Episode Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Denial Reason	Prescriber Decision Notes	Denials Overturned on internal appeal
12455912 JASON SCOTT REICHENBERG MD	Dermatology	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0	Criteria Not Met	This request has not been approved because our prior authorization criteria for risankizumab (SYRIZI) may be used to use reasons: 1) Chart notes were not sent to us to show your response to this drug. Please note: Chart notes sent to us were cut off. 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 risankizumab (SXYRIZI) have not been met. From the information we have received, the member does not meet number(s) a for up rior authorization criteria for Skyrizi for Plaque Psoriass (Continuing Therapy). The reason for	0.03111.83500
						denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Demathologist, John Demathologist,	
						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 bupropion - TRIED on serotonin-norepinephrine reuptake inhibitor (SNR1) (e.g. desveniafaxine extended release (ER) (Pristig equiv), venifaxine - TRIED, duloxetine), and two selective serotronin reuptake inhibitors (SRIE) (e.g. citalorgans, escataporan, flowocithe, paroetine, or sertraline). Please look at the formulary to see what drugs are 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	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this furly is not not 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 reseas for denial is expellent 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 crassons have been provided why alternatives have been been tried or medical crassons have been provided why alternative shave due to the covered drugs are shared and or spores, 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. 4) Prescription drug samples were not used to establish treatment. 5 Find a control of the provided of the provided of the story of the 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 drug.	
						Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupbiers. J 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.	
12638815 CODY PAULINE SEEL PA	Physician Assistant	DUPIXENT	DERMATOLOGICALS	L20.9 - Atopic dermatitis, unspecified	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupliumab (DUPIXENT) have not been met. From the information we have received, the member does not meet to four 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 occurage 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 almoying (TREID), Ajovy, and Emgality. Prior architectation may be required, quantity limits may apply. Please book at the formulary to see what drugs are 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	ADDITIONAL INFORMATION FOR YOUR HEALTH CASE PROVIDE: The request has not been approved because this firing is not not 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 rateria. The resean for denial is equiplant 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 atternatives have been tried or medical crassons 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 their 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, were 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, Ubrelyy (tried). 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	Please look at the formularly 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 rateria. The reason for denial is explained to the member above. The orbitain 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 filely 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 linadotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons:
				B96.81 - Helicobacter pylori [H.		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 bowed syndrome with conscipation (IESC-) (a health issue with stomach, plan and beloting associated with constipation). 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 buadiws (bisacody), semosidels, PEGS 3309 (MRALAN, GAY COAQA), or bulk off-chronig loxabative, (BEFAMUCIL, CITRUCEL, FIBERCON). These drugs are available over-the-counter (OTC) without a prescription. Your pharmacy benefit may not cover these OTC drugs. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12653176 AUGUSTIN ROGER BATLLE MD	Internal Medicine	LINZESS	GASTROINTESTINAL AGENTS - MISC.	pylori] as the cause of diseases classified elsewhere	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linadotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) and 2 of our prior authorization criteria for Linzess. The reason for denail 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 one-month trial (minimum) of ONE (1) of the following was ineffective, contraindicated, or not tolerated: stimulants (bisacodyl, sennosides), PEG 3350 (MIRRALX, GLYCLOAX), OR bulk chroming lastables (MERAPALCL, CLITERCE), FIBERCON). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Find 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 book at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care orovider may be able to success other treatments for your health issue. Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNIARO 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.
12661501 LAURA ELLEN PURDY MD	Family Practice	MOUNJARO	ANTIDIABETICS	R73.03 - Prediabetes	Criteria Not Met	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 Neillius. 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. Hore authorization may be required, and quantity limits may apply to covered drugs. Our prior authorization criteria for uppeadchairin (Rivnoya) have not been met. From the records that we have received, Rivnoq was denied for these reasons: 1) Records did not show a medium to very high potency topical sterod, such as betament-basence in habedbeslor craim, did not work for you. 2) Records did not show a broad-calicense in hibbitors, such as starchison continent, did not work for you. 3) Records did not show that immurosuppressant drugs, such as starchisonies, cytospornies, methodreade, mycophenolate mofetil, or a biologic drug, such as Supkent, did not work for you. For authorization and quantity limits may apply. 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. 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.
12665896 DANIEL ANTHONY CARRASCO MD	Dermatology	RINVOQ	TARGETED IMMUNOMODULATORS	atopic dermatitis	Citeria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approve because our prior authorization criteria for upadactinith (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. 1) Member is 12 years of age or older, AND 2) Prescribed by, or in consultation with, an Allerigist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema) at baseline; AND 3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema) at baseline; AND 3) Indicate ORE (c) of the following; (A) Greater than or equal to 10% body surface area (ESA) 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 5) A medium to very high potency topical setion of AND a topical action entire inhibitor have been ineffective, contraindicated, or not tolerated (documentation required to be submitted for an approval); AND 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 7) Pikmory 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. 1) The drug is not being used for Type 2 Dabetes. This is a health issue where received, TRULICITY No. 15,50 sead denied for this reason: 1) The drug is not being used for Type 2 Dabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quality limits may age.
12697302 MANUEL JOSEPH MARTIN MD	Family Practice	TRULICITY	ANTIDIABETICS	obesity	Criteria Not Met	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 reasons 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
12700465 SHERWIN SHAOYU YEN	Endocrinology, Diabetes & Metabolism	MOUNJARO	ANTIDIABETICS	Z68.44 - Body mass index [BMI] 60.0-69.9, adult	Plan Exclusion	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 morrider may be walken to sunder other treatments for your health sum.
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 book 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 success other treatments for your health issue. Our prior authorization criteria for upgadaction (Sirvino), have not been met. From the records that we have received, Rinvoq was denied for these reasons: 1) Records did not show a topical calcineurin inhibitor, such as tacrolimus ointment, did not work for you. 2) Records did not show that immunosuppressant drugs, such as azatipoine, cyclosporine, methodrexate, mycophenolate mofetil, or a biologic drug, such as Dupicent, did not work for you. 3) Records did not show that immunosuppressant drugs, such as azatipoine, cyclosporine, explosporine, methodrexate, mycophenolate mofetil, or a biologic drug, such as Dupicent, did not work for you. 5) Records did not show that immunosuppressant drugs, such as azatipoine, cyclosporine, cyclosporine, methodrexate, mycophenolate mofetil, or a biologic drug, such as Dupicent, did not work for you. 5) Records did not show that immunosuppressant drugs, such as azatipoine, cyclosporine, cyclosporine, methodrexate, mycophenolate mofetil, or a biologic drug, such as Dupicent, did not work for you. 5) Records did not show that immunosuppressant drugs, such as azatipoine, cyclosporine, cyclosporine, methodrexate, mycophenolate mofetil, or a biologic drug, such as Dupicent, did not work for you. 6) Records did not show that insurance are considered to the properties of the formulary that the properties of the properties
12708765 DANIEL ANTHONY CARRASCO MD	Dermatology	RINVOQ	TARGETED IMMUNOMODULATORS	L20.89 - Other atopic dermatitis	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approve because our prior authorization criteria for upadactinith (Rinvoq) have not been met. From the information we have received, the member does not meet number(s) S and 6 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 12 years of age or older, AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema) at baseline; AND 3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema) at baseline; AND 3) Member has investigated to the following (a) Greater than or equal to 10% body surface area (SES) 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 3) A medium to very high pictoric yopical setterial AND a topical calcineum inhibitor have been ineffective, contraindicated, or not tolerated (documentation required to be submitted for an approval); AND 7) Rinvoy will NDT be used in combination with another targeted immunomodulator product. 7) Rinvoy will NDT 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
12711564 CODY PAULINE SEEL PA	Physician Assistant	TRETINOIN	DERMATOLOGICALS	L82.1 - Other seborrheic keratosi	s Plan Exclusion	since create have not ceen me, we are unable to apprive coverage for this oring at this time, invaser ereer to our formularly for information on what is rounsed. Prior authorization may be remained and mainthit limits may analy for information for invaser dismans. This request cannot be approved because this drug is being used for seborn-bet 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 from as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suppose other treatments for your health issue.

						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 FEATH CARE PROVIDER: This request has no 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 chemist is explained to the member above. The criteria from the policy are isted there. 1) The drug is being used for a condition approved by the binded 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 melicially receives. The rest bould 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. Priors 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 summany. 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 crovider may be able to sousest 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	S Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drug 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 crovider may be able to succest 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
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. Drug used for this purpose are excluded from coverage as stated in your benefit summan. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your does not neath care crovider may be able to success other treatments for your health issue. We have received a request for 90 shalets for a 30 day supply for hydrocodone/acetaminophen. This amount is more than the amount covered for
12743965 KRISTY MICHELLE MARKELL PA	Physician Assistant	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	G89.4 - Chronic pain syndrome	Criteria Not Met	members who are new to using an opioid pain relever. Our Pharmacy and Therapeutics (PRT) committee, which is a group of doctors and pharmacists, sealects 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 drug. For members who do not show recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent use of an opioid pain reliever; OR I records show that you have recent us
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 done health care crowider may be able to success other treatments for your health issue. Our prior authorization criteria for duplinants (DUPLEWIT) have not been met. From the records that we have received, Dupkvent was denied for these
						reasons: 1) The drug is not being used for chronic rhinosinustits with nasal polypois that has lasted at least 12 weeks. 2) Records do not show the diagnosis was confirmed with a computed tomography (CT) scan. 3) Oral steroids (e.g. predisione) have not been tried and failed. 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 mide, we are not able to approve. Please took at our list of covered drugs, also known as the formulary, to see what is covered.
12761830 LAURENCE CHU MD	Otolaryngology	DUPIXENT	DERMATOLOGICALS	333.9	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has no been approved because our prior authorization criteria for dupilumab (DUPDENT) 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 net listed here. 1) Member is 18 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Otolanyngologist; AND 3) Member has a diagnosis of chronic rhinosinustis with nasal polyposis, lasting at least 12 weeks; AND 4) Bilatatera has allophysosis confirmed with shius computed tomography (CT) Sacri, AND 5) A trial of an areal corticosteroid was ineffective, contraindicated, or not tolerated; AND 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 nequest (documentation is required to be submitted). 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 unathorization may be required and unathorization may be required and unathor limits may and by to covered flore.
						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 escenperazole cap (MREVACID equiv), comparazole CR cap (PRILOSEC equiv), pantoprazole EC tab (PROTONIX equiv), rabeprazole EC tab (ACIPHEX equiv), 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.
12768539 MARIA EZIAFA CHIEJINA MD	Internal Medicine	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOLIN ERGICS	Other gastritis without bleeding	Not 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 2 of the exception policy ortenia. 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 Antiministation (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.
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 summany. 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 crovider may be able to suosest 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. Drug 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 crowider may be able to suosest other treatments for your health issue. Our Dapoiss Restricted criteria have not been met. From the records that we have received, Rybelsus tablet 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.
12776541 LAURA ELLEN PURDY MD	Family Practice	RYBELSUS	ANTIDIABETICS	E66.9	Criteria Not Met	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 Heilitus. 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 croords that we have received, these reasons caused the denial. If all covered drugs used for your health issue have not been tried and falled. Other drugs that can be used are questiagine OR 7 formulary artipsychotic agents. (respections, aripipacatic, clamapine, apressidone 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.

						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. 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.
12779494 LETICIA R PEREZ PA	Physician Assistant	DESCOVY	ANTIVIRALS	277.21	Criteria Not Met	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 request has not been approved because our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed there. 1) Prescribed above. The criteria are listed there. 2) 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 disoproxid fumarate (TRUADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bore mineral density experienced while on emtricitabine/tenofovir disoproxid fumarate (TRUADA) (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 (B) Documentation is provided (Ant notes including dates of therapy) of a severe adverse event or decrease effect that did not improve after at least four (4) to eight (8) weeks of restiment with emtricitabine/tenofovir disoproxid fumarate (TRUADA). (TRUADA). (TRUADA). (TRUADA). (TRUADA) is not provided of an approvally of the control of the first of the first and this first prevailed of the control of the first prevailed of the control of the control of the first prevailed of the control of the control of the first prevailed of the control of the control of the first prevailed of the control of the c
12781932 ALBERTO GLENDALYZ MD	Geriatric Medicine	RYBELSUS	ANTIDIABETICS	R73.09	Not Covered	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 Hellitus. 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 our authorization may be required, and quantity limits may apply to covered drug and the contraction of the provider of the provider of the contraction of the provider of the prov
						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 Entirel (tried), Hunira (tried), Taltz, Trenfyo, Cimzá, Otezá, Spórzi, Stelara (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.
12793922 CHRISTOPHER RIDDELL JONES JR MD	Dermatology	COSENTYX SENSOREADY PE	N TARGETED IMMUNOMODULATORS	PSORIASIS VULGARIS	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROUIDER: 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 next. From the information we have received, the member does not meet number 2 of the exception policy refres. The reason for denial is explained to the member above. The oriteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Durg Administration (FUA). 2) All formularly alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been neceived showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments have all what date of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. Since criteria have not been met, are an unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Finor 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 generic version of this drug, called amphetamine/dextroamphetamine er, has not been tried and falled. 2) All other covered drugs used for your health is sue have not been tried and falled. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, Vyvanse. 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. Please look at the formulary to see what drugs are covered.
12796699 MICHAEL ANDREW MUSGROVE M	D Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY	F90.0-ADHD	Not 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 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. 1) The generic from of the drug has been tried and falled, 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 Intelled States Food and Drug Administration (Foll) 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.accesstata.fda.gov/critefylmedwatch/. 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 way apply to covered drugs.
						want is covered. Prior automization may be required. Quantity limits may apply to covered drugs. Our prior authorization criteria for galaneanuma (EvidALTY 210mg) was oftened for these reasons: 1) Records did not show that you have had at least 4 migraine days per month for the last 3 months or longer. 2) Records did not show that you have had and failed (after using for at least 3 months) other drugs from at least ONE of the following drug classes: 2) Records did not show you have the following for a feast 3 months) other drugs from at least ONE of the following drug classes: 3) More information is needed to know if this drug will be used together with Botox. If Empality will be used together with Botox, records must also show you have had at least a three (3) month trial of Emplaity alone AND a time (3) month or and of priority and the company of the control of Botox alone. 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.
12799547 JOHN SANG HEE KIM MD	Family Practice	EMGALITY	MIGRAINE PRODUCTS	migraine	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for galcanezumab (EMCALTY 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. 1) Prescribed for the prevention of migrainer, AND 2) Member has four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month that if mon NE of the following drug dasses was ineffective, not tolerated, or contraindicated: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasactive agents (such as proprantoid, metoproid, etc.), or (c) antidopressants (such as amitriphyline, veniafaxine, etc.); AND 4) Emgality will NOT be used concomitantly with onabotulinumtoxink (BOTOX) injections for chronic migraine; OR 5) Emgality will be used concomitantly with onabotulinumtoxink (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 onabotulinumtoxin (BOTOX). Since criteria have not been met: we are unable to annother 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	KS1.90	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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) a 70 or prior authorization criteria for Humira for Ulcerative Collis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a disastroenterology Specialist, AND 2) Member has demonstrated a significant improvement in their condition, AND 3) Documented united a significant improvement within the past year submitted with this request (documentation is required to be submitted 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
12805150 JESUS NAJIB SAHAD MD	Pulmonary Disease	ALBUTEROL SULFATE HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	345.20-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 denials: 1) All covered drugs used for your health issue have not been tricked and failed. Other drugs that can be used are abluted IFA inhaled. PROVENTIL equity), VENTCUIN HFA INHALER. PROVENTIL equity), VENTCUIN HFA INHALER. 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 linted 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, 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.
12810412 FRANK ANTHONY BETANSKI III MD	Family Practice	OZEMPIC	ANTIDIABETICS	Z68.32 - Body mass index [BMI] 32.0-32.9, adult	Criteria Not Met	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 do or 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 Nilledus. Source goes for this drug at this time. Please refer to our formularly 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. Drug 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 formularry, to see what is covered by your plan. Your doctor or health care namider may be able to a unnest other treatment for your health issue. Our prior authorization criteria for apprecisals (CTEZAL) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Chart notes were not sent to us to show your response to this drug. 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 formularry, to see what is covered.
12819368 SHWOL-HUO DANNY KIANG DO	Dermatology	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: 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. 1) Prescribed by a Dermatologist, AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval); AND 4) Apremilast (OTEZLA) will not be used in combination with biologic 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
12822085 ROSIE AUGUSTIN-WHEELER MD	Family Practice	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Z68.35 - Body mass index [BMI] 35.0-35.9, adult	Plan Exclusion	covered. Frior authorization may be required and quantity limits may apply to covered drugs. This request cannot be approved because this drug is being used for well-plus. 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 orwider may be able to supposed other treatments for your health issue. 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: 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
12822865 MARGARET ELIZABETH BROWN MI	Dermatology	TRETINOIN	DERMATOLOGICALS	D23.4 - Other benign neoplasm of skin of scalp and neck	Criteria Not Met	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 0.025%. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of a cine vulgaris, acne rosacea, or actinic keratosis. Since criteria have not been met, we are unbelte 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 success 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 formularry, to see what is covered by your plan. Your doctor or health care should be a support of the property of the
12862217 JAMES NICHOLAS MCMULLEN PA	Physician Assistant	OZEMPIC	ANTIDIABETICS	E13.69 - Other specified diabetes mellitus with other specified complication	Criteria Not Met	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 meter humber 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 adaimstrated (numinwa) have not obeen met. From the records that we have received, numera was denied for these reasons:

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. 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.

