was denied for these reasons:
1) One of these drugs has not been tried and failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, tamsulosin cap, OR dustasteride/tamsulosin cap.
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.

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed.<br>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. |
| 13774969 | DANIEL NEIL SKOGLUND MD | Psychiatry | TRINTELLIX | ANTIDEPRESSANTS | MDD | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |
| 13786249 | GRACE LORENA HONLES MD | Family Practice | MYDAYIS | ADHD/ANTI-NARCOLEPSY | - | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), Vyvanse.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13790720 | JAMES COCHRAN ANDERSON IV MD | Pediatrics | QELBREE | ADHD/ANTI-NARCOLEPSY | F90.2 - Attention-deficit hyperactivity disorder, combined type | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are clonidine extended-release (ER), guanfacine ER, atomoxetine and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or Vyvanse).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13805554 | CYNTHIA LYNN BENTON MD | Psychiatry | TRINTELLIX | ANTIDEPRESSANTS | F33.1 | Criteria Not Met | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline (TRIED), citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed.<br>2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |
| 13812843 | MONICA RENEE SCHEPP | Physician Assistant | OTEZLA | TARGETED IMMUNOMODULATORS | PSORIASIS VULGARIS | Criteria Not Met | Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons:<br>1) 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.<br>2) 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.<br>3) 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.<br>4) Records show that you may not be able to use light therapy, methotrexate, or acitretin, but more information is needed to show why these treatments are not right for you.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) 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 Otezla for Plaque Psoriasis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Plaque psoriasis (PP) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND<br>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; AND<br>4) Apremilast (OTEZLA) will not be used in combination with biologic therapy.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13827289 | DEREK NELSON CUNNINGHAM OD | Optometrist | CEQUA | OPHTHALMIC AGENTS | H16.223 - Keratoconjunctivitis sicca, not specified as Sjogren's, bilateral | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Restasis.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13838855 | ASWINI RAJAN MD | Internal Medicine | LINZESS | GASTROINTESTINAL AGENTS - MISC. | K58.1 | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) Records did not show that another drug called plecanatide (TRULANCE) did not work for you.<br>2) Records did not show that another drug called lubiprostone (AMITIZA) did not work for you.<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND<br>2) The member is 18 years of age or older; AND<br>3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND<br>4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR<br>5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C).<br>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. |
| 13841815 | PRIYA GULZAR ALI | Nurse Practitioner | VIIBRYD | ANTIDEPRESSANTS | F31.4 - Bipolar disorder, current episode depressed, severe, without psychotic features | Criteria Not Met | Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone.<br>1) This drug is not being used for major depressive disorder. This is a health issue where feelings of sadness and low mood last for a long time.<br>2) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafaxine)<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) 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 vilazodone. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of major depressive disorder; AND<br>2) Member is 18 years of age or older; AND<br>3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND<br>4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine).<br>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. |
| 13844851 | DAVID CABELL GRAY MD | Family Practice | INSULIN GLARGINE SOLOSTAR | ANTIDIABETICS | dm | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin glargine-yfgn (single pen), Levemir, Toujeo, and Tresiba.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13851984 | NATALIA MILLIKEN NP-C | Advanced Practice Nurse | DESCOVY | ANTIVIRALS | Z72.52 - High risk homosexual behavior | Criteria Not Met | Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons:<br>1) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR<br>2) Prescribed for pre-exposure prophylaxis of HIV infection; AND<br>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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).<br>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 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13862100 | EMILY CATHERINE MINK NP-C | Nurse Practitioner | PRALUENT | ANTIHYPERLIPIDEMICS | I25.10 - Atherosclerotic heart disease of native coronary artery without angina pectoris | Not Covered |
| 13868357 | VICTOR MANUEL GARZA MD | Psychiatry | QELBREE | ADHD/ANTI-NARCOLEPSY | F90.0 - Attention-deficit hyperactivity disorder, predominantly inattentive type | Not Covered |
| 13870990 | DAVID LAWRENCE PHILLIPS | Urology | TESTOSTERONE | ANDROGENS-ANABOLIC | E29.1-testicular hypofunction | Criteria Not Met |
| 13870994 | RANI DAS MD | Internal Medicine | CAMBIA | MIGRAINE PRODUCTS | G43.009 | Not Covered |
| 13873480 | MARIA ROSE BONTRAGER | Optometrist | TYRVAYA | OPHTHALMIC AGENTS | Dry Eye Disease | 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 Repatha.
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.

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 atomoxetine (TRIED) and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or Vyvanse).
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.

Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1.62% was denied for these reasons:
1) More information is needed to know if your low levels of testosterone are age-related.
2) Records do not show you have symptoms of low testosterone.
3) Two low testosterone levels have not been sent to us. The labs must be drawn in the morning and must be from two different days.
4) A lab value from within the last 12 months was not sent to us.
5) A second lab value from within the last 24 months was not sent to us.
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: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3, 4, 5 of our prior authorization criteria for Initial 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 symptoms of hypogonadism; AND
3) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND
4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND
5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 months.
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.

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 four (4) oral non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen(tried), naproxen(tried) , diclofenac, flurbiprofen, meloxicam (tried), nabumetone, or others) and failure of one triptan (e.g. sumatriptan, naratriptan, rizatriptan, zolmitriptan).
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.

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
Specialist).
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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 13874898 | LEIGHA ANA SHARP MD | Dermatology | ZORYVE | DERMATOLOGICALS | I40.0 | Criteria Not Met |
| 13878461 | MICHAEL TIMOTHY BREEN MD | Family Practice | ESTROGEL | ESTROGENS | N95.1 | Not Covered |
| 13883585 | NATALIA MILLIKEN NP-C | Advanced Practice Nurse | DESCOVY | ANTIVIRALS | Z72.52 - High risk homosexual behavior | Criteria Not Met |
| 13883844 | ELIZABETH LYNN POLLOCK MD | Family Practice | DEXILANT | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS | K22.70 - Barrett's esophagus without dysplasia | Not Covered |
| 13886082 | MICHAEL ANDREW MUSGROVE MD | Psychiatry | ADDERALL XR | ADHD/ANTI-NARCOLEPSY | ADHD | Not Covered |
| 13887388 | HECTOR SANCHEZ MD | Family Practice | OZEMPIC | ANTIDIABETICS | Morbid (severe) obesity due to excess calories (HCC) | Plan Exclusion |

Our prior authorization criteria for roflumilast (ZORYVE) have not been met. From the records that we have received, Zoryve was denied for these reasons:
1) Records did not show that another drug called a topical steroid (e.g betamethasone, triamcinolone) did not work 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. Prior authorization and quantity limits may apply.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for roflumilast (ZORYVE) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Zoryve. The reason for denial is explained to the member above. The criteria are listed here.
1) Prescribed by, or in consultation with, a dermatologist; AND
2) Prescribed for a diagnosis of chronic plaque psoriasis; AND
3) Member is at least 12 years of age or older; AND
4) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval); AND
5) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis.
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.