12863262 DIANE LOISE BRINKMAN MD	Obstetrics & Gynecology	ETONOGESTREL/ETHINYL ESTR	CONTRACEPTIVES	Z30.015 - Encounter for initial prescription of vaginal ring hormonal contraceptive	Not 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 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 Inited 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 covered. From a substitution of the propagation of the properties of the prope
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 crowled may be able to success 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 too decide if a not-covered drug can be approved. The conditions in his policy have not been met. From the records that we have received, these reasons caused in 1.) All covered drugs used for your health issue have not been third and failed. Other drugs that can be used are Encuse and Lorshala. Please look at the formularly to see what drugs are covered. Prior authorisation may be required and quantity limits may apply to covered drugs.
12875025 SAPAN PATEL MD	Internal Medicine	YUPELRI	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	344.9 - Chronic obstructive pulmonary disease, unspecified	Not 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 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 includer 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 risankzumau (xi.fki.l.i) have not been met. From the records that we have received, skyria was denied for these reasons. 1) Chart notes were not sent to us to show your response to this drug. 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.
12877433 STEVEN ENIUM RASMUSSEN MD	Dermatology	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have denial is explained to the member above. The criteria are listed between the provider of the prov
						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 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.
12879465 JEREMY RAYMOND SEMEIKS MD	Emergency Medicine	DESCOVY	ANTIVIRALS	220.6	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approve because our prior authorization criteria for emtriciabine/tendrovir alafenamide (DESCOVY) have not been met. From this request has not been approve because our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are islade 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/tendrovir disported furnarate (TRUNADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decrosses in bone mineral deniety experienced white on entricitabine/tendrovir disported furnarate (TRINADA) (Documentation is required to be submitted for an approval); OR (C) Documentation is provided of an estimated creatinne clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an object of an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an approval); OR (C) Documentation is required to be submitted for an appro
						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 falled. Other drugs that can be used are demembly/pleniades testended release (ER), methy/pleniadae ER, amphetamine/plechroundput-damine ER (Adderall XR equivalent), Vyvanes. Please look at the formulary to see what drugs are covered. Prior authorisation may be required and quantity limits may apply to covered drugs.
12936898 GAYLE YVONNE AYERS PHD	Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY	F90.0	Not 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 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 includer 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. If all covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are winvaring, annover ning, zafemy patch (Xulane equivalent) 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.

12941781 STEPHANIE SAMII JAMES NP	Nurse Practitioner	FREESTYLE LIBRE 14 DAY/SE	MEDICAL DEVICES	E11.9 - Type 2 diabetes melitus without complications	Criteria Not Met	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 subdeted subjective or (1) of the following: (i) Member free unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) 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 fals to test with sufficient frequency, OR (ii) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabeties, AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabeties, AND 4) If above criteria are not met, rationale analy of counternation of any extensional gradient requiring used CGM is provided. 2) Or Diagnosia Reactivicted or the laws on the counternation of any extensional gradient requiring used CGM is provided. 3) Or Diagnosia Reactivicted or their laws on the her or the records that we have received, Ozempic was defined for this reason. 3) The drought 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 it mists may apply to covered drougs, also known as the formulary, to see what is covered.
12948764 MARINA LUZ SANCHEZ-ELLIG MD	Family Practice	OZEMPIC	ANTIDIABETICS	Type 1 diabetes mellitus without complications (HCC)	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CAPE 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 ment number 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(bried), oxycodone/acetaminophen, lydrocordone/acetaminophen, lydroco
12956245 LOUIS JOSEPH LUX MD	Internal Medicine	OXYMORPHONE HYDROCHLORIDE	ANALGESICS - OPIOID	c20	Not 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 2 of the exception policy criteria. The reason for denail is explained to the member above. The criteria from the policy are listed here. 1) the drug is been justed for a confliction approved by the United States for and ord ord and and provided in the policy are listed here. 2) the drug is been justed for a confliction approved by the United States for and ord ord ord and and and and and and and and and an
						Our prior authorization criteria for vilazodone (Vilbryd) 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-noreginephrine 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.
12957652 ISELA ARRIETA WERCHAN MD	Psychiatry	VILAZODONE HYDROCHLORIDE	ANTIDEPRESSANTS	f39	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Vilbryd) 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 otder; AND 3) Member must try and fall at least 2 selective serotonin reuptake inhibitor (SRIs) (settraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fall at least 2 selective serotonin reuptake inhibitor (SRIS) (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. Priors understation may be required and quantify 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 Virayler 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. escalatopram, fluoxetine, sertaine, evalifaxine, or others) 3) Records did not show that another drug called quetapine 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.
12961388 MARIYA BOBROVNYK PA-C	Physician Assistant	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	f33.2	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDED: 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 6.2 of the Viriginal exception policy criteria. This reason for determinal is explained to the member above. The criteria from the policy are listed here. 2) of the Viriginal exception policy criteria. This reason for determinal is explained to the member above. The criteria from the policy are listed here. 3) despite the Confederal explained in the confederal explaine
						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 quantify limits may applied. 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 formulany, to see what is covered.
12963723 MARINA LUZ SANCHEZ-ELLIG MD	Family Practice	OZEMPIC	ANTIDIABETICS	e10.9	Criteria Not Met	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 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 Melitlus. 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 Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of Freestyle Libra:

J 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.

							These book at the formularly to see material ago are covered. This databased may be required and quantity initial may apply to covered at ago.
1296823	12 JOHN SANG HEE KIM MD	Family Practice	NURTEC	MIGRAINE PRODUCTS	G43.009 - Migraine	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not no 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 critical. The reason for denial is explained to the member above. The criteria from the policy are listed there. 1) The drug is being used for a condition approved by the United States Ford and Drug Administration (FDA). 2) All formularly 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 recessors. 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 galcanezumab (EMGALTY 120mg) have not been met. From the records that we have received, Emgality 120mg was defined for these reasons: 1) Records did not show that you have had at least 4 migraine days per month for the lest 3 months or inoger. 2) Records did not show that you have the and related familiary and months) other drugs from at least ONE of the following drug classes: anticonvisiants (such as topiramate, sodium valgroate, etc.), vasoactive agents (such as proprianolol, metoprolol, etc.), or antidepressants (such as antiripphine, entralizatione, etc.). 3) More information is needed to know if this drug will be used together with Bottox. If Emgality will be used together with Bottox, records must also show you have had at least at there (3) month trial of Emgality alone AND a three (3) month trial of bottox alone. 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.
1297658	3 JOHN SANG HEE KIM MD	Family Practice	EMGALITY	MIGRAINE PRODUCTS	G43.009 - Migraine	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDES: This request has not been approved because our prior authorization criteria for galcanearumab (EMGALITY 120mg) have not been merc. From the enformment of the member above. The criteria are lated the entries are stated here. 1) Prescribed for the prevention of migraine; AND 2) Member has four (4) or more implicance and the previous three (3) months; AND 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, southin walprovade, etc.), (b) vasoactive agents (such as proprarolol, metoprolol, etc.), or (c) antidepressants (such as a mitriptyline, venlafaxine, etc.); (b) vasoactive agents (such as proprarolol, inctions for chronic migraine; OR
1298121	4 CLAYTON WARREN ADAMS MD	Anesthesiology	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	g89.4	Not Covered	**P) Engalary will not be described in the properties of the prope
							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 4 on those that another drug called quetapine OR colarapies used together with an antidepressant, medication did not work for you. Please look at the formulary to see what drugs are covered. Fivor authorization may be required and quantity limits may apply to covered drugs.
1299020	9 MARIYA BOBROVNYK PA-C	Physician Assistant	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	MDD	Not 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) 5 of the Varyair 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 Biosprier; ANIO 2) Arbiprazole (ABILLEY equivalent) has been tried and failed; ANIO 3) Member has had an inadequate response to antidepressant therapy during the current episode; ANIO 4) Two (2) or more antidepressant medications were ineffective or not tolerated; ANIO 5) A trail of questiagning CERKOQUEL KR equivalent (SR ADQUEL ARE) equivalent) when used with an antidepressant medication was
1299063	18 ROSIE AUGUSTIN-WHEELER MD	Family Practice	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Z68.34 - Body mass index [BMI] 34.0-34.9, adult	Plan Exclusion	Ineffective or not Interested. Since criteria have not been met, we unable to approve coverage for this forum 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 summany. 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 envolved may be able to suspect other treatments for your health issue. Our prior authorization criteria for apremilast (OTEZA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Chart notes were not sent to us to show your response to this drug. 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.
1299144	2 SHWOL-HUO DANNY KIANG DO	Dermatology	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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. 1) Prescribed by a Demandalogist, Another increase and the part of the p
1300081	2 BRUCE MICHAEL DOXEY MD	Family Practice	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	N40.1 - Benign prostatic hyperplasia with lower urinary tract symptoms	Formulary Alternatives Available	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formularly for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. Our prior authorization runs required and quantity limits may apply to covered drugs. Our prior authorization criteria for step inversity nave not open met. step i nerspy means that corner oruge will necessary to the create and raised and referenced that the where received. Taddlardli was deried for these reasons. 1) One of these drugs has not been tried and falled: doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride Smg tab, alfuzosin tab, silcodosin cap, terazosin cap, but substanced and the substanced productions 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 formularly, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
					uact symptoms		This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have neceived, the member does not meet number 1 of our prior authorization criteria. The reason for denal 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 formularly 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 formularly 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 Reyrow and Ubrelyy.

Please look at the formulary to see what drugs are 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 linaciotide (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 PROVIDEN: This request has not been approved because our prior authorization criteria for linaciotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 or un prior authorization criteria for Linzess. The reason for denial is explained to the member above. 1) Member has a diagnosis of ONE (s) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A trial of pleanable (TRULANCE) was inefficiency, contraindicated, or not Identicated. 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 Xyrem have not been met. From the records that we have received, the tollowing caused the denial or Xyrem. 1) Records did not show this drug is working for you to improve suddens deep attacks or muscle weakness.
13021101 MONIQUE DENISE MULVANY APN	Nurse Practitioner	XYREM	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	G47.419 - Narcolepsy without cataplexy	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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 of our prior authorization criteria for Xyrem (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, symptoms of idiopathic hypersonnia, or cataplexy attacks is provided with the request (documentation is required for approval).
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 tretrian in this policy have not been met. From the records that we have received, these reasons caused the definition of the drugs of the covered drugs can information is needed if this does not work for you. 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are desmethylphenidate extended release (EI), methylphenidate Eq. and Yuyanse. 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 efficiency and safety problems with the generic drug. Please book at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALT FLOARE PROVIDEN: 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 requests the single properties of the provided provided that the provided provided in 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. 2) All Orimulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; 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 from, which documents efficiency 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.fda.gov/medwatch/getforms.htm or submitted online at https://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.fda.gov/medwatch/getf
13040353 MONIQUE DENISE MULVANY APN	Nurse Practitioner	xxwav	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: 1) All covered drugs used for your health issue have not been tried and falled. Other drugs that can be used are Xyrem, modefinif (irrido,) amodafinif (tried), Sunos (tried), and Valex. Please bok 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 PROVIDES: 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 the exception policy granted. The removement of the covered property of the cover
13045212 GAIL CONDECREAR MD	Internal Médicine	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. 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 (bisacody, senosides); Red SSQ (MIRALAX, GLYCOLAX); OR buik-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 buils-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). 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	records that we have received, TADALAFIL TABLET SMG was denied for these reasons: 1) One of these drugs has not been tried and failed: document found and failed: document for the reasons and the present capsule, the reasons and the present capsule, the reasons and the present capsule. 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.
13066333 MEGAN OLIVER JACOBSON PA-C	Physician Assistant	IVERMECTIN	ANTHELMINTICS	U07.1 - COVID-19	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because our prior suthorization 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 strongolidasis due to Orthocerca volvulus, OR (C) Teathernet of ascariasis, OR (C) Treatment of ascariasis, OR (C) Treatment of dermitosis due to mittes, OR (F) Treatment of dermitosis due to mittes, OR (F) Treatment of dermitosis due to mittes, OR (F) Treatment of infection by Wucheeria bancrofti, OR (F) Treatment of infection by Wucheeri
13072977 ELIZABETH LEIGH JAGGERS MD	Internal Medicine	MOUNJARO	ANTIDIABETICS	E78.5	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
13077916 COREY JAY ZELLER MD	Family Practice	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	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 lisse. 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 number may be able to nument either brantments for wur health leaus. Our prior authorization criteria for dupilumab (DUPDENT) 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, azarthoprine, cyclosporine, methorterate, and mycophenolate modelt, 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.
13080305 EDWARD LEWIS LAIN MD	Dermatology	DUPIXENT	DERMATOLOGICALS	L20.89 - Other atopic dermatitis	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CASE PROVIDER: This request has not been approved because our prior suthorization criteria for dupilumab (DUPDENT) 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 ner is tested here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allerijst, 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 (EAS) is affected, and percent EAS is provided, OR (B) The EAS 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); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation is required to be submitted for an approval); (documentation
13085758 SIMONA MARIANA SCUMPIA MD	Endocrinology, Diabetes & Metabolism	WEGOVY	ANTI-OBESITY/ANOREXIANTS	R73.02 - Impaired glucose tolerance (oral)	Plan Exclusion	Since criteria have not been met, we are unable to acronve coveriges for this draw at this time. Please when to a form form in information on what is This request cannot be approved because this drug is being used for well-by lies. Surgius 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 supposed their 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: Simulants (biscoxoly, semosides); PEG 330 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Since the criteria have not been met, we are not able to approve.
13089752 GAIL CONDE CREAR MD	Internal Medicine	TRULANCE	GASTROINTESTINAL AGENTS - MISC.	E11.9 - Type 2 diabetes mellitus without complications	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH 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 (BSC): AND 2) A one-month trial (minimum) of ONE (1) of the following was ineffective, contraindicated, or not tolerated: stimulants (bisacodyl, sennosides); PEG 3350 (HIRALX, GLYCOLX); On bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON).
13092830 PAMELA JAYNE HOWARD MD	Neurology	NURTEC	MIGRAINE PRODUCTS	G43.909-migraine	Not Covered	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 ned thet your plan does not cover hunce when used for migraine prevention. Covered drugs that may be used for migraine prevention include anti-seizure drugs (e.g. topiramate immediate release (RIX,TRED), valproic acid), beta-blockers (e.g. propranoiol), metoproiol(TRIED), timolol), Aimovig(recent claim seen), Ajovy(TRIED), Engality, 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.
13105442 ELIZABETH LEIGH JAGGERS MD	Internal Medicine	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 suspess other treatments for your health issue.