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 ¿estradiol oral tablet, Premarin oral tablet, one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent).
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.

Our prior authorization criteria for emtricitabine/tenofovir alafenamide (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 experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.
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 emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 (C) 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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
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

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 omeprazole, pantoprazole(tried), rabeprazole, lansoprazole, esomeprazole(tried).
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.

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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, lisdexamfetamine (Vyvanse equivalent).
2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.
Please look at the formulary to see what drugs are covered.

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 & 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 generic form of the drug has been tried and failed; AND
2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND
3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.
Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs.

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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 13892629 | KRISTIN DIANE FOLEY NP | Nurse Practitioner | XHANCE | NASAL AGENTS - SYSTEMIC AND TOPICAL | J33.0 - Polyp of nasal cavity | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray (RHINOCORT AQUA equivalent) and fluticasone nasal spray (FLONASE equivalent) (TRIED).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13897530 | MICHAEL ANDREW MUSGROVE MD | Psychiatry | ADDERALL XR | ADHD/ANTI-NARCOLEPSY | F90.0 | 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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, lisdexamfetamine (Vyvanse equivalent).<br>2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.<br>Please look at the formulary to see what drugs are covered.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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, 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The generic form of the drug has been tried and failed; AND<br>2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND<br>3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.<br>Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs. |
| 13898737 | ELIZABETH HAVEY MILLER MD | Dermatology | DUPIXENT | DERMATOLOGICALS | atopic dermatitis | Plan Limits Exceeded | The requested amount of Dupixent 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 Dupixent at 1 injection every 2 weeks for this use. The higher number of 1 injection every week is not an approved dose for your health issue. In order for the higher quantity 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. |
| 13900230 | MATTHEW JOEL HELLMAN MD | Anesthesiology | BELBUCA | ANALGESICS - OPIOID | 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:<br>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), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13906353 | KRISTIN DIANE FOLEY NP | Nurse Practitioner | XHANCE | NASAL AGENTS - SYSTEMIC AND TOPICAL | nasal polyps | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray (RHINOCORT AQUA equivalent) and fluticasone nasal spray (FLONASE equivalent)-(TRED).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13910008 | ELIZABETH HAVEY MILLER MD | Dermatology | DUPIXENT | DERMATOLOGICALS | AD | Plan Limits Exceeded | The requested amount of Dupixent 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 Dupixent at 2 injections per 28 days for this use. The higher number of 4 injections per 28 days is not an approved dose for your health issue. In order for the higher quantity 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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13912148 | KATHERINE DAWN KELLER DO | Family Practice | NURTEC | MIGRAINE PRODUCTS | g43.909 | Not Covered |
| 13926988 | AMMAR MOIN AHMED MD | Adolescent Medicine | TRETINOIN | DERMATOLOGICALS | L81.4 - Other melanin hyperpigmentation | Plan Exclusion |
| 13927441 | GEOFFREY FULTON HUGHES FNP-C | Nurse Practitioner | PHENTERMINE HCL | ANTI-OBESITY/ANOREXIANTS | Z68.32 - Body mass index [BMI] 32.0-32.9, adult | Plan Exclusion |
| 13933990 | MATTHEW JOEL HELLMAN MD | Anesthesiology | BUPRENORPHINE HCL | ANALGESICS - OPIOID | Opioid abuse dependence | Not Covered |
| 13936584 | YAMINI APARNA AKKANTI | Family Practice | LANTUS SOLOSTAR | ANTIDIABETICS | E11.8 | Not Covered |
| 13943316 | JAY LELAND VIERNES MD | Dermatology | DUPIXENT | DERMATOLOGICALS | atopic derm | Criteria Not Met |
| 13946743 | BETH ANN HELLERSTEDT MD | Oncology, Medical | DEXLANSOPRAZOLE | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS | K21.9 - Gastro-esophageal reflux disease without esophagitis | 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 Reyvow and Ubrelvy.
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.

Drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.

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.

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: buprenorphine/naloxone sublingual tablet or film (SUBOXONE SL equivalent), Zubsolv sublingual tablet, and Vivitrol.
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.

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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) The biosimilar version(s) of this drug, called insulin glargine-yfgn , have not been tried and failed. A biosimilar is a biological product that is approved by the United States Food and Drug Administration (FDA) to be highly similar to, and have no clinically meaningful differences from, the original product.
2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Levemir, Toujeo, Tresiba.
3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the biosimilar drug.
Please look at the formulary to see what drugs are covered.

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 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 biosimilar form(s) of the drug have been tried and failed; AND
2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND
3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the biosimilar drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.
Since criteria have not been met, we are not able 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. 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 number(s) 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 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 covered drugs.

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 omeprazole (TRIED), pantoprazole, rabeprazole, lansoprazole (OTC), and esomeprazole (OTC).
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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 13949211 | MICHAEL ANDREW MUSGROVE MD | Psychiatry | VRAYLAR | ANTIPSYCHOTICS/ANTIMANIC AGENTS | F33.2 | Not Covered |
| 13959025 | KOHLBE THOMAS PA-C | Physician Assistant | HYDROCODONE BITARTRATE/AC | ANALGESICS - OPIOID | G89.4 - Chronic pain syndrome | Not Covered |
| 13961046 | ANDRE SHAW CHEN MD | Family Practice | BUPRENORPHINE HCL | ANALGESICS - OPIOID | F11.20 - Opioid dependence, uncomplicated | Not Covered |
| 13964871 | NATALIA MILLIKEN NP-C | Advanced Practice Nurse | CLOMIPHENE CITRATE | ENDOCRINE AND METABOLIC AGENTS - MISC. | E29.1 - Testicular hypofunction | Not Covered |
| 13972850 | JOHN SANG HEE KIM MD | Family Practice | UBRELVY | MIGRAINE PRODUCTS | G43.009 | Criteria Not Met |
| 13973447 | CATHERINE MARIE BREEN PA-C | Physician Assistant | SUNOSI | ADHD/ANTI-NARCOLEPSY | G47.419 - Narcolepsy without cataplexy | Criteria Not Met |

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 our Vraylar exception policy have not been met. From the records that we have received, these reasons caused the denial:
1) Records did not show aripiprazole (Abilify equivalent) did not work for you.
2) Records did not show that another drug called quetiapine OR olanzapine used together with an antidepressant medication did not work for you.
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, 5 of the Vraylar 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 prescribed for the adjunctive treatment of Major Depressive Disorder; AND
2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND
3) Member has had an inadequate response to antidepressant therapy during the current episode; AND
4) Two (2) or more antidepressant medications were ineffective or not tolerated; AND
5) A trial of quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication was ineffective or not tolerated.
Since criteria have not been met, we 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.