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.

13112471 ALMA D CARTER PA-C	Physician Assistant	STELARA	TARGETED IMMUNOMODULATORS	Psoriasis	Citteria 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: 2) 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 abile 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 PROVIDEN: 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 sisteiara for Haque Psoriasis (Initial Coverage). The reason for denial 1 Prescribed by a Dematalogist, Albu Certa are laisted here. 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Medicarate to servere plaque 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) Memimum of 15 sessions of phototherapy; OR (8) methorizate (minimum dose of 15 mg/week); OR (C) activating (SORIATANE); OR (D) ALL are contraindicated AND contraindication is required for information or interiorant or method restricters, AND
13136227 APRIL WEST FOX MD	Surgery, Colon & Rectal	SODIUM SULFATE/POTASSIUM	LAXATIVES	Z12.11 - Encounter for screening for malignant neoplasm of colon	Not Covered	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 apoly 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: Peg 3350/electrolytes. Peg 3350/electrolytes. Peg 3350/electrolytes. Peg 3350/electrolytes. 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 concidions 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 orteria from the policy are listed here. 1) The drug is been justed for a condition approved by the unlined States Ford and Drug Administration (FDA). 2) All formularly alternatives have been inted or medical reasons have been provided why all other covered drugs cannot be tried. 4) Precurption drug samples were not used to establish treatment. 4) Precurption drug samples were not used to establish treatment. 5) Precurption drug samples were not used to establish treatment. 6) Precurption drug samples were not used to establish treatment. 6) Precurption drug samples were not used to establish treatment. 6) Precurption drug samples were not used to establish treatment.
13144333 JAMES ALLEN ZACHARY MD	Infectious Diseases	LINZESS	GASTROINTESTINAL AGENTS - MISC.	R10.13	Criteria Not Met	Our prior authorization criteria for linaciotide (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 dring called Trialiance 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 linacidated (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 real tested here. 1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constitution (CIC) or Irritable Bowel Syndrome with Constitution (IBS-C); AND 2) A trial of pleasantedic (TRUANEC) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at the 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.
13166977 DAVE FITZGERALD CLARKE MD	Neurology, Pediatric	JORNAY PM	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: 1) All covered drugs used for your health issue have no been brief and falled. Other drugs that can be used at decembriphentation to entered release (EBI/TREID), methylphendate ER(TREID), amphetamine/destroamphetamine ER (Adderall XR equivalent), Vyoanse, and destroamphetamine ER, Please look at the formularly to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFCRMATION 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 riteria. 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 rug 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 seasothis the 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 frugs.
13177848 COREY JAY ZELLER MD	Family Practice	RYBELSUS	ANTIDIABETICS	E66.9 - Obesity, unspecified	Criteria Not Met	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 PROVIDES: This request has not been approved because for Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number. I do ur Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number. I do ur 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 Milkly limits rows apply to covered drugs. 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. Low have received, levabuted HFR habets was denied for these reasons:
13186778 NATALIE ADRIANNE WILLIAMS MD	Family Practice	LEVALBUTEROL TARTRATE HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Mild intermittent asthma, uncomplicated	Criteria Not Met	1) Records did not show that Ventolin HFA inhaler has been tried and failed. Records did not show that you had dise 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 accounted forms without the member and the constitution of the member and the constitution of the constitut

				Type 1 diabetes mellitus without		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.
13206356 MARINA LUZ SANCHEZ-ELLIG MD	Family Practice	OZEMPIC	ANTIDIABETICS	rype I undetes mentus without complications (HCC)	Criteria Not Met	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 obbetes Helitus. Since criteria have not been met, we are unable to apport 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. Covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
						 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 (INSAID) (e.g. buprofen, naproxen, or others). Quantity imits may apply. I've 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.
13206897 ERICA MARIA RIVAS-RODRIGUEZ MD	Neurology	UBRELVY	MIGRAINE PRODUCTS	G43.111	Criteria Not Met	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 and 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 striptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a soxond 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
						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 recrost that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been their and failed. Other drugs that can be used are decembrifyle/heirable extended release (ER), methylpheniable ER, ampletenime/pelcoroum/pleanine. ER (Addeal XR equilement), and Vyvanse. Please look at the Formulary to see what drugs are covered. Fror 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	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: In sequest, has no been approved because this drug is not not 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 orteria. The reseason for denal set equalised 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 (FIA). 2) All formulary alternatives have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments traited with dates of trail 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 merk, were 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. Places 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 success their treatments for your health issue. This request cannot be approved because this drug is being used for well bused for this purpose are excluded from coverage as stated in your
13224286 COREY JAY ZELLER MD	Family Practice	OZEMPIC	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	this request country to approve declared the fail of some green of mergin lasts longs seen for this purpose are excluded infort overlage as stated in your benefit summary. Please look it 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 breatments for your health issue.
						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 recrofts that we have received, these reasons det decide if an of- 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.
13261041 SAMI MOHAMAD ABOUMATAR MD	Neurology	VIMPAT	ANTICONVULSANTS	G40.911 - Epilepsy, unspecified, intractable, with status epilepticu	s Not Covered	ADDITIONAL INFORMATION FOR YOUR REALTH 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 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are islated here. 1) The generic from of the drug has been third and falled; 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 limited States Food and Drug Administration (FOR) MediNatch from, 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/medvatch/getforms.htm or submitted online at https://www.scessida.fda.gov/protypi/medvatch/.) 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. From authorization may be required. Quantity limits may apply to covered drugs.
						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.
13265510 FRANCHELL HAMILTON MD	Surgery, General	MOUNJARO	ANTIDIABETICS		Criteria Not Met	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 of our Restricted Diagnosis criteria. The reasons 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
13272005 FRANCHELL HAMILTON MD	Surgery, General	OZEMPIC	ANTIDIABETICS	e66.9	Plan Exclusion	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 summany. 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 movider may be able to succest 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 rugs used for your breakth issue have not been tried and failed. Other drugs that can be used are discidences. Single discidences where the control of the description of the control of
13278884 MARY ANN MARTINEZ MD	Dermatology	KLISYRI	DERMATOLOGICALS	L57.0 - Actinic keratosis	Not 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 2 of conditions in our Coverage Determinations: Exceptions policy are met. From the information we have received, the member does not meet a condition approved by the United States Food and Drug Administration (FRA). 2) All formulary alternatives have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments trade with dates dot rail 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. 5) ince 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 (PRT) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a "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 gain 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.
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: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are femofibrace capsile (CDFIBA equiv), femofibrate tables (TRICID's equivalent) (TRICID's femofibrace tables (TRICID's equivalent), femofibrate (TRICI
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: 1) all covered drugs used for your health issue have not been tried and falled. Other drugs that can be used are demembly/benefate extended release (ER), methylphenidate ext. any beta are incentively described in the control of t
13313SS1 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: All 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) activetin. 2) 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 approve because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member above. The criteria are listed here: 1) Prescribed by a Dermatologist; AND 2) Member has a adiagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque posoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar posoriasis; 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 photocherapy; OR (B) methotrezate (minimum dose of 15 mg/week); OR (C) activetin (SORIATANE); OR (D) Allar secrotraindicated AND contraindication is specified. NOTE: A contraindication or infolerance to methotrezate does NOT cancel the requirement of a trial of activetin. Since criteria have not been met, we are unable to approve occurage for this drug at this time. Please refer to our formularly for information on what is covered. Prior authorization may be required to where the wave received, the following caused the denial of
13325214 CAGDAS ERNST RN	Advanced Practice Nurse	VILAZODONE HTDROCHLORIDE	ANTIDEPRESSANTS	F32.1	Criteria Not Met	Valuations. 1) Two (2) drugs in a class of drugs called selective serotion reuptake inhibitors (SSRIs) have not been tried and failed, (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine). 2) One (1) drug in a class of drugs called servicon-norepinephrine reuptake inhibitors (SSRIs) has not been tried and failed, (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine). 2) One (1) drug in a class of drugs called servicon-norepinephrine reuptake inhibitors (SRRIs) has not been tried and failed, (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine). ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibyd) have not been met. From the information we have request has not been approved because our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are fiscal discussed incorder, AND 2) Member has a diagnosis of major depressive disorder, AND 2) Member must by and fail at least 2 selective serotion in eruptake inhibitors (SRRIs) (dalovestine, escitalopram, fluoxetine, paroxetine); AND 3) Member must by and fail at least 3 selective serotion in eruptake inhibitors (SRRIs) (dalovestine, venifazione). Fine 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 furiors.
13325965 ANDRE SHAW CHEN MD	Family Practice	BUTALBITAL/ACETAMINOPHE N	ANALGESICS - NONNARCOTIC	G44.309 - 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: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are illupredien, parpowan, cidorienac tablet, and rizatriptan. 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 PROVIDES: 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 the exception policy creates. The resum for fedral is explained to the member above. The creates 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 stemathers 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 their dwift dates of trial and responses, and any other evidence to show the covered drugs are likely to be infective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 5) Riscord critical have not been merk were 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.

						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	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linadicistic (LINZESS) have not been met. From the information we have received, the member does 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 Islingathic Constipation (CLC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A trial of plecaratide (TRULANDE, was inefficiety, 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 entricitabine/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 bones got weaker while taking a drug called Truvada. 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. 5) Records were not sent to us to show you experienced a severe side effect after taking as drug called Truvada for at least 4 weeks. 5) Records were not sent to us to show you experienced a severe side effect after taking as drug called Truvada. 5) Records were not sent to us to show you experienced a severe side effect after taking as drug called Truvada. 5) Records were not sent to us to show you experienced a severe side effect after taking as drug called Truvada. 5) Records were not sent to us to show you compenienced a severe side effect after taking as drug called Truvada.
13334381 IVAN JESUS PALACIOS PA-C	Physician Assistant	DESCOVY	ANTIVIRALS	Z20.2	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for entricitabine/tendovir 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 immunodeflicency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take enthricibalnity-fendovirul disporant flumarate (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 entricitabine/tendoris desprovally. (DR (D) Documentation is required to be submitted for an approvally; OR (C) Documentation is provided (rhar notes including dates of therapy) of a severe (Documentation is required to be submitted for an approvally; OR (C) Documentation is provided (rhar notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after a fleats from (F) to egift (8) weeds of the tenternal than intricibalnity-enforition disporant flumarate (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 creds that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been field and full other drugs that can be used are Protocol HC cream (AMMOS HC equillent), ideoaine/hydrocortisone cream (AMMOS
13337470 AFREEN KHAN MD	Family Practice	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	L29.0 - Pruritus ani	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: It is request has not been approved because this drug is not on formularly. An exception to allow coverage of a non-formularly 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 oriteria 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 formularly alternatives have been tred 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 recessery. 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.
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 hold at the list of occred drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care nowider may be able to suspect other treatments for your health issue. Our prior authorization criteria for entriticibine/tendoriva alfareamide (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-approvid may be needed and there may be limits on the amount of drug covered at a time.
13347765 MARIA HOOPER FNP-C	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z72.51 - High risk heterosexual behavlor	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tendovir 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 numan immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricibation/tendovid risoproad 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 emtricibation/tendovid disoproal fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (8) Documentation is provided of an estimated reclamine clearance between 30 and 60 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 emtricibation/tendovir disoproal/fumarate (TRUVADA).
13353128 KRISHNA POKALA MD	Internal Medicine	вотох	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 charmacy benefit. Prior authorization may be required. Quantitly limits may about 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:
13356472 YEN DANG NIEMAN	Ophthalmology	TYRVAYA	OPHTHALMIC AGENTS	H04.123 - Dry eye syndrome of bilateral lacrimal glands	Not Covered	1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Restasis. Please look at the formularly 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-formularly drug may be granted if all conditions in our loverage beterminations: Exception policy are met. From the information we have received, in emember 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 initied States Ford and Drug Administration (FDA). 2) All formularly alternatives have been fixed or medical reasons have been provided with all other covered drugs and explained to the control of the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 4) Prescription drug samples were not used to establish treatment. 5) Cinica 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 formularly for information on what is covered. Prior authorization may

						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.
13361132 CHRISTY TAYLOR RISINGER N	4D Internal Medicine	OZEMPIC	ANTIDIABETICS	R73.09	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approve 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 17 pez 2 Diabetes Hellitus. 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 linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 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 (ISEC) (a health issue with stomach plan and bloating associated with constipation). 2) 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.
13361217 MATTHEW SCOTT HILL DO	Family Practice	LINZESS	GASTROINTESTINAL AGENTS - MISC.	k59.00	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linadotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) I and 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 diagnoss of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A trail of plecandatide (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 emperazed (FIRED) and propriet (FIRED). (TRIED), rabeprazole, larsoprazole (TRIED), and esomeprazole (TRIED). Please look at the formularly to see what drugs are 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/ANTICHOLIN ERGICS	I K21.9	Not 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 2 of the exception policy criteria. The reason for derival 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 includer elevent 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.
						Out prior adminization criteria or indepressions (PPI) 12A9 have not used nines. From the records that we have received, noupressions was defined on treasons. 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 build-forming laxatives (e.g., Metamucil, Citrucel, Fibercon). Since the criteria have not been me, 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.
13372167 MATTHEW SCOTT HILL DO	Family Practice	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	CIC-female member	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR FEATH CARE PROVIDER: This request has no been approve 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) of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Islignathic Conslipation (CIC) in an adult member; OR. 2) Prescribed for the treatment of Irritable Bowell Syndrome with Constiguation (ISFC) in an adult female member; OR. 3) Prescribed for the treatment of Opioid-induced Constigation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AMI). 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (6) PSCG 330 (Pinkland, Gylorak), or (Duble-forming) pastakes (Metamucii, Citrucel, Fibercon). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is
						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 falled. Other drugs that can be used are emergrazed (TRIED), pathograzed, pathograzed (TRIED), and the comparable (TRIED), and the comparable (TRIED), and the comparable (TRIED) are expected. From authorization may be required and quantity limits may apply to covered drugs.
13375646 MARIA EZIAFA CHIEJINA MD	Internal Medicine	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOLIN ERGICS	K21.9, Z87.11	Not Covered	ADDITIONAL INFORMATION FOR YOUR FEATH CARE PROVIDER: This request has no been approved because this timp is not no 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 rates. The reason for clenial 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 formularly alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received whoming the requested drug is melically necessary. These should include relevant medical history and lab results, past treatments tried with distance of trail and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription upsumples 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. Price 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 piecanatide (TRULANCE) 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.
13375653 MATTHEW SCOTT HILL DO	Family Practice	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.04-CIC	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approve because our prior authorization criteria for linadoidide (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 islated here. 1) Prescribed for the treatment of chronic idiopathic constipation (CLC) or irritable bowel syndrome with constipation (IBS-C); AND 2) A trial of pleacanatide (TRULANCE) was ineffective, not tolerated, or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formularly 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 HYDROCHLORIDI	E ANALGESICS - OPIOID	M17.0 OA of knee	Not Covered	We have received a request for 90 tablets for a 30 days day supply for Tranadol Sting. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmany and Therapeutics (PR3) committee, which is a group of footors and pharmacyles selects which drugs have dispensing limits. We will only cover up to a 7 days day supply for the TRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if un recrods 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: 1) Record's 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.