We have received a request for 110 tablets for a 30 day supply for hydrocodone/acetaminophen. 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 day supply 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.

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 buprenorphine/naloxone required (Suboxone film/Zubsolv tab).
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.

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 Testicular hypofunction . This is not an approved use.
2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿testosterone cypionate, testosterone enanthate, testosterone gel packet or pump 1% (Androgel equivalent), testosterone gel packet or pump 1.62% (Androgel equivalent), testosterone solution (Axiron equivalent), Androderm patch.
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.

Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for these reasons:
1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan, rizatriptan, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply.
2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply.
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 ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2,3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here.
1) Member has a diagnosis of migraine; AND
2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND
3) A trial of a second triptan 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 Sunosi have not been met. From the records that we have received, the following caused the denial of Sunosi.
1) Records did not show that you have had fewer symptoms of excessive daytime sleepiness since starting this medication.
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 Sunosi have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here.
1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (documentation is required to be submitted for an approval); AND
2) If prescribed for Excessive Daytime Sleepiness due to Obstructive Sleep Apnea, the medication will continue to be used in conjunction with positive airway pressure therapy.
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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 13982323 | CASEY EDWARD COTON DO | Psychiatry | ADZENYS XR-ODT | ADHD/ANTI-NARCOLEPSY | F90.2 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (tried) (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent) (tried) , lisdexamfetamine (Vyvanse equivalent).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13986659 | JAMES COCHRAN ANDERSON IV MD | Pediatrics | AZSTARYS | ADHD/ANTI-NARCOLEPSY | F90.2 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER) (TRIED), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 13992423 | KYMBERLI KAY MCCLAIN FNP | Nurse Practitioner | LIVALO | ANTIHYPERLIPIDEMICS | E78.5 - Hyperlipidemia, unspecified | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are simvastatin (80 mg may not be covered), pravastatin (TRIED), atorvastatin (TRIED), lovastatin, rosuvastatin (TRIED).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14017819 | JOHN ROBERTSON JEFFERSON MD | Internal Medicine | LYRICA | ANTICONVULSANTS | M79.2 - Neuralgia and neuritis, unspecified | Plan Limits Exceeded | The requested amount of pregabalin 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 pregabalin at 3 capsules per day for this use. The prescribed dose is 4 capsules per day. This drug comes in a 150mg capsule. The same dose can be reached by taking one 150mg capsule twice daily. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered. |
| 14018098 | CRAIG HEWELL COUCH MD | Neurology | NURTEC | MIGRAINE PRODUCTS | g43.009 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow and Ubrelvy.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14029731 | VANESSA K MOORE MD | Psychiatry | VIIBRYD | ANTIDEPRESSANTS | f41.1 | Criteria Not Met | Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone.<br>1) This drug is not being used for major depressive disorder. This is a health issue where feelings of sadness and low mood last for a long time.<br>2) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline(tried), citalopram, escitalopram, fluoxetine, paroxetine)<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 1 and 3 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of major depressive disorder; AND<br>2) Member is 18 years of age or older; AND<br>3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND<br>4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine).<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14031879 EDGAR MARTINEZ SR | Dermatology | HUMIRA PEN | TARGETED IMMUNOMODULATORS | Psoriasis | Criteria Not Met | Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Humira was denied for these reasons:<br>1) Records did not show that at least one (1) of the following treatments has been tried and did not work for you: (A) minimum of 15 sessions of light therapy, OR (B) methotrexate at a dose of 15mg per week or higher, OR (C) acitretin.<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Adalimumab Products have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has a diagnosis of 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<br>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 the contraindications are specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin.<br>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. |
| 14032599 VANESSA K MOORE MD | Psychiatry | VIIBRYD | ANTIDEPRESSANTS | F41.1 | Criteria Not Met | Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone.<br>1) This drug is not being used for major depressive disorder. This is a health issue where feelings of sadness and low mood last for a long time.<br>2) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline(tried), citalopram, escitalopram, fluoxetine, paroxetine)<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 1,3 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of major depressive disorder; AND<br>2) Member is 18 years of age or older; AND<br>3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND<br>4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine).<br>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. |
| 14036274 JENELYN JOY RAMOS | Family Practice | LANTUS SOLOSTAR | ANTIDIABETICS | E11.65 | 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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) The biosimilar version(s) of this drug, called insulin glargine-yfgn, have not been tried and failed. A biosimilar is a biological product that is approved by the United States Food and Drug Administration (FDA) to be highly similar to, and have no clinically meaningful differences from, the original product.<br>2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Levemir(tried), Toujeo, Tresiba.<br>3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the biosimilar drug.<br>Please look at the formulary to see what drugs are covered.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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 1,2,3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The biosimilar form(s) of the drug have been tried and failed; AND<br>2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND<br>3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the biosimilar drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.<br>Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs. |
| 14041313 IAN STEVEN ALWARD MD | Family Practice | ADDERALL XR | ADHD/ANTI-NARCOLEPSY | G47.419 | 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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) The generic version of this drug, called Amphetamine-dextroamphetamine, has not been tried and failed.<br>2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are modafinil, armodafinil(tried), Sodium Oxybate oral solution, Wakix, Sunosi, Lumryz.<br>3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.<br>Please look at the formulary to see what drugs are covered.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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) 1,2,3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The generic form of the drug has been tried and failed; AND<br>2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND<br>3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.<br>Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs. |
| 14045804 TAMILSELVI PERIASAMY MD | Internal Medicine | DICLOFENAC SODIUM | DERMATOLOGICALS | m79.18 | Criteria Not Met | Our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the records that we have received, diclofenac 3% gel was denied for these reasons:<br>1) This drug is not being used to treat actinic keratosis. This is a skin issue caused by too much sun. It causes scaly, rough, or bumpy spots on the skin.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for diclofenac 3% gel. The reason for denial is explained to the member above. The criteria are listed here.<br>1) The medication is prescribed for the treatment of Actinic Keratosis.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14046654 | CARTER REID HANSON PA-C | Physician Assistant | TESTOSTERONE | ANDROGENS-ANABOLIC | e29.1 | Criteria Not Met |
| 14054077 | JEANETTE LYN BETTES PA | Physician Assistant | BRIMONIDINE TARTRATE | DERMATOLOGICALS | L71.9 - Rosacea, unspecified | Plan Exclusion |
| 14057033 | AHMAD BILAL TABBARA FNP-C | Nurse Practitioner | CLOMID | ENDOCRINE AND METABOLIC AGENTS - MISC. | E29.1 - Testicular hypofunction | Not Covered |
| 14057418 | KAREN JENIFER ROMERO DO | Family Practice | MOUNJARO | ANTIDIABETICS | R73.09 | Plan Exclusion |
| 14061023 | FARHEEN YOUSUF MD | Endocrinology, Diabetes & Metabolism | WEGOVY | ANTI-OBESITY/ANOREXIANTS | Obesity, unspecified | Plan Exclusion |
| 14067087 | THERESA EBANKS WAGNER MD | Ophthalmology | XIIDRA | OPHTHALMIC AGENTS | H04.123 | Not Covered |
| 14067443 | RICKY CHANDRA MEHTA | Rheumatology | HUMIRA | TARGETED IMMUNOMODULATORS | L40.50 | Criteria Not Met |
| 14069105 | DAVID JON REVERE MD | Cardiology | PRALUENT | ANTIHYPERLIPIDEMICS | E78.5 - Hyperlipidemia, unspecified | Not Covered |
| 14074013 | WILLIAM MARC LEWIS DO | Internal Medicine | LOMAIRA | ANTI-OBESITY/ANOREXIANTS | E66.9 - Obesity, unspecified | Plan Exclusion |

Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, testosterone gel was denied for these reasons:
1) More information is needed to know if your low levels of testosterone are age-related.
2) Two low testosterone levels have not been sent to us. The labs must be drawn in the morning and must be from two different days.
3) A second lab value from within the last 24 months was not sent to us.
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: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 3, 4 and 5of our prior authorization criteria for Initial 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 symptoms of hypogonadism; AND
3) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND
4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND
5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 months.
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.

This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.

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 Hypogonadism. This is not an approved use.
2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are cтestosterone cypionate, testosterone enanthate, testosterone gel packet or pump 1% (Androgel equivalent), testosterone gel packet or pump 1.62% (Androgel equivalent), testosterone solution (Axiron equivalent).
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.

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.

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.

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 cyclosporine (Restasis equivalent).
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.

Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Humira was denied for these reasons:
1) Records did not show that either methotrexate OR sulfasalazine did not work for you, OR that you have a contraindication to both of these drugs and cannot take either of them.
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. Prior authorization and quantity limits may apply.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for Adalimumab Products have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira. 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 ONE (1) of the following: (A) Peripheral Ankylosing Spondylitis (AS); OR (B) Psoriatic Arthritis (PsA); OR (C) Reactive Arthritis; AND
3) A trial of ONE (1) of the following was ineffective or not tolerated: (A) methotrexate or (B) sulfasalazine; OR (C) Member has contraindication to BOTH drugs AND the contraindication is specified.
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.

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 Repatha (tried), Nexletol, Nexlizet.
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.

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.