						Cold Co.
13408106 ELIZABETH HAVEY MILLER MD	Dermatology	DUPIXENT	DERMATOLOGICALS	L20.9	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPDENT) 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. 1) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 2) Dupbent 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 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. 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.
13410583 KAREN JENIFER ROMERO DO	Family Practice	MOUNJARO	ANTIDIABETICS	Prediabetes	Criteria Not Met	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 do or 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 Miller us. 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 hold at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care novider may be able to success the cause this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your fibir 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
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 yor benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. You of cloror health care convider may be able to success other treatments for your health issue. Our Diagnosis Restricted criteria have not been met. From the records that we have received, BYDUREON BCISE 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.
13438125 SUSAN BALITE NUNEZ MD	Endocrinology, Pediatric	BYDUREON BCISE	ANTIDIABETICS	R73.03	Criteria Not Met	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.
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 (RPG). Committee, related to the review of not covered drugs, Also, drugs used for a cosmetic purpoes, 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. our prior automization criteria for immanization (SN-KLLL) nave not open met. From the records that we have received, skyriz was denied for these reasons: 1) Chart notes were not sent to us to show your response to this drug. 3) Chart notes were not sent to us to show your response to this drug. 3) Chart notes were not sent to us to show your response to this drug. 3) Chart notes were not sent to us to show your response to this drug.
13449001 STEVEN ENIUM RASMUSSEN MD	Dermatology	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR FEATH CARE PROVIDER: The request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received that not been approved because our prior and understanding the prior of the provided for any provided for any provided for the provide
13461509 KAREN JENIFER ROMERO DO	Family Practice	MOUNJARO	ANTIDIABETICS	R73.03	Criteria Not Met	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 humber 1 of our Restricted Diagnosis criteria. The reasons 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.
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 the joily is have not been met. From the records that we have ecoleved, these easons caused the denix! 1) All covered drugs used for your health issue have not been third and failed. Other drugs that can be used are morphine suitate extended release (ER) (MS Contine quilselent), Lampace (ER), expositione (ER), expositione (ER), hydrocotone bitartrate ER (Hysingla ER or Zohydro ER equivalent), turnandol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent), Please look at the formular 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 free. 1) The drug is been justed for a condition approved by the United States Food and Drug Administration (FEM). 2) All formularly 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 interpretation drug samples. Are are unable to approve coverage for this drug at this little for drug a relief or information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent.

1) Records show this drug is being used together with another biologic drug.

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.

13480319 STEVEN ENIUM RASMUSSEN MD	Dermatology	SKYRIZI	TARGETED IMMUNOMODULATORS	L40.0	Criteria Not Met	Our prior autinorization criteria for risansizumal (SKTRLLI) have not oben met. From the records that we have received, skyriz was denied for these reasons: 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. 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 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. 1) Prescribed by a Dermatologist, AND 2) Vermber has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approxing). 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
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 on the approved. The conditions in the joidy lower on the emate 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 Contine quidweint), tampus ER, oncydone ER, feetrany platch (Duragos) equivalent, buyers ER (paperhald ER), hydrocodone bilartrate ER (Hysingla ER or Zohydro ER equivalent), tampad ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans 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. Form 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 there. 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 includer 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 necessary and treatments. Since criteria have not been met, we are unable to approve covereges for this drug at this tim
13491531 RUDXANDRA AGUIAR MD	Internal Medicine	LINZESS	GASTROINTESTINAL AGENTS - MISC.	k59.09	Criteria Not Met	Our prior authorization criteria for linacloide (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 piecanatide (TRULANCE) 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 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 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 linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization or interials for unitable bowed sprior dome with constipation (IBS-C); AND 2) A Ital of plecanatide (TRILANCE) was ineffective, not tolerated, or contrandicated. Since criteria have not been ente, 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 criteria for transettible (MEKINIST) have not been met. From the records that we have received, the following caused the denial of Mekinist. 1) Records did not show that this drug will be used together with another cancer drug called Tafniar. 2) Records did not show that this drug will be used together with another cancer drug called Tafniar.
13502675 MIMI I-NAN HU MD 13504999 JAMES ALLEN ZACHARY MD	Endocrinology, Diabetes & Metabolism	MEKINIST	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES ANTI-OBESITY/ANOREXIANTS	. E66.9 - Obesity, unspecified	Criteria Not Met Plan Exclusion	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 trametinib (MEXINIST) 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 cells of the member of the prior authorization criteria for Mekinist. The reason for denial is explained to the member of the prior of
13514826 STEPHANIE JILL REICH MD	Obstetrics & Gynecology	VIVJOA	ANTIFUNGALS	837.32	Not Covered	This drug is not on us 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 drug used for your health sizes where not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health sizes where not been tried and falled. Other drugs that can be used are terronazele (TRIED). Micronazole (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. 2) All formulary plantaristics have been trade or medical reasons have been provided ulty all plantaristics have been trade or medical reasons have been provided ulty 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. 5) Richards when to 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 covere

13534189 ERIC BRANDON PEREZ FNP-C	Nurse Practitioner	DESCOVY	ANTIVIRALS	220.6 - Contact with and (suspected) exposure to human immunodeficiency virus [HV]	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tendrowir 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 inmunoeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take entiricitabine/tendrowir disoproral 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/tendrowir disoproral fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (5) Documentation is provided of an estimated creatinine clearance between 30 and 60 mt per minute (Documentation is required to be submitted for an approval); OR (5) Documentation is provided (chart notes including dates of therapy) of a severe deverse event or adverse effect that do not improve a fear at least four (4) to eight (6) weeds of treatment with enrichtabine/tendrowir disoproral fumarate (TRUVADA). Since criteria have not been met. we are unable to approve one of this drug at this time. Please refer to our formulary for information on what is
			antiasthmatic and			This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions polity is used to decide if a not-covered drug can be approved. The conditions in this polity have not been met. From the records that we have received, these reasons caused the denils: 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, Stoito Respinat, 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
13536493 ABHILASHA GUPTA MD	Internal Medicine	SPIRIVA HANDIHALER	BRONCHODILATOR AGENTS	j44.9	Not Covered	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 reseaso for denial see septianed 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 (FIPA). 2) All formulary alternatives have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates for time and ersponses, 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 rugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyow and Utbreity. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13543533 BRIANTERRY MILLER DO	Allergy & Immunology	NURTEC	MIGRAINE PRODUCTS	g43.101	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: In Fis request has not been approved because this drug is not not 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 reseason for denial see 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 (FIA). 2) All formulary alternatives have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates for till 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 riteria 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 requises used for your health issue have not been tried and failed. Other drugs that can be used are harmorig/freet, Alynox Programs, Programs of the programs of
13546132 SCOTT ADAM BORUCHOW MD	Neurology	QULIPTA	MIGRAINE PRODUCTS	Migraine with aura, intractable, without status migrainosus	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: In Fis request has not been approved because this stiry just not no 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 reseas for denial see 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 (FBA). 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 liet of covered drugs, also known as a formulany. 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 another; 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, algrazation, disrepsm, loraxepam 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.
13559406 STEVEN KIRK FÖSTER MD	General Practice	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	5 anxiety	Not 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 office the provided of the control of the

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 bidneys are not working like normal based on lab tests.

4) Records were not sent to us to show your bidneys are not working like normal based on a but sets.

5) Records were not sent to us to show your bidneys are not working like flect after taking a drug called Truvada for at least 4 weeks.

5) Ricce 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.

13560730 MANUEL JOSEPH MARTIN MD	Family Practice	PROAIR DIGHHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	345.40 - 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: 3) All covered drugs used for your health issue have no been tried and falled. Other drugs that can be used are Ventolin HFA inhaler, albuterol HFA inhaler (Proverent) equivalent), levabuterol. Quantity limits may apply. 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 met number 2 of conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not met number 2 of 1.0 miles of the providence of the
13565082 FRANK STEWART FLOCA MD	Psychiatry	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	MDD	Not Covered	1) Records did not show aripiorazole (Ablify equivalent) did not work for you. 2) Records did not show that another dring called quelespine OR oblanzapine used 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 beterminations - Exceptions policy are met. From the information we have received, the member does not meet number 2.8 5 are listed here. are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder. The calculations are listed here. 2) Aripiprazole (RaUITY equivalent) has been tried and failed; AND
13570238 ALICE DIANE FRIEDMAN MD	Gastroenterology	STELARA	TARGETED IMMUNOMODULATORS	uc	Plan Limits Exceeded	3) Member has had an inadequate response to antidepressant therapy during the current episode; AND (4) Member has history of failure or intolerance to two (2) or more antidepressant medications; AND (5) Member has tried and failed or was intolerant to questignine (SEROQUEL or SEROQUEL NR equivalent) OR obstrazapine (ZYPREXA equivalent) when used with an antidepressant medication. Since orients 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 The requested amount of Stelans as 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 nake sure a drug is used the right way, We will cover Stelan at 0.5 mile, every 0 vessels for this use. The prescribed dose is 1 mil. every 0 vessels as 0.5 mile, every 0 vessels for this use. The prescribed dose is 1 mile every 0 vessels as 0.5 mile, every 0 vessels for this use. The prescribed dose is 1 mile every 0 vessels as 0.5 mile, every 0 vessels of this use. The prescribed dose is 1 mile every 0 vessels as 0.5 mile, every 0 vessels of this use. The prescribed dose is 1 mile every 0 vessels as 0.5 mile, every 0 vessels of this use. The prescribed dose is 1 mile every 0 vessels as 0.5 mile, every 0 vessels of this use. The prescribed dose is 1 mile every 0 vessels of the vessels of 0.5 mile and 0.5 mile every 0 vessels of the vessels of 0.5 mile of 0.5 mile every 0 vessels of the vessels of 0.5 mile every 0 vessels of the vessels of 0.5 mile of 0.5 mile every 0 vessels of 0.5 mile of 0.5 mile every 0 vessels of the vessels of 0.5 mile of 0.5 mil
13572936 JENELYN JOY RAMOS	Family Practice	ANUCORT-HC	ANORECTAL AGENTS	K64.9 - Unspecified hemorrhoids	Not Covered	drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are proctosol HC cream, ildocaine/hydrocordisone cream, Proctofoam HC, 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 reques han to 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 Ford and Drug Administration (FDA). 2) All formulary alternatives have been bried 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.
13573909 KARA ELIZABETH SJOGREN DO	Family Practice	SAXENDA	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refler 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 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 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 benefit summary. Drugs to the list of the covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or benefit summary. Please look at our summary to the covered drugs, also known as the formulary, to see what is
13580259 UTTAM KESHAV RAO MD	Hematology & Oncology	PREVYMIS	ANTIVIRALS	AML	Criteria Not Met	Covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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. 1) Prescribed by, or in consultation with, a Hematologist, Oncologist, Transplant, or Infectious Disease Specialist; AND 2) Member is of comegalovinus (CMV)-seropositive; AND 3) Prescribed for the primary prophylaxis of CMV infection or disease after an allogeneic hematopoietic stem cell transplant; AND 4) Letermoric (REVINIS) will be inlited within 30 days after transplant; OR 5) Prescribed for secondary prophylaxis of CMV infection or disease following pre-emptive therapy for post-hematopoietic stem cell transplant CMV infection, AND 6) Prescribed therapy is limited to one tablet daily for up to 100 days without renewal. 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
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 formulany. 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 hypotruction. This is not an approved use. 2) All covered drugs used for your health issue have not been theid and failed. Other drugs that can be used are testosterence typical building the state of the st

						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 Tyne 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.
13587727 JORGE LUIS ARIZMENDI PA-C	Physician Assistant	OZEMPIC	ANTIDIABETICS	R73.03 - Prediabetes	Criteria Not Met	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 have not been met. The restricted Diagnosis criteria have not been met. The restricted Diagnosis 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 ray be required, and quantity limits may apply to covered drugs. Our prior authorization criteria for inlineatiode (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CLC) (a health issue of ongoing constipation without any known cause), or for irritable bowel syndrome with constipation (ISSC) (a health issue with stomach join and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 3) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 4) Records did not show that another drug called plecanatide (TRULANCE) did not work for you. 5) Records did not show that another drug called plecanatide (TRULANCE) did
13595426 KRISTINA TRUONG DO	Family Practice	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.03-drug induced constipation	n Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDE: This request, has no been approve because our prior authorization criteria for linadotide (LINZESS) have not been met. From the information we have received, the member dose 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 critical are listed here. 1) Prescribed for the treatment of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of pilecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of pilecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 5) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 5) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 5) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 5) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 5) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 5) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 5) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 6) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 7) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 8) Linadotide (LINZESS) is prescribed for male member with irritable bowel syndrome with constitution (IBS-C). 9) Linadotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constitution (IBS-C). 9) Linadotide (LINZESS) is prescr
13598813 LETICIA R PEREZ PA	Physician Assistant	DESCOW	ANTIVIRALS	277.21 - Contact with and (suspected) exposure to potentially hazardous body fluids	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has no been approved because or a prior authorization criteria for entricitabine/tendfovir 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 rae itself there. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR. 2) Prescribed for pre-exposure prophylass of HIV infection; AND. 3) Member is unable to take emtricitabine/tendfovir disoproval finamate (TRIJVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral deniently experienced while on emtricitabine/tendfovir disoproval fumarate (TRIJVADA) (Documentation is provided of a renal adverse event or decreases in bone mineral deniently experienced while on entiricitabine/tendfovir disoproval fumarate (TRIJVADA) (Documentation is provided of a required to be submitted for an approval); OR (E) Documentation is provided of an estimated reaction eclearance between 30 and 60 mt. per minute (Documentation is provided of an estimated reaction eclearance between 30 and 60 mt. per minute (Documentation is provided of 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 entiricitabine/tendfovir disoproval finamate (TRIVADA). (TRIVADA) (INDEPRIVADA) (IND
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 overlage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formularly, to see what is covered by your plan. Your doctor or health care notified may be able to suppose the tenth tenth the covered by your plan. Your doctor or health care notified may be able to suppose their tenth tenth for your health issues.
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 summan. 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 account the treatments for your health issue to the provider of the pr
13631808 UTTAM KESHAV RAO MD	Hematology & Oncology	PREVYMIS	ANTIVIRALS	825.9	Criteria Not Met	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 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. 1) Prescribed by or in consultation with, a Hematologist, Oncologist, Transplant, or Infectious Disease Specialist; AND 2) Member is cytomegalovins (CMV)-seropositive; AND 3) Prescribed for the primary prophylaxis of CMV infection or disease after an allogeneic hematopoietic stem cell transplant; AND 3) Prescribed for eccordary prophylaxis of CMV infection or disease following pre-emptive therapy for post-hematopoietic stem cell transplant CMV infections and the control of the con
13633114 DANIEL ANTHONY CARRASCO MD	Dermatology	OPZELURA	DERMATOLOGICALS	L20.9	Criteria Not 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 Our prior allocarization criteria for recovering (Live Zuchous) flaver not been indet. From this forcors make wave received, upcause was seemed for mess reasons: Jince 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 (GPZELURA) 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 slets dhere. 1) Prescribed by, or in consultation with, a Dermatilogist; AND 2) Vember has a diagnosist of mild to moderate atopic dermatitis (AD); AND 3) Trails of BOTH of the following have been ineffective, contraindicated, or not tolerated: (A) a topical corticosteroid, AND (B) a topical calcineurin inhibitor. 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	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drule is not do framulary. 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 dealis is explained to the member above. The criteria from the policy are listed there. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FEA). 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. Uur prior authorization may be required and quantity limits may apply to covered drugs. Uur prior authorization tries not respect to respect the presence of the prior prior authorization tries for the member. 1) One of these drugs has not been tried and failed: Noolin 70/30, Noolin No. Noolin No. Noolin No.
13646500 MANUEL JOSEPH MARTIN MD	Family Practice	HUMULIN 70/30 KWIKPEN	ANTIDIABETICS	E11.65	Criteria Not Met	1) Once of uteset drugs that is not ober from a far aniset. Notional 17/19/05, involvant in, or housian it, or housian it. Records did not show that you had side effects or had other reasons with some other drug could not be used. Since step therapy has not been met, we are not able to approve Please bolt at our fix 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 abose not meet number of our purior 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 considered the control of the co
						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.
13655957 AMY ROMINGER MASON MD	Dermatology	OPZELURA	DERMATOLOGICALS	L20.84 - Intrinsic (allergic) eczema	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ruxoiltinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 10 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. 5) 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 froug 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.
13663890 YEN DANG NIEMAN	Ophthalmology	TYRVAYA	OPHTHALMIC AGENTS	H04.123	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not formulary. An exception to allow coverage of a non-formulary drug may be granted if all this request has not been approved because this drug is not formed. From the information we have received, the member does not meet number 2 of the exception policy crateria. The reason for denial is explained to the member above. The order is from the policy are listed there. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FBA). 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 convertd orgus used for your health issue have not been tried and falled. Other drugs that can be used are morphine sulfate and ended release (ER) (MS Contin equivalent), Xampaz ER, coxycodone ER, fentamy lanch (Duragesic equivalent), Nusynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysinglis ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buyenorphine patch (Butrans equivalent)-friend. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13666781 TIMOTHY IAN HILTON NP	Advanced Practice Nurse	BELBUCA	ANALGESICS - OPIOID	G89.4	Not 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 net. From the information we have received, the member does not meet number 2 of the exception policy crateria. The reseas not release is explained to the member above. The criteria from the policy are listed there. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FEA). 2) All formulary alternatives have been tred 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 treatments. 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.
13670819 SERENA HON MD	Family Practice	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Morbid (severe) obesity due to excess calories (HCC)	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 orroider may be able to succeed their treatments for your health issue.
13682542 TIMOTHY ANDRE MACK	Nurse Practitioner	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	N52.9 - Male erectile dysfunction unspecified	¹ , Plan Exclusion	torowner many or autor sources (uner used unless to viola meant 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 under many the property of
13686345 MICHAEL JOSEPH REGAN IV MD	Emergency Medicine	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	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 suppose to their treatments for your health issue.
13686447 MICHAEL JOSEPH REGAN IV MD	Emergency Medicine	SAXENDA	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weighbloss. 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 norwider may be able to sunnest 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. If all covered drugs used for you herealth issue have not been tried and failed. Other drugs that can be used are repident, allegion, trazdone (TRIED), escopictore, rameltison, and delsonna.

Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.

13691406 STEVEN ENIUM RASMUSSEN MD	Dermatology	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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) a four prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for derial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) 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 Our prior authorization criteria for eltrombopag (PROMACTA) have not been met. From the records that we have received, Promacta was denied for these reasons: 1) Records did not show at least one other treatment for your health issue has been tried and failed. 2) Records do not show at least one other treatment for your health issue has been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.
13712430 COURTNEY SHEA-RAINER YAU MI		PROMACTA	HEMATOPOIETIC AGENTS DIETARY PRODUCTS/DIETARY	D69.59 - Other secondary thrombocytopenia	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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[02] of our prior authorization criteria for Promacta. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Hernatology Specialist; AND 2) Diagnosis of Chronic Immune Thrombocytopenia (ITPI), and BOTH of the following are met: A) At least ORM (C) I prior ITP therapy (placcorticodes, intravenous immunoglobulin (IVIS), or splenectomy) has been tried and failed; AND 8) Platetet count is less than (<) 30,000/microller; OR 3) Diagnosis of Hepatitis Cassociated thrombocytopenia, and BOTH of the following are met: A) Member needs to initiate interferon-based therapy; AND 9) Member has a degree of thrombocytopenia that requires treatment with eltrombopag (PROMACTA) in order to initiate or maintain interferon-based therapy; OR order to initiate or maintain interferon-based therapy; OR A) Member has had an insafficient response to immunosuppresses therapy; OR 8) Member has had an insafficient response to immunosuppresses therapy; OR 8) Member has had an insafficient response to immunosuppresses therapy; OR 9) Since ratheral shave not here mer de ware unable in a nonorous consense for this drin a yell his time. Please a refer to rue formularly for information on what is This request cannot be approved because your plan has chosen this dring/product, so known as the formularly, to see what is the list of covered drouge/products for your health issue may be covered by your plan.
13713026 MICHELLE ELIZABETH MOYER DO	rsychiatry	L-METHYLFOLATE FORTE	MANAGEMENT PRODUCTS	recurrent, moderate	Plan exclusion	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 ontions will not channe the evolution of this drun from crowener. 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 decreethylphenidate extended release (ER), methylphenidate ER (Addreat), Ralian La, or Metadate Co equivalent), amplearamique/deutroamphetamine ER (Addreal IX equivalent), Vyvanse chevable, dextroamphetamine ER, and others. Please note: ER capsules can be opened and sprinkled over applesauce. Please look at the formular to see what drugs are overed. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
13714448 SHERI MICHELLE RAVENSCROFT	MD Developmental-Behavioral Medicine	QUILLIVANT XR	ADHD/ANTI-NARCOLEPSY	F84.0	Not Covered	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 found provided with all other covered drugs cannot be tried. 3) Ricordish are 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 rifieria 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:) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estadiol tablet, Premarin tablet, one-time weekly estradiol patch (Viewle-Dot equivalent), and two-times weekly estradiol patch (Viewle-Dot equivalent). Proved the provided of
13725758 ROBERT KYLE COWAN JR MD	Obstetrics & Gynecology	ESTROGEL	ESTROGENS	N95.1 - Menopausal and female climacteric states	Not 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 listed here. If the drug is being used for a condition approved by the United States Food and Durg Administration (FLQ). If the drug is being used for a condition approved by the United States Food and Durg Administration (FLQ). She drug is being used for a condition approved by the United States Food and Durg Administration (FLQ). 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. Proceedings of the process of the processor. These should include relevant medical history and lab results, past treatments their 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. Processing the processor of the processo
						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 fluconazole (tried), and terconazole cream or suppository. Please look at the formular 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:
13741184 BIANCA ELISA FALCON	Nurse Practitioner	BREXAFEMME	ANTIFUNGALS	B37.31 - Acute candidiasis of vulva and vagina	Not Covered	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 betweeningtones. Exceptions policy are mit. 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 her 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.

covered.

Our prior authorization criteria for risankizumao (SKTRIZLI) nave not been met. From the records that we have received, Skyrizi was denied for these The plant authorization interests for instructional control plant for deed interest in the records has we have exceeded, skylind was defined to discretizations.

1) Chart notes were not sent to us to show your response to this drug.

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

13741289 DAVID LAWRENCE PHILLIPS	Urdogy	GEMTESA	URINARY ANTISPASMODICS		Not Covered	This drug is not on our list of covered drugs, also known as a formularly. 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 their dand failed. Other drugs that can be used are Mybetrity and 3 other drugs for your health issue, as do as oxybetym Febrerde Release, prosplant, between divergent of the drugs are covered. Their authoritication may be required and quantity limits may apply to covered drugs. Please look at the formularly to see what drugs are covered. Prior authoritication 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 listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formularly 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. Mirca additional many be required and quantity limits may apply to covered drugs.
13746299 RABIN KHERADPOUR MD	Internal Medicine	STELARA	TARGETED IMMUNOMODULATORS	ис	Criteria Not Met	our prior autorizazion criteria or succuraneous useseniumae (p. 1ELMAR. S.), nave not been met. From the records that we nave received, seeara S. 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 do 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 with the legs key are submitted with this request (documentation is required to be submitted from control above on the critical base of the submitted of the proprosity.
13756620 KATHERINE DAWN KELLER DO	Family Practice	NURTEC	MIGRAINE PRODUCTS	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: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used an Revyow and Unbrevely. Please look at the formulary to see what drugs are covered. First 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 rised 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 critical have not been med, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. First achievable may be required and quantity limits may apply to covered drugs.
13763223 JAMES COCHRAN ANDERSON IV MI	D Pediatrics	JORNAY PM	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 demis: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used and edemethylpheniatate extended release (ER), methylpheniatate ER, amphetamine, effectivamphetamine 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 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.
13772398 CODY PAULINE SEEL PA	Physician Assistant	TRETINOIN	DERMATOLOGICALS	D23.39 - Other benign neoplasm of skin of other parts of face	Criteria Not Met	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 MEALTH 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) "rescribed 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.
13773003 PAUL BENARD MOORE MD	Endocrinology, Diabetes & Metabolism	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	NS2.9 - Male erectile dysfunction, unspecified	Formulary Alternatives Available	OUR prior authorization criteria or Step Inerapy have not been met. Step Inerapy means that other drugs will need to be tried and failed inst. From the records that we have received, tadisfill was defined for these reasons: 1) One of these drugs has not been tried and failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride/campa failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride/campa failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride/campa failed some failed failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride/campa failed

						covered.
13774969 DANIEL NEIL SKOGLUND MD	Psychiatry	TRINTELLIX	ANTIDEPRESSANTS	MDD	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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: 1) Member has a diagnosis of Major Depressive Disorder (MDIO), AND 2) Patient has ticl and failed, or was intoferant to, two selective serotonin reuptake inhibitors (SSRIs), AND 3) Patient has triced and failed, or was intoferant to, one serotonin-noreginephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this line. 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 mit- From the records that we have received, these reasons often determinations. 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are desmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dectroamphetamine ER (Adderall XR equivalent), Vyvanse. Please look at the formularly to see what drugs are covered. Pror 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	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 evaluated to the exception policy refres in the reason for denial is evaluated to the exception policy refres in the reason for denial is evaluated in the expection of EVA. 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 may 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 defined: 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), guarfacine ER, atomoscitine and one long-acting stimular long (e.g., amphetamine/dextroamphetamine ER or Vyoranse). Please look at the formularly to see what drugs are covered. Prior authorization may be required and quantify limits may apply to covered drugs.
13790720 JAMES COCHRAN ANDERSON IV M	ID Pediatrics	QELBREE	ADHD/ANTI-MARCOLEPSY	F90.2 - Attention-deficit hyperactivity disorder, combine type	d Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH 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 crients. The reason for denial is explained to the member adose. 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 this 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 treatments. This have not tobe mine, 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 pier authorization criteria for Trintellik have not been met. From the records that we have neceived, the following caused the denial of Trintellix. 1) Records did not shor VNO (2) selective serocinic reuptake inhibitor (SSRI) antidepressants, such as sertraline (TRIED), citalopram, eschalopram, fluoxetine, or paroxetine, have been tried and failed. 2) Records did not show ONE (1) serotom-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.
13805554 CYNTHIA LYNN BENTON MD	Psychiatry	TRINTELLIX	ANTIDEPRESSANTS	F33.1	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, two selective serotroin reuptake inhibitors (SSRIs), AND 3) Patient has tried and failed, or was intolerant to, one serotroin-norepinephrine reuptake inhibitors (SNRI), 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 apoly to covered drugs.
						Our pior authorization criteria for apremilats (OTEZA) have not been met. From the records that we have received, Oxetal was denied for these reasons: 1) Records did not show that your health issue is impacting you. 2) Records did not show that you have palmoplantar poroiasis. This is a health issue where skin cells build up and form lictly, dry patches and scales on your palms of the hands and the soles of the feet. 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) activetion. 4) Records show that you may not be able to use light therapy, methotrexate, or activetin, but more information is needed to show why these treatments are not right for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
13812843 MONICA RENEE SCHEPP	Physician Assistant	OTEZLA	TARGETED IMMUNOMODULATORS	PSORIASIS VULGARIS	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for apremiliast (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. 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) Plaque psoriasis (PP) AND Member has significant functional disability, OR (B) Deblittating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tenerated (commentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methorizate (minimum dose of 15 maylweek); OR (C) activetin (SCRIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methorizate does NOT cancel the requirement of a trial of activetin; AND 4) Apremilast (OTEZLA) will not be used in combination with biologic 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.

Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix.

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.

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

13827289 DEREX NELSON CUNNINGHAM OI	D Optometrist	CEQUA	OPHTHALMIC AGENTS	H16.223 - Keratoconjunctivitis sicza, not specified as Sjogren's, bilateral	Not 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 net. From the Information we have received, the member does not meet number 2 of the exception policy criteria. The reason for clerial is explained to the member above. The orbitaris from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FPA). 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:
13838855 ASWINI RAJAN MD	Internal Medicine	LINZESS	GASTROINTESTINAL AGENTS - MISC.	KS8.1	Criteria Not Met	1) Records did not show that another drug called placenatède (TRULANCE) did not work for you. 2) Records did not show that another drug called lubipostone (ANITIZA) did not work for you. 2) Records did not show that another drug called lubipostone (ANITIZA) did not work for you. 2) Records did not show that show the control of the con
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 (Vilbryd) 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 sezotoni-norepinephrine reuptake inhibitors (SNR1s) has not been tried and falled. (e.g., dulosetine, veniafaxine) 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 approve because our prior authorization criteria for vilazodone (Vilbryd) 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. 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 fall at least 2 selective serrodnin reuptake inhibitors (SSR1s) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fall at least 2 selective received and control final from the produced provided the produced provided pro
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: 1) All covered drugs used for your health save have not been tried and failed. Other drugs that can be used are insulin glargine-yfgn (single pen), Levenir, Toujeo, and Tresiba. 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.
13851984 NATALIA MILLIKEN NP-C	Advanced Practice Nurse	DESCOVY	ANTIVIRALS	Z72.52 - High risk homosexual behavior	Citleria Not Met	Our prior authorization criteria for entriclabine/hendovir 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 formularly, to see what is covered. Pre-approval may be needed and there may be lentified 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 entricitabine/hendovir alafenamide (DESCOVY) have not been met. From the information we have received, by 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. 2) Proceived for the breatment of human in highly infection; OR 2) Proceived for the breatment of human in highly infection; AND 3) Member is unable to take entiricitabine/hendorivir disoproval furnarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decrasses in bone mineral denisty experienced while on entiricitabine/hendorivi disoproval furnarate (TRIVADA) (Documentation is required to be submitted for an approval;) OR (C) Documentation is provided of a remail adverse event or decrasses in bone mineral denisty experienced while on entiricitabine/hendorivid regionary of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with entricitabine/hendorivid discoproval furnarate (TRIVADA). 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 Restasis.