| | | | | | | |
|---|---|---|---|---|---|---|
| 14095095 CODY PAULINE SEEL PA | Physician Assistant | DUPIXENT | DERMATOLOGICALS | L20.9 | Criteria Not Met | Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons:<br>1) Records did not show that at least 10% of your body surface area (BSA) is affected by your health issue.<br>2) Records did not show that sensitive areas of your body are affected by your health issue.<br>3) Records did not show that at least TWO (2) other treatments, such as topical steroids, topical calcineurin inhibitors (e.g. tacrolimus, pimecrolimus), light therapy, azathioprine, cyclosporine, methotrexate, and mycophenolate mofetil, did not work for you.<br>4) More information is needed to know if this drug is being used together with another biologic drug for atopic dermatitis (eczema).<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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(s) 3, 4, and 5 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member is 6 months of age or older; AND<br>2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND<br>3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND<br>4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval):<br>(A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND<br>5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.<br>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 |
| 14097121 MARC EVAN WENZEL MD | Endocrinology, Diabetes & Metabolism | INSULIN DEGLUDEC FLEXTOUC | ANTIDIABETICS | e10.65 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Tresiba (tried), Lantus (tried), Basaglar, Semglee, Levemir, Toujeo .<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14097911 JOHN SANG HEE KIM MD | Family Practice | UBRELVY | MIGRAINE PRODUCTS | G43.009 | Criteria Not Met | The requested amount of Ubrelvy 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 Ubrelvy at 10 tablets per 30 days, 6 fills per year for this use. The higher number of 16 tablets per 30 days is not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, or Emgality, must be used to help prevent migraine headaches. Prior authorization may be required. Quantity limits may apply. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs. |
| 14106777 MATTHEW SCOTT HILL DO | Family Practice | LINZESS | GASTROINTESTINAL AGENTS - MISC. | K59.00 | Criteria Not Met | Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:<br>1) Records did not show that another drug called plecanatide (Trulance) did not work for you.<br>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. Prior authorization and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND<br>2) The member is 18 years of age or older; AND<br>3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND<br>4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR<br>5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C).<br>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. |
| 14107061 SARA JANE PAVITT MD | Neurology | ALMOTRIPTAN MALATE | MIGRAINE PRODUCTS | G43.709 - Chronic migraine without aura, not intractable, without status migrainosus | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are rizatriptan and zolmitriptan nasal spray.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14108490 CYDNEY PALMER RANA FNP-C | Nurse Practitioner | PREVYMIS | ANTIVIRALS | b25.8 | Plan Limits Exceeded | The requested amount of Prevymis 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 Prevymis at 100 tablets per 6 months for this use. The higher amount of more than the 100 tablets is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14114998 | EDGAR MARTINEZ SR | Dermatology | COSENTYX SENSOREADY PEN | TARGETED IMMUNOMODULATORS | L40.0 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Enbrel,an adalimumab product (Humira, Hadlima, adalimumab-adaz, adalimumab-fkjp, Amjevita), Taltz, Tremfya, Cimzia, Otezla, Skyrizi, and Stelara.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14115046 | EDGAR MARTINEZ SR | Dermatology | HUMIRA PEN | TARGETED IMMUNOMODULATORS | pp | Criteria Not Met | Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Humira was denied for these reasons:<br>1) Records did not show that at least one (1) of the following treatments has been tried and did not work for you: (A) minimum of 15 sessions of light therapy, OR (B) methotrexate at a dose of 15mg per week or higher, OR (C) acitretin.<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Adalimumab Products have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has a diagnosis of 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<br>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 the contraindications are specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin.<br>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. |
| 14133989 | MELODY ANN DENSON MD | Urology | INTRAROSA | VAGINAL AND RELATED PRODUCTS | n95.2 | 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:<br>1) This drug is being used for post menopausal atrophic vaginitis. This is not an approved use.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14138723 | LOUIS FERNAND FABRE JR MD | Psychiatry | ADDERALL XR | ADHD/ANTI-NARCOLEPSY | F90.9 - Attention-deficit hyperactivity disorder, unspecified type | 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 criteria in this policy have not been met. From the records that we have received, these reasons caused the denial:<br>1) The generic version of this drug, called amphetamine/dextroamphetamine extended release (ER), has not been tried and failed. (Paid claims seen but more information is needed to determine if this drug did not work for you).<br>2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, lisdexamfetamine (Vyvanse equivalent).<br>3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.<br>Please look at the formulary to see what drugs are covered.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The generic form of the drug has been tried and failed; AND<br>2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND<br>3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.<br>Since criteria have not been met, we are not able 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. Quantity limits may apply to covered drugs. |
| 14147286 | MICHELE AGUSTIN MD | Obstetrics & Gynecology | ADDYI | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | R68.82 - Decreased libido | Not Covered | This request has not been approved because this medication is a non-formulary medication and is not covered based on our Pharmacy and Therapeutics (P&T) Committee guidelines for the coverage of non-formulary medications. The P&T Committee uses evidence-based medicine to determine coverage of medications. This medication is not covered due to lack of efficacy and significant safety concerns. Please discuss other possible treatment options with your prescriber. |
| 14149180 | EDGAR MARTINEZ SR | Dermatology | COSENTYX SENSOREADY PEN | TARGETED IMMUNOMODULATORS | L40.9 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Other drugs that can be used are Enbrel,an adalimumab product (Humira, Hadlima, adalimumab-adaz, adalimumab-fkjp, Amjevita), Taltz, Tremfya, Cimzia, Otezla, Skyrizi, and Stelara (TRIED) .<br>2) Chart notes showing your health records and past treatments were not received.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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 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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14153352 | AMY KRISTIN EASTERLING DO | Emergency Medicine | QVAR REDIHALER | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | J30.9 - Allergic rhinitis, unspecified | 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:<br>1) This drug is being used for Allergic rhinitis. This is not an approved use.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14171319 | TERA CHRISTINA BROOKS MD | Family Practice | TRINTELLIX | ANTIDEPRESSANTS | F32.0 | Criteria Not Met | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed.<br>2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |
| 14181061 | EMILY NADEZHDA STAHL | Clinical Nurse Specialist | BOTOX | NEUROMUSCULAR AGENTS | Chronic migraine w/o aura, not intractable, w/o stat migr | Plan Exclusion | This drug is not on our list of covered drugs, also known as our formulary. BOTOX is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs. |
| 14202871 | TERA CHRISTINA BROOKS MD | Family Practice | TRINTELLIX | ANTIDEPRESSANTS | mdd | Criteria Not Met | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed.<br>2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |
| 14209405 | SHAO-CHUN ROSE CHANG-JACKSON MD | Obstetrics & Gynecology | ORIAHNN | ESTROGENS | Abnormal uterine and vaginal bleeding, unspecified | Criteria Not Met | Our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the records that we have received, Oriahnn was denied for these reasons:<br>1) More information is needed to show you are pre-menopausal. This means your body has not gone through the changes of menopause yet.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Oriahnn. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND<br>2) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND<br>3) Member has NO known osteoporosis; AND<br>4) Member is premenopausal; AND<br>5) A trial of a hormonal contraceptive was ineffective, contraindicated, or not tolerated.<br>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. |
| 14226598 | MARIA NICHOLE PEREZ MD | Internal Medicine | TRAMADOL HYDROCHLORIDE | ANALGESICS - OPIOID | M53.3-Sacrococcygeal disorders | Not Covered | We have received a request for 30 tablets for a 15 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 day supply 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:<br>1) Records show that you have recent use of an opioid pain reliever; OR<br>2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.<br>Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. |
| 14229864 | CHRISTOPHER DAVID MCCOY MD | Cardiology, Interventional | NEXLETOL | ANTIHYPERLIPIDEMICS | E78.5 | Criteria Not Met | Our prior authorization criteria for bempedoic acid (NEXLETOL), bempedoic acid-ezetimibe (NEXLIZET) have not been met. From the records that we have received, Nexletol was denied for these reasons:<br>1) Records did not show this drug is being used together with diet changes.<br>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. Prior authorization and quantity limits may apply.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for bempedoic acid (NEXLETOL), bempedoic acid-ezetimibe (NEXLIZET) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Nexletol. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of heterozygous familial hypercholesterolemia (HeFH); OR<br>2) Member has a diagnosis of established atherosclerotic cardiovascular disease (ASCVD); AND<br>3) Nexletol will be used as an adjunct to diet; AND<br>4) Nexletol will be used as an adjunct to maximally tolerated statin therapy; AND<br>5) Member's low-density lipoprotein (LDL) is greater than or equal to 70mg/dL with concomitant use of both of the following: (A) Ezetimibe (Zetia), AND (B) Maximally tolerated statin therapy or statin-intolerant.<br>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 tralokinumab (ADBRY) have not been met. From the records that we have received, Adbry was denied for these reasons:<br>1) Records showing this drug is working well have not been received.<br>2) More information is needed to know if this drug is being used together with another biologic drug.<br>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. |
| 14231697 | ERYN MECHEL MCINTYRE PA-C | Physician Assistant | ADBRY | DERMATOLOGICALS | I20.89 | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for tralokinumab (ADBRY) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Adbry. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Documentation of positive clinical response is provided with the request (documentation is required to be submitted for an approval); AND<br>2) Tralokinumab (ADBRY) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.<br>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 Androgens: Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1.62% was denied for these reasons:<br>1) More information is needed to know if your low levels of testosterone are age-related.<br>2) Two low testosterone levels have not been sent to us. The labs must be drawn in the morning and must be from two different days.<br>3) A lab value from within the last 12 months was not sent to us.<br>4) A second lab value from within the last 24 months was not sent to us.<br>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. |
| 14232426 | BRAD ERIC VENGHAUS MD | Hospitalist | TESTOSTERONE | ANDROGENS-ANABOLIC | E29.1 | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 3, 4 and 5 of our prior authorization criteria for Initial Therapy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND<br>2) Member has symptoms of hypogonadism; AND<br>3) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND<br>4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND<br>5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 months.<br>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 elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the records that we have received, Oriahnn was denied for these reasons:<br>1) More information is needed to show you do not have osteoporosis. This is a health issue where bones become weak and brittle. Use of this drug can increase risk of weakened bones.<br>2) More information is needed to show you are pre-menopausal. This means your body has not gone through the changes of menopause yet.<br>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. |
| 14235976 | SHAO-CHUN ROSE CHANG-JACKSON MD | Obstetrics & Gynecology | ORIAHNN | ESTROGENS | N93.9-Abnormal uterine and vaginal bleeding | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the information we have received, the member does not meet number(s) 3, 4 of our prior authorization criteria for Oriahnn. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND<br>2) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND<br>3) Member has NO known osteoporosis; AND<br>4) Member is premenopausal; AND<br>5) A trial of a hormonal contraceptive was ineffective, contraindicated, or not tolerated.<br>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 |
| | | | | | | | 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:<br>1) Records did not include your diagnosis. More information is needed to know what health issue is being treated.<br>2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are covered antihistamine nasal sprays (azelastine 0.1% nasal spray, azelastine 0.15% nasal spray, olopatadine nasal spray) used in combination with covered steroid nasal sprays (budesonide nasal spray, flunisolide nasal spray, fluticasone nasal spray, triamcinolone nasal spray, Flonase Sensimist). Please note: since your diagnosis was not provided, this may not be an accurate list of alternatives to be tried.<br>3) Chart notes showing your health records and past treatments were not received.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. |
| 14236013 | AMANDA KAY WATERMAN | Family Practice | AZELASTINE HYDROCHLORIDE/ | NASAL AGENTS - SYSTEMIC AND TOPICAL | None | Not Covered | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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, 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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| | | | | | | | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) The drug is not being used for Major Depressive Disorder (MDD).<br>2) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram (TRIED), fluoxetine, or paroxetine, have been tried and failed.<br>3) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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. |
| 14236337 | LINDSAY ARLENE BISBY PMHNPBC | Advanced Practice Nurse | TRINTELLIX | ANTIDEPRESSANTS | F31.81 | Criteria Not Met | ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 1, 2, and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14238749 | BRAD ERIC VENGHAUS MD | Hospitalist | TESTOSTERONE | ANDROGENS-ANABOLIC | E29.1 | Criteria Not Met | Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, testosterone gel was denied for these reasons:<br>1) More information is needed to know if your low levels of testosterone are age-related.<br>2) Two low testosterone levels have not been sent to us. The labs must be drawn in the morning and must be from two different days.<br>3) A lab value from within the last 12 months was received, but a second lab value from within the last 24 months was not sent to us.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 3, and 4 of our prior authorization criteria for Initial Therapy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND<br>2) Member has symptoms of hypogonadism; AND<br>3) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND<br>4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND<br>5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 months.<br>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 druqs. |
| 14286664 | TRICIA LYNN WINTERS PA | Physician Assistant | OTEZLA | TARGETED IMMUNOMODULATORS | PSORIASIS VULGARIS | Criteria Not Met | Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons:<br>1) 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.<br>2) Chart notes were not sent to us to show the details of your health issue and how you responded to previous treatments.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Otezla for Plaque Psoriasis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Dermatologist; AND<br>2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Plaque psoriasis (PP) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND<br>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; AND<br>4) Apremilast (OTEZLA) will not be used in combination with biologic therapy.<br>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. |
| 14293384 | JOSEMARIA JOSEMARIAP PATERNO MD | Anesthesiology | BELBUCA | ANALGESICS - OPIOID | Z79.891 | 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:<br>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, fentanyl patch (Duragesic equivalent).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14297196 | ERYN MECHEL MCINTYRE PA-C | Physician Assistant | ADBRY | DERMATOLOGICALS | L20.89 - Other atopic dermatitis | Criteria Not Met | Our prior authorization criteria for tralokinumab (ADBRY) have not been met. From the records that we have received, Adbry was denied for these reasons:<br>1) Records showing this drug is working well have not been received.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for tralokinumab (ADBRY) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Adbry. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Documentation of positive clinical response is provided with the request (documentation is required to be submitted for an approval); AND<br>2) Tralokinumab (ADBRY) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.<br>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. |
| 14301189 | KIMBERLEE MARIE SLAUGHTER OD | Optometrist | XDEMVY | OPHTHALMIC AGENTS | H01.003-Unspecified blepharitis right eye | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are erythromycin ophthalmic ointment, BACITRACIN OPHTHALMIC OINTMENT.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14305830 ANA MARIA HERRERA | Nurse Practitioner | DESCOVY | ANTIVIRALS | Z20.6 - Contact with and (suspected) exposure to human immunodeficiency virus [HIV] | Criteria Not Met | Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons:<br>1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada.<br>2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada.<br>3) Records were not sent to us to show your kidneys are not working like normal based on lab tests.<br>4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR<br>2) Prescribed for pre-exposure prophylaxis of HIV infection; AND<br>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); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).<br>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 |