Please book at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.

13862100 EMILY CATHERINE MINK NP-C	Nurse Practitioner	PRALUENT	ANTIHYPERLIPIDEMICS	125.10 - Atherosclerotic heart disease of native coronary arten without angina pectoris	y Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CABE 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 for Good 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 encessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and resporses, 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 critical have not been met, use a made to approve or with drug and grain time. Please refer to the formulary for information on what is covered. First authorization may be required and quantity limits may apply to covered drugs.
13868357 VICTOR MANUEL GARZA MD	Psychiatry	QELBREE	ADHD/ANTI-NARCOLEPSY	F90.0 - Attention-deficit hyperactivity disorder, predominantly inattentive 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: 1) All covered drugs used for you health issue have not been tried and failed. Other drugs that can be used are abmowsteine (TRIED) and one long-acting stimulant drug (e.g., amphetamine/dectroamphetamine ER or Vyoanse). 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 INFCRNATION 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 mist 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 for Good 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 includer 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 imeffective or unsafe for the member. 4) Prescription drug samples were not used to scalable the treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Hease refer to the formulary for information on what is covered. Prior authorization may be recquired and quantity limits may apply to covered drugs.
13870990 DAVID LAWRENCE PHILLIPS	Urology	TESTOSTERONE	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, TESTOSTERONE GEL 1.6.27% 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 lestosterone levels have not been sent to us. Since the control of the state of the 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 control of 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 control of 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 control of the criteria has not been personed 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 details 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 a program of the control of the last 2 months. 3) TWO (2) morning testosterone levels on separate dysf fall below the normal range for a healthy adult male are provided with the request; AND 3) One lab value must be from within the last 2 months. AND the second of the control of the side of the order of the order of the side of the order of
13870994 RANE DAS MD	Internal Medicine	CAMBIA	MIGRAINE PRODUCTS	G43.009	Not Covered	This drug is not on our list of covered drugs, also known as a formulany. 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 denials: 1) All covered drug used for your health issue have not been intel and failed. Other drugs that can be used are four (y) or all non-studial anti-inflammatory drugs (NEADD) (e.g., bluprofer(rived), paproxen(rived), disciplence, fluidiprofere, melosizam (tried), nabumetone, or others) and failure of one triptan (e.g., suramipripan, naratipripan, nizatipripan, nizitipripan, comitty participan). 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 1 CABE 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 mits. 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 resporses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were control used to establish treatment. Since criteria have not been med, we are unable to approve coveregue for this drug at this time. Please refer to the formulary for information on what is covered. Prior activation and present and the pr
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 RESTASIS (Restricted to Ophthalmology or Optometry Specialist). Pleases look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFCRNATION 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 tred. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments their with doles of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Since criteria have not been med, 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 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.

						covered. Prior authorization and quantity limits may apply.
13874898 LEIGHA ANA SHARP MD	Dermatology	ZORYVE	DERMATOLOGICALS	140.0	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because our prior authorization criteria for roflumilast (ZCRYVE) have not been met. From the information we have received, the member does not meet number(s) of our prior authorization criteria for Zoryve. The reason for denial is explained to the member above. 1) Prescribed by, or in consultation with, a demanticlogist; AND 2) Prescribed for of adjanosis of chronic plaque poroinsies; AND 3) Member is at least 12 years of age or older, AND 4) At isial 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), deucravactinib (Sotyktu), or biologic therapy for the treatment of plaque positions. 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 drug.
						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 extentation and tablet, one-time veedly estradiol patch (Climara openial most in the second patch (Climara openial most income to the second patch (Vieted Control openial most income to the complex openial most drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13878461 MICHAEL TIMOTHY BREEN MD	Family Practice	ESTROGEL	ESTROGENS	N95.1	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because this drug is not on formularly. An exception to allow coverage of a non-formularly 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 formularly 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 ungs is melically recessary. 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 toused 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. First authorization may be required and quantity limits may apply to covered drugs.
						Our prior authorization criteria for entricitabine/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 last of covered drugs, also known as the formulary, to see what is covered. Pre-approved may be needed and there may be limits on the armount of drug covered at a time.
13883585 NATALIA MILLIKEN NP-C	Advanced Practice Nurse	DESCOVY	ANTIVIRALS	Z72.52 - High risk homosexual behavior	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tendrovir 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 inmunudeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylassis of INV infection; AND 3) Member is unable to take entiriticitabine/tendroir disported funarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a restal adverse event or decreases in bone mieral density experienced while on entricitabine/tendroir disportal funarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (E) Documentation is provided of an estimated present between 30 and 60 mt. per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (that notes including dates of therapy) of a severe adverse event or decreases in the material to the provider of the submitted for an approval); OR (E) Documentation is provided (that notes including dates of therapy) of a severe adverse event or deverse effect that did not improve after at least four (4) to eight (8) weeks of the teaching that intricitabine/tendroir disported funarate (TRUVADA).
						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 emprazoide, principaciot(tried), rabeprazoide, jarsoprazoide, esomeprazoide, esomeprazoide, principaciote, comparazoide, principaciote, or some prazoide, principacione, or some prazoide, principacione, or some prazoide, o
13883844 ELIZABETH LYNN POLLOCK MD	Family Practice	DEXILANT	ULCER DRUGS/ANTISPASMODICS/ANTICHOLIN ERGICS	K22.70 - Barrett's esophagus without dysplasia	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH 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 orients. The reason for denial is explained to the member above. The criteria from the policy are issted free. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formularly alternatives have been freed 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 recessary. These should include relevant medical history and lab results, past terminants 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. First 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 necords that we have received, these reasons caused the defialt. I All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dozemstyhyhenidate extended release (EIX), methylphenidate EX, lisdexamfetamine (EVyanse equivalent). 2) A completed funked 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 formularly to see what drugs are covered.
13886082 MICHAEL ANDREW MUSGROVE MD	Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY	ADHD	Not 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 oplicy 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. 2) All formulary alternatives have been tried and falled, 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 (FIOs) MedWatch from, 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.cosssabla.fda.gov/srips/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.
13887388 HECTOR SANCHEZ MD	Family Practice	OZEMPIC	ANTIDIABETICS	Morbid (severe) obesity due to excess calories (HCC)	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 suspect other treatments for your health issue.

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.

13892629 KRISTIN DJANE FOLEY NP	Nurse Practitioner	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	333.0 - Polyp of nasal cavity	Not 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 neceived, the member does not meet number 2 of the exception policy criteria. The reason for definal 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 thriefd States Food and Drug Administration (FEAL). 2) All formulary afternitives 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 distincts 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 demethylehendate extended release (ER), methylehendate ER, isdexamfetamine (Tyvarse equivalent). 2) A completed funded 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. Rease look at the formulary to see what drugs are covered.
13897530 MICHAEL ANDREW MUSGROVE MI	D Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY	F90.0	Not 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 from of the drug has been tried and falled; 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 Trug Administration (FOA) MediVatch from, 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/imedwatch/getforms.htm or submitted online at https://www.cscessdatafd.ago/pscrips/imedwatch/j. 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. Quantityli 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 levels 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 apport 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 whe been failed, and reasons why other treatments cannot be used. Please look at the list of covered druiss. Also known as the formulare. In see what is crowned by voru rian.
						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 denials: 1) All covered drugs used for your health issue have not been tried and falled. Other drugs that can be used are morphine sulfate excepted release (ER) (MS contin equivalent), Xampaza ER, oxycotione ER, fertanry lastric (Duragesic equivalent), Nurynta ER (tapentadd ER), hydrococdone bitartrate ER (Hysriga ER or Carbyfor ER equivalent), Tamado ER label (Ultram ER equivalent), Durpomorphine patch (Eutrans 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.
13900230 MATTHEW JOEL HELLMAN MD	Anesthesiology	BELBUCA	ANALGESICS - OPIOID	chronic pain syndrome	Not Covered	ADDITIONAL INFORMATION FOR YOUR REALTH CARE PROVIDER: This request has not been approved because this drug just not no 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 orderia. The research of 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 received 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 mety, 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 budesonide nasal spray (RNHNOCORT AQUA equivalent) and fulfucason enast spray (RNHSE equivalent). Tellow provided in the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13906353 KRISTIN DJANE FOLEY NP	Nurse Practitioner	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	nasal polyps	Not 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 - Exception 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 requiseded 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.
13910008 ELIZABETH HAVEY MILLER MD	Dermatology	DUPIXENT	DERMATOLOGICALS	AD	Plan Limits Exceeded	The requested amount of Dupkent 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 Dupkent 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 whe been failed, and reasons why other treatments cannot be used. Please look at the list of covered druins, also known as the formulary. In sew what is crowned by varur rish.

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 recrods that we have received, these reasons caused the denial:

1) All covered drugs used for you health issue have not been trited and failed. Other drugs that can be used are budsenside reads (IPHIDCORT AQUA equivalent) and fundament and a series of the contraction o

						Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13912148 KATHERINE DAWN KELLER DO	Family Practice	NURTEC	MIGRAINE PRODUCTS	943.909	Not 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 - Exception spoke; 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 free. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formularly alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received whoming the requested drug is medically recessary. 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.
13926988 AMMAR MOIN AHMED MD	Adolescent Medicine	TRETINOIN	DERMATOLOGICALS	L81.4 - Other melanin	Plan Exclusion	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
13927441 GEOFFREY FULTON HUGHES FNP		PHENTERMINE HCL	ANTI-OBESITY/ANOREXIANTS	hyperplamentation Z68.32 - Body mass index [BMI] 32.0-32.9, adult	Plan Exclusion	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 noroider may be able to suosest other treatments for our health issue.
13933990 MATTHEW JOEL HELLMAN MD	Anesthesiology	BUPRENORPHINE HCL	ANALGESICS - OPIOID	Opioid abuse dependence	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. In All covered drugs used for your health issue have note been tried and failed. Other drugs that can be used are: buppercepting-invalonous estilingual tablet or film (SUBDXONE St. equivalent), Zubsolv sublingual tablet, and Vivitor. Please look at the formularly 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 (FDM.) 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 whoming the requested drugs is made 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.
13936584 Yamini aparna akkanti	Family Practice	LANTUS SOLOSTAR	ANTIDIABETICS	E11.8	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: 1) The biosimilar version(s) of this drug, called insulin glargine-yign, have not been tried and failed. A biosimilar is a biological product that is approved by the United States Food and Drug Administration (FDA) Medit and the Coverage of the state of the Coverage of th
						Our prior authorization criteria for dupilumab (DUPPKENT) have not been met. From the records that we have received, the following caused the denial of Dupbent. 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.
13943316 JAY LELAND VIERNES MD	Dermatology	DUPIXENT	DERMATOLOGICALS	atopic derm	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupliumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 1 of up 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. 5) ince 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.
13946743 BETH ANN HELLERSTEDT MD	Oncology, Medical	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOLIN ERGICS	K21.9 - Gastro-esophageal reflux disease without esophagilis	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 falled. Other drugs that can be used are emperazed (RIED), pantoprazole, rabeprazole, lansoprazole (OTC), and esomeprazole (OTC). Please lock at the formularly to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR VOIL REATH 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 the exception policy criteria. The reason for denial is explained to the member drugs are considered from the policy are inside there. 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 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 infective or unaffer or the member. 4) Prescription drug samples were not used to establish treatment.
						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 Reyrow and Ubrelyy.

Please look at the formulary to see what drugs are 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 another drug called questapine OR obsuragine used together with an antidepressant medication did not work for you. 2) Records did not show that another drug called questapine OR obsuragine 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.
13949211 MICHAEL ANDREW MUSGROVE ME) Psychiatry	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F33.2	Not 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 constructions of the provided of
13959025 KOHLBE THOMAS PA-C	Physician Assistant	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	G89.4 - Chronic pain syndrome	Not Covered	We have received a request for 110 tablets for a 30 day supply for hydrocodome/acetaminophen. This amount is more than the amount covered for members who are new to using an opiop plan releiver. Our Pharmacy and Therapeutsic (RPI) committee, which is a group of doctoral 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 grian. 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 last of covered drugs, also known as our formularly, 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 trick and failed. Other drugs that can be used are uppersorphine/nalsoone required (Subsono 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.
13961046 ANDRE SHAW CHEN MD	Family Practice	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20 - Opioid dependence, uncomplicated	Not 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 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed free. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDM). 3) Records the received beautiful to the control of the provided free provided with a state of the provided free provided
						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 drugs is being used for Testicular hypofruction. This is not an approved use. 2) All covered drugs used for your health issue have not been this and failed. Other drugs that can be used are ¿testosterone cypionate, testosterone enanthate, testicosterone egi packet or pump \$1.62% (Androgel equivalent), testicosterone packet or pump \$1.62% (Androgel equival
13964871 NATALIA MILLIKEN NP-C	Advanced Practice Nurse	CLOMIPHENE CITRATE	ENDOCRINE AND METABOLIC AGENTS - MISC.	E29.1 - Testicular hypofunction	Not 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 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 (FIA). 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 pror authorization criteria for uprographint (UBNELVT) have not peen met. From the records that we have received, upreny 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 (INSAID) (e.g. buprofein, pagrocen, 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.
13972850 JOHN SANG HEE KIM MD	Family Practice	UBRELVY	MIGRAINE PRODUCTS	G43.009	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELIVY) 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 striptan with a nonsteroidal anti-inflammatory drug (INSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second riptan 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 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 overed. Prior authorization may be required and quantity limits may apply to covered drugs.
13973447 CATHERINE MARIE BREEN PA-C	Physician Assistant	SUNOSI	ADHD/ANTI-NARCOLEPSY	G47.419 - Narcolepsy without cataplexy	Criteria Not Met	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 met 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 hypersonnia 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 CASEYEDWARD COTON DO	Psychiatry	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formularly. An exception to allow coverage of a non-formularly 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 detail 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 formularly atternatives have been fixed or medical reasons have been provided why all other covered drugs cannot be tried. 2) All formularly atternatives have been fixed or medical reasons have been provided why all other covered drugs cannot be tried. 3) All formularly atternatives have been fixed or medical reasons have been provided with all office and include relevant medical history and lab results, past restancts the with dates of trial and responses, such as the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 5) Force criteria have not been met, we are unable to soprove coverage for this drug at this like. Please refer to the formularly 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: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are demethylpheniated release (ER) (TRED), methylpheniadate ER, amphetamine/dectroamphetamine ER (Adderall XR equivalent), isdexamfetamine (Vyvanse equivalent), destroamphetamine 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. 2) All formulary alternatives have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past teratements their 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. 5) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past retardments their 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.
13992423 KYMBERLI KAY MCCLAIN FNP	Nurse Practitioner	LTVALO	ANTHYPERLIPIDEMICS	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: 1) All covered drugs used for your health issue have not been tried and falled. Other drugs that can be used are sinvastatin (RIRED), abovastatin (R
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 doze is 4 capsules per day. This drug comes in a 150mg capsule. The same doze can be reached by taking one 150mg capsule twice daily. Please look at the list of covered drugs, also known as the formulan. In sew what druck are rowered.
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, here reasons caused in 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow and Ubrefly. 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 there. 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 includer 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.
14029731 VANESSA K MOORE MD	Psychiatry	VIIBRYD	ANTIDEPRESSANTS	f41.1	Criteria Not Met	Our prior authorization criteria for vilazodone (Vilbryd) 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) This (2) drugs in a class of drugs called selective serotionin reuptake inhibitors (SSKIs) have not been tried and falled. (e.g., setraline[tried]), citalopram, escitalopram, function, promotering. 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 FROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Vilbryd) 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. 1) Member has a diagnosis of major depressive disorder; AND 3) Member has a diagnosis of major depressive disorder. AND 3) Member must by and fail at least 2 selective serotionin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluovetine, paroxetine); AND 4) Member must by and fail at least 2 selective serotionin reuptake inhibitors (SSRIs) (divoetine, varial/fauline). Since criteria have not by and fail at least 2 selective serotionin reuptake inhibitors (SSRIs) (divoetine, varial/fauline). Since criteria have not formularly for information on what is covered. From authorization may be required and quantify limits may apply to covered force.