| 14309114 CARTER REID HANSON PA-C | Physician Assistant | ANDROGEL | ANDROGENS-ANABOLIC | E29.1 - Testicular hypofunction | Criteria Not Met | Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, ANDROGEL GEL 1.62% was denied for these reasons:<br>1) Records show that this drug is being used for age-related low testosterone levels. This is not a covered use on your drug plan.<br>2) Two low testosterone levels have not been sent to us. The labs must be drawn in the morning and must be from two different days.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 3, 4, 5 of our prior authorization criteria for Initial Therapy. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND<br>2) Member has symptoms of hypogonadism; AND<br>3) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND<br>4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND<br>5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 months.<br>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. |
| 14310475 LUKE CONNOR JOHNSON PA-C | Physician Assistant | SILDENAFIL CITRATE | CARDIOVASCULAR AGENTS - MISC. | E29.1 | 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. |
| 14323830 LIDIA YESENIA LOPEZ | Physician Assistant | TRI-LUMA | DERMATOLOGICALS | L81.1 - Chloasma | Plan Exclusion | This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. |
| 14333591 ERYN MECHEL MCINTYRE PA-C | Physician Assistant | ADBRY | DERMATOLOGICALS | L20.89 | Criteria Not Met | Our prior authorization criteria for tralokinumab (ADBRY) have not been met. From the records that we have received, Adbry was denied for these reasons:<br>1) Records showing this drug is working well have not been received.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for tralokinumab (ADBRY) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Adbry. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Documentation of positive clinical response is provided with the request (documentation is required to be submitted for an approval); AND<br>2) Tralokinumab (ADBRY) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.<br>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. |
| 14334282 TIMOTHY IAN HILTON NP | Advanced Practice Nurse | TRAMADOL HYDROCHLORIDE | ANALGESICS - OPIOID | M17.0 | Not Covered | We have received a request for 60 tablets for a 30 day supply for tramadol. 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 day supply 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:<br>1) Records show that you have recent use of an opioid pain reliever; OR<br>2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.<br>Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. |
| 14339578 VINCENZ LIM DECASTRO | Family Practice | MOMETASONE FUROATE | NASAL AGENTS - SYSTEMIC AND TOPICAL | J30.2 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray, flunisolide nasal spray, fluticasone nasal spray, triamcinolone nasal spray, and Flonase Sensimist.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14341157 HYOJIN HAN PMHNPBC | Advanced Practice Nurse | TRINTELLIX | ANTIDEPRESSANTS | F33.1 | Criteria Not Met | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14361711 | JACQUELINE MARIE KERR MD | Family Practice | TESTOSTERONE | ANDROGENS-ANABOLIC | R89.1 - Abnormal level of hormones in specimens from other organs, systems and tissues | Criteria Not Met | Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1% (50MG) was denied for these reasons:<br>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.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND<br>2) Member has been established on testosterone replacement therapy; AND<br>3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment.<br>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. |
| 14363656 | JAMES COCHRAN ANDERSON IV MD | Pediatrics | JORNAY PM | ADHD/ANTI-NARCOLEPSY | F90.2 - Attention-deficit hyperactivity disorder, combined type | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14368848 | NEERAJ MANCHANDA MD | Internal Medicine | XYREM | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | G47.419 - Narcolepsy without cataplexy | Criteria Not Met | Our prior authorization criteria for XYREM have not been met. From the records that we have received, XYREM was denied for these reasons:<br>1) This drug is not being used for excessive daytime sleepiness with narcolepsy, cataplexy with narcolepsy or idiopathic hypersomnia. There are all specific health issues that cause extreme sleepiness during the day. Please note: additional criteria apply for each covered health issue.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria ivabradine XYREM have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for XYREM. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of excessive daytime sleepiness with narcolepsy, cataplexy with narcolepsy, or idiopathic hypersomnia; AND<br>2) Additional criteria for covered diagnosis are met.<br>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. |
| 14371461 | DOMINICK ANDREW RUIZ MD | Family Practice | BROMPHEN/PSEUDOEPHEDRINE | COUGH/COLD/ALLERGY | Acute upper respiratory infection, unspecified | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are guaifenesin/codeine syrup, promethazine DM syrup, promethazine VC syrup, promethazine VC/codeine syrup, and other covered cough syrups.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14374973 | IVAN SRDANOVIC PMHNPBC | Advanced Practice Nurse | TRINTELLIX | ANTIDEPRESSANTS | ADHD | Criteria Not Met | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) The drug is not being used for Major Depressive Disorder (MDD).<br>2) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed.<br>3) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet numbers 1, 2, and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |
| 14378843 | SHERI MICHELLE RAVENSCROFT MD | Developmental-Behavioral Medicine | QUILLIVANT XR | ADHD/ANTI-NARCOLEPSY | F84.0 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER (Concerta, Ritalin LA, or Metadate CD equivalent), amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamphetamine (Vyvanse equivalent) chewable tablet, dextroamphetamine ER, and others. Please note: ER capsules can be opened and sprinkled over applesauce.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14392092 PAUL DANIEL CAUVIN MD | Family Practice | LEVALBUTEROL TARTRATE HFA | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | J20.9 - Acute bronchitis, unspecified | 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, LEVALBUTEROL TARTRATE HFA was denied for these reasons:<br>1) VENTOLIN HFA has not been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested.<br>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. |
| 14396905 MICHAEL ANDREW MUSGROVE MD | Psychiatry | TRINTELLIX | ANTIDEPRESSANTS | F33.2 | Criteria Not Met | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed.<br>2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |
| 14406728 NATALIE ADRIANNE WILLIAMS MD | Family Practice | HUMALOG KWIKPEN | ANTIDIABETICS | E11.9 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Insulin Aspart (Novolog equivalent) or Fiasp.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14415390 RAJESH ANAND SHETTY MD | Pulmonary Disease | OFEV | RESPIRATORY AGENTS - MISC. | ILD | Criteria Not Met | Our prior authorization criteria for nintedanib (OFEV) have not been met. From the records that we have received, Ofev was denied for these reasons:<br>1) Records did not show that your health issue is getting worse, or progressive.<br>2) More information is needed to know about the specific testing that was done to confirm your health issue.<br>3) Records did not show the dates and results of a breathing test called Forced Vital Capacity (FVC).<br>4) Records did not show the dates and results of a breathing test called the diffusing capacity for carbon monoxide (DLCO).<br>5) Records did not show that your breathing problems have gotten worse.<br>6) Records did not show that changes have been seen on a chest X-Ray or CT scan.<br>7) Records did not show that one of the following drugs did not work for you: azathioprine, cyclosporine, mycophenolate mofetil, oral corticosteroids (e.g. more than 20mg of prednisone per day), cyclophosphamide, OR rituximab, OR tacrolimus. Prior authorization may be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for nintedanib (OFEV) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for Ofev for Chronic Fibrosing Interstitial Lung Disease. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Pulmonologist; AND<br>2) Member has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype; AND<br>3) Disease is progressive, as defined by two (2) of the following occurring within the past 12 months with no alternative explanation: (A) Worsening respiratory symptoms, or (B) Absolute decline in forced vital capacity (FVC) of greater than or equal to 5% predicted within one (1) year of follow-up, and FVC values and dates are provided, or (C) Absolute decline in diffusing capacity for carbon monoxide (DLCO) (corrected for hemoglobin) of greater than or equal to 10% predicted within one (1) year of follow-up, and DLCO values and dates are provided, or (D) Radiological evidence of disease progression, as evidenced by at least one (1) of the following is provided with the request (documentation is required to be submitted for an approval: increased extent or severity of traction bronchiectasis and bronchiolectasis or new ground-glass opacity with traction bronchiectasis or new fine reticulation or increased extent or increased coarseness of reticular abnormality, or new or increased honeycombing, or increase lobar volume loss.<br>4) Progression occurred despite treatment with at least one (1) of the following: (A) azathioprine, (B) cyclophosphamide, (C) cyclosporine, (D) mycophenolate mofetil, (E) oral corticosteroids equivalent to prednisone dose of greater than (>) 20 mg per day, (F) rituximab, OR (H) tacrolimus.<br>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. |