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 falled. Other drugs that can be used are demethylphenialde extended release (tried) (ER), methylphenialdet ER, amphetamine/destroamphetamine ER (Adderall XR equivalent) (tried), isdexanfetamine (Vyvanse equivalent). Please box at the formular to see what drugs are covered. Prior authorization may be required and quantity tims 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 retisons: 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) methotresule at a dose of 15mg per week or higher, OR (C) activetin. 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.
14031879 EDGAR MARTINEZ SR	Dermatology	HUMIRA PEN	TARGETED IMMUNOMODULATORS	Psoriasis	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approve 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 is lead here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of ONE (1) of the following (documentation is required to be submitted for an approval); (a) Medicate to severe plaque 2) Member has a diagnosis of ONE (1) of the following (documentation is required to be submitted for an approval); (b) Debilitating palmoplantar postriosis; AND 3) Trial of ONE (1) of the following was ineffective or not blerated (documentation is required to be submitted for an approval); (b) Pinimum of 15
						sessions of photocherapy, OR (B) methotroxale (minimum dose of 15 mg/week); OR (C) activeth (SORIATANE); OR (D) ALL are contraindications are specified. NOTE: A contraindication or intolerance to methotreate do so NOT cancel the requirement of a trial of activethen. 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 nave he required and outsuit limits may avail to covered and the contrained are required and outsuit limits may avail to covered and the value of the required and outsuit limits may avail to covered and the value of the required and and a required
14032599 VANESSA K MOORE MD	Psychiatry	VIIBRYD	ANTIDEPRESSANTS	F41.1	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Vilbryd) 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 reteria 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 by and fall at least 2 selective servotion resuptake inhibitors (SSRIs) (sertraline, citalognam, escitalognam, fluoxetine, paroxetine); AND 4) Member must by and fall at least 2 selective servotion resuptake inhibitors (SSRIs) (duloxetine, venlafasine). Since criteria have not keen mitt, we are unable to approve coverage for this frug at this time. Please refer to our formulary for information on what is covered. Minor authorization may be required and quantity limits may apply to covered fusion.
						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 definal: 1) The biosnilar version(s) of this drug, called insuling lagrine-yfign, have not been tried and failed. A biosnilar 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 when not been tried and failed. Other drugs that can be used are Levernif(tried), Togles, Treisba. 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 book at the formulary to see what drugs are covered.
14036274 JENELYN JOY RAMOS	Family Practice	LANTUS SOLOSTAR	ANTIDIABETICS	E11.65	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has no been approve because this frug 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 net. 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. 1) The biosimilar form(s) of the drug have been tried and falled; 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) MediVatch from, which documents efficacy and safety problems with the biosimilar drug, has been completed and abuntited with the request. The form can be downloaded from http://www.fda.go//medwatch/getforms.htm or submitted online at https://www.accessdas.fda.go/scripts/medwatch/. Since criteria have not been enter, 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 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 generic version of this drug, called Amphetamine-destroamphetamine, has not been third and failled. 2) All other covered drugs used for your health issue have not been tried and failled. Other drugs that can be used are modafinil, armodafinil(tried), Sodium Oxybate or all solution, Walks, Sunosi, Lumry. 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. Please look at the formulary to see what drugs are covered.
14041313 IAN STEVEN ALWARD MD	Family Practice	ADDERALL XR	ADHD/ANTI-NARCOLEPSY	G47.419	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: No sequest has no been approved because this drug js 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 next. From the information we have received, the member does not meet number(s) 1,2,3 of the exception policy criters. The reason for details exceptioned because the drug has been tried and failed; AND 3.1 Reginate from of the drug has been tried and failed; AND 3.2 All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3.3 A United States Food and Drug Administration (FDA) Med/Watch from, 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/med/watch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.
						what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs. Our prior authorization criteria for Dictofenac 3% (SOLARAZE) have not been met. From the records that we have received, dictofenac 3% gel was denied for these reasons: 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. 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.
14045804 TAMILSELVI PERIASAMY MD	Internal Medicine	DICLOFENAC SODIUM	DERMATOLOGICALS	m79.18	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Dicidenac 3% (SOLARAZE) have not been met. From the information we have received, the member does not meet number of 'Our prior authorization criteria for dicidenac 3% gel. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for the treatment of 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 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 testoacreen 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.
14046654 CARTER REID HANSON PA-C	Physician Assistant	TESTOSTERONE	ANDROGENS-ANABOLIC	e29.1	Criteria Not Met	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 to the proposadism, AND 2) Member has symptoms of hypogenadism, and DI 3 TWO (2) morning studisterone 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 22 mortism. AND the second lab value must be from within the last 23 mortism. 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 quantify limits may apply to covered drugs.
14054077 JEANETTE LYN BETTES PA	Physician Assistant	BRIMONIDINE TARTRATE	DERMATOLOGICALS	L71.9 - Rosacea, unspecified	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 took at the list of covered drugs, also known as the formulary, to see what its 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 denal: 1) This drug is being used for Hypogonadism. This is not an approved use. 2) All covered drugs used for your beath issue have not been tried and failed. Other drugs that can be used are clestosterone cypionate, testosterone enanthate, testosterone gel packet or pump 156 (Androgel equivalent), testosterone gel packet or pump 1.62% (Androgel equivalent), testosterone solution (Axioro equivalent).
14057033 AHMAD BILAL TABBARA FNP-C	Nurse Practitioner	CLOMID	ENDOCRINE AND METABOLIC AGENTS - MISC.	E29.1 - Testicular hypofunction	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH 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 sitematives have been tred or medical reasons have been provided with 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 reasonshave been with dates of trial and response, 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.
14057418 KAREN JENIFER ROMERO DO	Family Practice	MOUNJARO	ANTIDIABETICS	R73.09	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 suspect other treatments for your health issue.
14061023 FARHEEN YOUSUF MD	Endocrinology, Diabetes & Metabolism	WEGOVY	ANTI-OBESITY/ANOREXIANTS	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 formularly, to see what is covered by your plan. Your doctor or health care monider may be able to sunned with returnment for the materials.
14067087 THERESA EBANKS WAGNER MD	Ophthalmology	XIIDRA	OPHTHALMIC AGENTS	H04.123	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 falled. Other drugs that can be used are cyclosporine (Restasse 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 platematives 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. 5) Gince 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.
14067443 RICKY CHANDRA MEHTA	Rheumatology	HUMIRA	TARGETED IMMUNOMODULATORS	L40.50	Criteria Not Met	our prior autorization critical for Adalimuman products nave not oben fines. From the records risk we nave received, numinar 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 formularly, 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 or up rior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumaticogy Specialist; AND 2) Member has a diagnosis of ORE (1) of the following: (A) Peripheral Ankylosing Spondylitis (AS); OR (B) Psoriatic Arthritis (PAA); OR (C) Reactive Arthritis; AND 3) A rial 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
14069105 DAVID JON REVERE MD	Cardiology	PRALUENT	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 in 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Repatha (fired), Nexletol, Nexl
14074013 WILLIAM MARC LEWIS DO	Internal Medicine	LOMAIRA	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 norm/der max he able to cunned other treatments for vour health issue.

14095095 CODY PAULINE SEEL PA	Physician Assistant	DUPDIENT	DERMATOLOGICALS	L20.9	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPDENT) 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 10% of your body surface area (BSA) is affected by your health issue. 2) Records did not show that at least 10% (2) other treatments, such as topical steroids, topical dicineurin inhibitors (e.g., tacrolimus, pimerorilmus), light did not show that at least 170% (2) other treatments, such as topical steroids, topical dicineurin inhibitors (e.g., tacrolimus, pimerorilmus), light and the such that the such that the such that the such that the such as topical steroids, topical dicineurin inhibitors (e.g., tacrolimus, pimerorilmus), light 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 dupiturab (DUPDENT) have not been met. From the information we have received, the member does not meter unber(e); 34, and as 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 for months of age or older; ANI 2) Member is for months of age or older; ANI 3) Member is formation and the substitute of the subst
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: 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), Bassglar, Semglee, Leveniir, Toujou. 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 lindrimation we have received, the member does not meet number 2 of 1.0 the drug is being used for a condition approved by the United States For all information (FPA). 2) All formularly 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 roug is medically received. The covered drugs cannot be tried. 3) Records have been received showing the requested roug is medically received. 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 from a contraction of the 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 Ubrelyy 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 Ubrelyy at 10 tablets per 30 days, 6 filis per year for this use. The higher number of 16 tablets per 30 days, 5 ind 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 Amoving, Algory, or Emgality, must be used to help prevent migraine headaches. Filir authorization may be required. Quantity limits may apply, Plauss lock at our formularly to see what drugs are covered on your pharmost, benefit. Prior authorization may be required. Quantity limits may apply, Plauss lock at our formularly to see what drugs are covered on your pharmost, benefit. Prior authorization may be required. Quantity limits on your planting that the prior authorization control in the prior authorization and the prior drug called pleanached (Fruillancy) 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 to covered drugs.
14106777 MATTHEW SCOTT HILL DO	Family Practice	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.00	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linadoidide (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. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of pleastanded (TRUANAP) was ineffective, not tolerated, or contraindicated; AND 4) A trial of fusionation (AMTIZA) was ineffective, not tolerated or contraindicated; ROS 5) Linadoided (LIVILESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). 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: 1) All covered drugs used for you health issue have not been tried and failed. Other drugs that can be used are ristarption and zolimityptan nasal spray. 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 ortificia 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 with 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. 5) Ricca rotter labs are to show and are evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 6) Fine cartest have not been men, 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
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.

1411998 EDGAR MARTINEZSR	Dermatology	COSENTYX SENSOREADY PE	N 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. 1) all incovered drugs used for your health size the records that the control of the policy of the can be used are Entred, an additionably product (Humina, the control of the control o
14115046 EDGAR MARTINEZ SR	Dermatology	HUMIRA PEN	TARGETED IMMUNOMODULATORS	pp	Criteria Not Met	Our prior authorization criteria for Adalimunab Products have not been met. From the records that we have received, Humira was denied for these reasons: 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) methorizeds at a dose of 15mg per week or higher, OR (C) actretin. 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 HEATTH 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 slieted here. 1) Prescribed by a Dermatologist; AND 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 poraises (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (6) Echilitating palmopinatral poraises; (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (6) Attained (A) Member has sessions of phototherapy, OR (8) methorizated (minimum dose of 15 mg/week); OR (C) actretin (SORIATANE); OR (O) Att. are contraindicated AND the contraindications are specified. NOTE: A contraindication or intolerance to methorizate does NOT cancel the requirement of a trick of activeth. 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 out and covered.
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 denials: 1) This drug is being used for post menopausal actorylor vaignists. This is not an approved use. Pleases look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. Pleases look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL IMPORMATION FOR YOUR HEALTH CABE 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 itself with the properties 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 whowing 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) Preccription drug samples were not used to sestablish 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.
14138723 LOUIS FERNAND FABRE JR MD	Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY	F90,9 - Attention-deficit hyperactivity disorder, unspecifie type	nd 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. 1) The generic version of this drug, called amphetamine/fectarcomphetamine extended release (ER), has not been tried and falled. (Paid claims seen but more information is needed to determine if this drug did not work for you). 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), morthylphenidate ER, jidochamidtennine (Pyvanore equivalent). 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), morthylphenidate extended release (ER), morthylphenidate extended release (ER), morthylphenidate is an extended release (ER), and the control of the properties of the control of the co
14147286 MICHELE AGUSTIN MD	Obstetrics & Gynecology	ADDYI	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	R68.82 - Decreased libido	Not Covered	(PRT) Committee guidelines for the coverage of non-formulary medications. The PRT 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 PE	N 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: 1 All covered drugs used for your health issue have not been tried and failed. Other drugs after can be used are Other drugs that can be used are Other drugs that can be used are Other drugs that can be used are Chert drugs. All continues are covered. Significant process of the Chert of t
						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.