| 14420260 SHWOL-HUO DANNY KIANG DO | Dermatology | DUPIXENT | DERMATOLOGICALS | L20.89 | Criteria Not Met | Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons:<br>1) Chart notes showing details of your health issue, such as how much of your body is affected and what other treatments you have tried, were not received.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member is 6 months of age or older; AND<br>2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND<br>3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND<br>4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval):<br>(A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND<br>5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.<br>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 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14420456 | BONNIE LEIGH POPE APRN | Nurse Practitioner | JAKAFI | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES | D89.811 | Criteria Not Met | Our prior authorization criteria for Jakafi have not been met. From the records that we have received, the following caused the denial of Jakafi.<br>1) Records did not show that corticosteroids (e.g. prednisone) have been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Jakafi have not been met. From the information we have received, the member does not meet number 4 of our prior authorization criteria for Jakafi. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for a diagnosis of moderate to severe chronic graft-versus-host disease (GVHD) after allogenic hematopoietic stem cell transplant; AND<br>2) Prescribed by, or in consultation with, an Oncologist, Hematologist, or Transplant Specialist; AND<br>3) Member is 12 years of age or older; AND<br>4) Member is refractory to corticosteroids alone.<br>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. |
| 14421291 | MICHAEL ANDREW MUSGROVE MD | Psychiatry | VILAZODONE HYDROCHLORIDE | ANTIDEPRESSANTS | F33.2 | Criteria Not Met | Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone.<br>1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram-(TRIED), fluoxetine, paroxetine)<br><br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of major depressive disorder; AND<br>2) Member is 18 years of age or older; AND<br>3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND<br>4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine).<br>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. |
| 14435224 | CHRISTY TAYLOR RISINGER MD | Internal Medicine | ZEPBOUND | ANTI-OBESITY/ANOREXIANTS | e66.01 | Plan Exclusion | This request cannot be approved because this drug/product is in a class of drugs/products called anti-obesity, or weight loss, drugs. Drugs/products of this type are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs/products, 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. |
| 14437059 | AHMAD BILAL TABBARA FNP-C | Nurse Practitioner | ALBUTEROL SULFATE HFA | ANTIASTHMATIC AND BRONCHODILATOR AGENTS | J45.909 - Unspecified asthma, uncomplicated | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Ventolin HFA inhaler, albuterol HFA inhaler (Proair equivalent), albuterol HFA inhaler (Proventil equivalent).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14442308 | MOHAMMAD ABDALLA YOUSEF MD | Gastroenterology | SUTAB | LAXATIVES | Z12.11 | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Golytely, polyethylene glycol (PEG) 3350/electrolytes (Colyte equivalent), PEG 3350/electrolytes ¿(Nulytely equivalent), sodium/potassium/magnesium solution (Suprep equivalent), PEG 3350 solution (Moviprep equivalent)¿, Clenpiq.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14453719 | ELIZABETH HAVEY MILLER MD | Dermatology | LEVICYN | DERMATOLOGICALS | L30.4 | Plan Exclusion | This request has not been approved because this product was approved by the United States Food and Drug Administration (FDA) as a medical device. Medical devices are non-drug products that are meant to help diagnose and treat health issues. Medical devices cannot be approved and are excluded from coverage under your pharmacy benefit. This product may be covered under your medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. There also may be over-the-counter (OTC) products that you can buy without a prescription that may treat your health issue. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs. |
| 14454964 | RAJESH ANAND SHETTY MD | Pulmonary Disease | OFEV | RESPIRATORY AGENTS - MISC. | J84.9 | Criteria Not Met | Our prior authorization criteria for nintedanib (OFEV) have not been met. From the records that we have received, Ofev was denied for these reasons:<br>1) Records did not show that one of the following drugs did not work for you: azathioprine, cyclosporine, mycophenolate mofetil, oral corticosteroids (e.g. more than 20mg of prednisone per day), cyclophosphamide, OR rituximab, OR tacrolimus. Prior authorization may be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for nintedanib (OFEV) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Ofev for Chronic Fibrosing Interstitial Lung Disease. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed by a Pulmonologist; AND<br>2) Member has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype; AND<br>3) Disease is progressive, as defined by two (2) of the following occurring within the past 12 months with no alternative explanation: (A) Worsening respiratory symptoms, or (B) Absolute decline in forced vital capacity (FVC) of greater than or equal to 5% predicted within one (1) year of follow-up, and FVC values and dates are provided, or (C) Absolute decline in diffusing capacity for carbon monoxide (DLCO) (corrected for hemoglobin) of greater than or equal to 10% predicted within one (1) year of follow-up, and DLCO values and dates are provided, or (D) Radiological evidence of disease progression, as evidenced by at least one (1) of the following is provided with the request (documentation is required to be submitted for an approval: increased extent or severity of traction bronchiectasis and bronchiolectasis or new ground-glass opacity with traction bronchiectasis or new fine reticulation or increased extent or increased coarseness of reticular abnormality, or new or increased honeycombing, or increase lobar volume loss.<br>4) Progression occurred despite treatment with at least one (1) of the following: (A) azathioprine, (B) cyclophosphamide, (C) cyclosporine, (D) mycophenolate mofetil, (E) oral corticosteroids equivalent to prednisone dose of greater than (>) 20 mg per day, (F) rituximab, OR (H) tacrolimus.<br>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. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14467545 | ARPY JITENDRA KOTHARI PA | Physician Assistant | WINLEVI | DERMATOLOGICALS | L70.8 - Other acne | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin (TRIED) or erythromycin, tretinoin (TRIED), adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14472813 | SUSANNA-RACHEL SALOME SEAY PMHNP | Advanced Practice Nurse | TRINTELLIX | ANTIDEPRESSANTS | F33.1 | Criteria Not Met | Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.<br>1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed.<br>2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Member has a diagnosis of Major Depressive Disorder (MDD), AND<br>2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND<br>3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).<br>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. |
| 14474379 | JAMES COCHRAN ANDERSON IV MD | Pediatrics | JORNAY PM | ADHD/ANTI-NARCOLEPSY | F90.2 - Attention-deficit hyperactivity disorder, combined type | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended-release (ER) capsule (TRIED), amphetamine/dextroamphetamine ER capsule (TRIED), methylphenidate ER tablet or capsule, dextroamphetamine ER capsule, and lisdexamfetamine capsule or chewable tablet (TRIED).<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |
| 14474623 | LIZANN BAKER ROGERS | Nurse Practitioner | FERROUS SULFATE | HEMATOPOIETIC AGENTS | D50.9 - Iron deficiency anemia, 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 ferrous sulfate and others. 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.<br><br>Please note: Your pharmacy drug plan covers Ferrex 150 Forte, Multigen, Multigen Folic, Multigen Plus, and others. Check with your provider if these, or other treatment options, might be right for your health issue. |
| 14477961 | VIKTORYIA V DZISKA PA-C | Physician Assistant | ACETAMINOPHEN EXTRA STREN | ANALGESICS - NONNARCOTIC | R51.9 | 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 acetaminophen tablet, capsule, and oral solution (Tylenol equivalents). 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. |
| 14498094 | ADRIANA AZAR PRATT MD | Family Practice | DEXCOM G7 SENSOR | MEDICAL DEVICES | E11.59 - Type 2 diabetes mellitus with other circulatory complications | Criteria Not Met | Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, DEXCOM G7 was denied for these reasons:<br>1) Records did not show that you are using insulin.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) 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.<br>1) Member is currently using insulin.<br>Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply. |
| 14504687 | DAVID J ESCAMILLA | Pharmacology | SIMVASTATIN | ANTIHYPERLIPIDEMICS | E78.00 - Pure hypercholesterolemia, unspecified | 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:<br>1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: simvastatin (TRIED) (80mg not covered), pravastatin, atorvastatin, lovastatin, rosuvastatin, fluvastatin capsule.<br>Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>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.<br>1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).<br>2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.<br>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.<br>4) Prescription drug samples were not used to establish treatment.<br>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. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14513824 MARC EVAN WENZEL MD | Endocrinology, Diabetes & Metabolism | OZEMPIC | ANTIDIABETICS | R73.03 | Criteria Not Met | Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic injection was denied for this reason:<br>1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply.<br>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.<br><br>ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:<br>This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.<br>1) Prescribed for the treatment of Type 2 Diabetes Mellitus.<br>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. |