REPORT WINDOWS DEPOS DEP							riease look at the formulary to see what drugs are covered. From autionization may be required and qualitity limits may apply to covered drugs.
Hallist PREVIOURNE TO BE THE WARREN BETTER AT THE THE WARREN BETTER AT THE THE THE THE WARREN BETTER AT THE THE THE THE THE THE THE THE THE TH	14153352 AMY KRISTIN EASTERLING DO	Emergency Medicine	QVAR REDIHALER		J30.9 - Allergic rhinitis, unspecified	Not Covered	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 orderia. The reason for denial is explained to the member above. The criteria from the policy are isted 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
Part							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. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
Habitati DRIT WOCDOA STANL HABITATI DRIT WOCAN HABITATI DRIT WOCAN HABITATI DRIT WOCAN HABITATI DRIT WOCAN HABITATI DRIT WOCDOA HABITATI DRIT WOCAN HABITATI DRIT HABITATI DRIT WOCAN HABITATI DR	14171319 TERA CHRISTINA BROOKS MD	Family Practice	TRINTELLIX	ANTIDEPRESSANTS	F32.0	Criteria Not Met	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. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and falled, or was intolerant to, two selective serotonin recuptake inhibitors (SSRIs), AND 3) Patient has tried and falled, or was intolerant to, now selective serotonin recuptake inhibitors (SNRIs). 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 drug.
This required has not been approved because or grift authorization criteria for Tribellis have not been met. From the information in what not been approved because or grift authorization criteria for Tribellis have not been met. From the information in what is not been may be a displaced or the method of the province of Might Deproved Ended (MDD), ADD (MDD)	14181061 EMILY NADEZHDA STAHL	Clinical Nurse Specialist	вотох	NEUROMUSCULAR AGENTS		Plan Exclusion	are excluded from coverage as indicated in your benefit summany. This drug may be covered as a medical benefit, as decided by your health plan. Please between your method plan. Please look and our formularly to see what the covered by your health plan. Please look at our formularly to see what drugs are covered on your obarmany benefit. Prior authorization may be required. Quantity limits may anoth to reserved drugs. Our prior authorization criteria for Trinfellis have not been met. From the records that we have received, the following caused the deenial of Trintellis. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertaline, citalopram, escitalopram, fluoxetine, or parouetine, have been tried and falled. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and falled. 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
Anomal uturine and signal bleeding, unspecified M2040 M20 M20 M204 M204 M20 M204 M204 M	14202871 TERA CHRISTINA BROOKS MD	Family Practice	TRINTELLIX	ANTIDEPRESSANTS	mdd	Criteria Not Met	This request has not been approved because our prior authorization criteria for Trintellix nave 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. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 3) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), SIND 3) Patient has tried and failed, or was intolerant to, one serotonin-neceping-inprine reuptake inhibitor (SSRIs). 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 quality limits may apply to covered drugs. Our prior authorization rate reagonized standard to the covered prior authorization rate reagonized to the covered prior authorization rate received, unamn was denied for these reasons: 1) More information is needed to show you are pre-menopausual. This means your body has not gone through the changes of menopause yet. 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
14226598 MARIA NICHOLE PEREZ MD Internal Medicine TRAMADOL HYDROCHLORIDE ANALGESICS - OPIOID M53.3-Sacrococygeal disorders Not Covered M54.3-Sacrococygeal disorders Not Covered dispusphy for the file fleeding health bissue, or hospice care. Please book at the list of covered dispusphy for the file fleeding health bissue, or hospice care. Please book at the list o	14209405 SHAO-CHUN ROSE CHANG-JACKSON MD	Obstetrics & Gynecology	ORIAHNN	ESTROGENS	Abnormal uterine and vaginal bleeding, unspecified	Criteria Not Met	This request has not been approved because our prior authorization criteria for elagolix/estradio/horethindrone (ORLAHNN) have not been met. From the information we have received, the member does not meet number(s) of our prior authorization criteria for Oriahnn. The reason for denial is explained to the member above. The criteria are listed here. 3) Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB(GYN) or other women's health reproductive specialist; AND 2) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND 3) Member has No known osteoprocosis; AND 4) Member is premenopausal; AND 5) A trail of a homomal contraceptive was ineffective, contraindicated, or not tolerated.
ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for bempedoic acid (NEXLETCL), bempedoic acid ezertimibe (NEXLEZET) have not been must, 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. 1 Member has a diagnossis of established atherosportotic cardiovascular disease (ASCVD); AND 3) Nexleted will be used as an adjunct to maximally tolerated stain therapy, AND 4) Nexleted will be used as an adjunct to maximally tolerated stain therapy or stain-intolerant. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formularly for information on what is	14226598 MARIA NICHOLE PEREZ MD	Internal Medicine	TRAMADOL HYDROCHLORIDE	ANALGESICS - OPIOID	M53.3-Sacrococcygeal disorders	Not Covered	new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacsts, selects which drugs have dispensing limits. We will only over up to a 7 day supply for the IRISF. Iff I did no pioid 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, mone than a 7 day supply for this first fill can be approved if records are seen in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is limited to an active cancer diagnosa, all file-ending health issue, or hospice care. Please book at the list of covered drugs, also known as our formularly, for which drugs are covered. Please book at the list of covered drugs, also known as our formularly, for which drugs are covered. Please book at the list of covered drugs, also known as our formularly, for which drugs are covered. 1) Records did not show this drug is being used together with diet changes. 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 formularly, to see what is
	14229864 CHRISTOPHER DAVID MCCOY MD	Cardiology, Interventional	NEXLETOL	ANTIHYPERLIPIDEMICS	E78.5	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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 denal is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of restancyous familal hypercholesterolemia (HeFH); OR 2) Member has a diagnosis of established atherosclerotic cardiovascular disease (ASCVD); AND 3) Nexletol will be used as an adjunct to maximally tolerated stain therapy; AND 4) Nexletol will be used as an adjunct to maximally tolerated stain therapy or SIMEN or explain the properties of the following: (A) Ezetimibe (Zetia), AND (B) Maximally tolerated stain therapy or statin-intolerant. 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) This drug is being used for Allergic rhinitis. This is not an approved use.

Please book at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.

14231697 ERYN MECHEL MCINTYRE PA-C	Physician Assistant	ADBRY	DERMATOLOGICALS	120.89	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization richies 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. 1) Documentation of positive dinicial response is provided with the request (documentation is required to be submitted for an approval); AND 2) Tralokinumab (ADBRY) will NOT be used in combination with another targeted immunromodulator product used for adoptic dermatitis. 2) Tralokinumab (ADBRY) will NOT be used in combination with another targeted immunromodulator product used for adoptic dermatitis. 3) Train of the product of the product of the product is not product to the product used for adoption of the product of the product used for adoption on what is covered. Prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1.25% was denified 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. 3) A lab value from within the last 12 months was not sent to us. 4) A second lab value from within the last 24 months was not sent to us. 5) Ince 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: This request has not been approved because our prior authoritation 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 authoritation criteria for Initial Therapy. The reason for denial is explained to the member above. The criteria are lated here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has a given prior 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) late values are submitted with the request (alst, 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. 1) Where 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. 2) Where information is needed to show you are pre-menopausal. This means your body has not gone through the changes of menopause yet. 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 MD	Obstetrics & Gynecology	ORIZAHNN	ESTROGENS	N93.9-Abnormal uterine and vaginal bleeding	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for elagolis/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. 1) Prescribed by, or in consultation with, an Obstertician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND 2) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND 3) Member has NO known osteoprossis; AND 4) Member is premenopausal; AND 5) A trial of a hormonal contraceptive 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 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) Records did not include your diagnosis. More information is needed to know what health issue is being treated. 2) All covered drugs used for your health issue have not been inted and failed. Other drugs that can be used are covered antihistamine nasal sprays (outseldine nasal sprays, (hutcasone nasal sprays, floutseldine and sprays, floutseldine nasal sprays, (hutcasone nasal sprays, floutseldine and sprays, f
14236013 AMANDA KAY WATERMAN	Family Practice	AZELASTINE HYDROCHLORIDE/	NASAL AGENTS - SYSTEMIC AND TOPICAL	None	Not Covered	provided, this may not be an accurate list of alternatives to be tried. 3) Chart notes showing your health records and past treatments were not received. Please book 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, and 3 of the exception policy retries. The reason for demail 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 flictly to be infective or unaffe for the member. 4) Prescription drug samples were not used to establish treatment. 5) Records have been received and 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.
14236337 LINDSAY ARLENE BISBY PMHNPBC	Advanced Practice Nurse	TRINTELLIX	ANTIDEPRESSANTS	F31.81	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. 1) The druly is not being used for Nagior Depressive Disorder (NDD). 2) Records did not show TNV (2) selective serctorini reuptake inhibitor (SRII) antidepressants, such as settraline, citalopram, escitalopram (TRIED), fluovetine, or parasotrine, have been tried and falled. 3) Records did not show ONE (1) serctorini-norepinephrine reuptake inhibitor (SRII) antidepressant, such as duloxetine or veniafaxine, has been tried and falled. 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 Trintellix have not been met. From the information we have received, the member does not meet runnber 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 there. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and falled, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SRII), 3) Patient has tried and falled, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SRII).

Our prior authorization criteria for tralokinumab (ADBRY) have not been met. From the records that we have received, Adbry was denied for these reasons: 1) Records showing this drug is working well have not been received.
2) More information is needed to know if this drug is being used together with another biologic drug.

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.

						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) All ba value from within the last 21 months was received, but 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 formularly, to see what is covered.
14238749 BRAD ERIC VENGHAUS MD	Hospitalist	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1	Criteria Not Met	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, 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. 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) also 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 2 months, AND the second lab values 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 recruited and quantity limits may apply to covered drugs.
						Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that your heath issue is causing significant functional disability for you. More information is needed to show how your heath issue is impacting you. 2) 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.
1428664 TRICIA LYNN WINTERS PA	Physician Assistant	OTEZLA	TARGETED IMMUNOMODULATORS	PSORIASIS VULGARIS	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROJUDES: This request has not been approved because user prior authorization criteria for agreenilast (OTEZIA) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Otezia for Plaque Psoriasis (Initial Therapy). The reason for denial is equilated to the member above. The criteria are listed here: 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at less OME (1) of the following (documentation is required to be submitted for an approval); (A) Plaque psoriasis (PP) AND Member has significant functional disability, OR (8) Debilitating palmoplantar psoriasis; AND 3) Trial of OME (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 (8) methorizeate (minimum dose of 15 mg/week); OR (2) activelin (SORIATANE); OR (0) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or infolerance to methodreaate does NOT cancel the requirement of a trial of activeti; AND 4) Apremilast (OTEZIA) will not be used in combination with biologic 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.
						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:) All covered drug used for your health issue have not been tried and failed. Other drugs that can be used are morphine suitleted erelease (ER) tablet, oxycodone ER tablet, Xtampza ER, Nucynta ER, hydrocodone ER tablet (Hysingla equivalent) or hydrocodone ER capsule (Zohydro equivalent), transdol ER tablet, bupernorphine patch, fentary hydroch (Ourageisc quevivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14293384 MD	O Anesthesiology	BELBUCA	ANALGESICS - OPIOID	Z79.891	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request his not been approved because this drule is not not normalary. 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 received. 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 tred 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 trail 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 tralokinumab (ADBRY) have not been met. From the records that we have received, Adbry was denied for these reasons: 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.
14297196 ERYN MECHEL MCINTYRE PA-C	Physician Assistant	ADBRY	DERMATOLOGICALS	L20.89 - Other atopic dermatitis	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROJUDES: 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. 1) Documentation of positive clinical response is provided with the request (documentation is required to be submitted for an approval); AND 2) Tralokinumab (ADBRY) will NOT be used in combination with another targeted immunomodulator product used for atopic demantists. 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 quality 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: J All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are eythromycin politic ortinent, BACITRACIN CPHTHALMIC OINTHENT. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14301189 KIMBERLEE MARIE SLAUGHTER O	iD Optometrist	XDEMVY	OPHTHALMIC AGENTS	H01.003-Unspecified blepharits right eye	Not 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 between instancians. Exceptions policy are listed never. In the condition is not coverage between the provided in the member above. The criteria from the poky are listed here. 1) The drug is being used for a condition approved by the Inited States Food and Drug Administration (FDA). 2) All formulary alternatives have been tred 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 trail and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Precception drug samples were not used to establish treatment. 5 sec criteria have not been made, use are unable to approve covered. Price authorization may be required and quantity limits may apply to covered drugs.

						covered. Pre-approval may be needed and there may be limits on the amount or drug covered at a time.
14305830 ANA MARIA HERRERA	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z20.6 - Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authoritation criteria for entricitabine/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 prophylass of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproal flumarate (TRIVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in home mineral destity experienced while on entricitabine/tenofovir disoproal flumarate (TRIVADA) (Documentation is provided to be submitted for an approval); OR (6) Documentation is provided (Chart notes including dates of therapy) of a severe (Documentation adverse effect that did not improve after at least four (4) to eight (9) veets of treatment with entricitabine/tenofovir disoproal fumarate (TRIVADA). Since criteria have not been met, we are unable to assorted for the drivant and the service of the drivant and the
14309114 CARTER REID HANSON PA-C	Physician Assistant	ANDROGEL	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	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 not 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. 1) Member has a diagnosis of primary or secondary hypogoradism and does NOT have age-related hypogonadism; AND 1) TIMO (2) The properties of the prope
14310475 LUKE CONNOR JOHNSON PA-C 14323830 LIDIA YESENIA LOPEZ	Physician Assistant Physician Assistant	SILDENAFIL CITRATE TRI-LUMA	CARDIOVASCULAR AGENTS - MISC. DERMATOLOGICALS	E29.1 L81.1 - Chloasma	Plan Exclusion Plan Exclusion	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 convider may be able to sucused other treatments for your health issue. 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 (Ref) Committee, related to the review of not covered drugs. Also, drugs used for a consentic purpose, such as improving your appearance,
14323830 LIDIA TESERIA LUPEZ	Physician Assistant	IKI-LUMA	DERMATOLOGICALS	L81.1 - Cnioasma	Plan Exclusion	Interapeutics (Part J Committee, reacted to the review or not covered drugs, also, drugs used for a cosmete purpose, such as impriving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulative, to see what is covered by your plan. Our prior authorization criteria for trainfoixnumab (ADBRY) have not been met. From the records that we have received, Adbry was denied for these reasons: 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.
14333591 ERYN MECHEL MCINTYRE PA-C	Physician Assistant	ADBRY	DERMATOLOGICALS	L20.99	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for traidoinumab (ADBRY) have not been met. From the information we have received, the member does not meet number(s) of our prior authorization criteria for Adbry. The reason for denial is explained to the member above. The received, the member does not meet number(s) of our prior authorization criteria for Adbry. The reason for denial is explained to the member above. The substance of the prior and
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 opicid pain reliever. Our Pharmacy and Therapeutics (PR1) 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 opicid pain reliever such as the drug requested. For fluture fills, a longer day supply may be dispensed if our records show recent use of an opicid drug. For members who do not show recent use of an opicid 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 opicid pain reliever; OR. 2) Your pain is linked to an active cancer diagnosis, a filler-ending health issue, or hospice care. 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 FURGATE	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 net-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 use for your health issue have no been tried and falled. Other drugs that can be used are busdesonide nasal syray, funisoidine assal spray, and Florase Sersimist. Please look at the formularly to see what drugs are covered. Pivor authorisation 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 formularly. An exception to allow coverage of a non-formularly 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 orders. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is been used for a condition approved by the United States Ford and Drug Administration (FDA). 2) All formularly alternatives have been tred 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 recessary. 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 from gamples were not used to establish treatment. Since criteria have not medical 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. 1) Records did not show ONE (1) serctonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venialraxine, has been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDED: This request has not been approved because or prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SSRIS), AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SIRIS). 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 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 bones got weaker while taking a drug called Truvada.

4) Records were not sent to us to show your bidneys are not working like normal based on lab tests.

4) Records were not sent to us to show you gordineys are not working like format based on all bates.

5) Records were not sent to us to show your bidneys are not working like format based on a bate standard of the sent to see 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.

						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: 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. 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.
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	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because our pire authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement Henapy, AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered unge.
						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 sizes have not been inted and falled. Other drugs that can be used are demembly plentialed sectored release (ER), methylphenidate ER, amphetamine/decircoamphetamine (P. Goderall XR. equivalent), indicameficamine (Vyvanore-quivalent), decircoamphetamine Please look at the formular to see what drugs are occurred. First authorisation may be required and quantitis timits may apoly to occurred.
14363656 JAMES COCHRAN ANDERSON IV ME) Pediatrics	JORNAY PM	ADHD/ANTI-NARCOLEPSY	F90.2 - Attention-deficit hyperactivity disorder, combined type	Not 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 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 includer relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs care 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.
						LIVE prior authorization criteria for XTREM have not open met. From the records that we have received, XTREM was denied for these reasons: 1) This drug is not being used for excessive daytime selepines with annotelepy or ideopathic hypersomnia. There are all specific health issues that cause extreme sleepiness during the day. Please note: 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.
14368848 NEERAJ MANCHANDA MD	Internal Medicine	XYREM	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	G47.419 - Narcolepsy without cataplexy	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CASE PROVIDES: This request has not been approved because our prior authorization criteria instruction and YREM have not been met. From the information we have received, the member does not meet number(s) I and 2 of our prior authorization criteria for XYREM. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of excessive daytime sleepiness with narcolepsy, cataplexy with narcolepsy, or idiopathic hypersomnia; ANID 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
						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 you he tental issue have not been tried and failed. Other drugs that can be used are qualifiencistrifications group, promethazine VC and the covered cough syrups. Please lock at the formularly to see what drugs are covered. Prior authorisation may be required and quantity limits may apply to covered drugs.
14371461 DOMINICK ANDREW RUIZ MD	Family Practice	BROMPHEN/PSEUDOEPHEDRI NE	COUGH/COLD/ALLERGY	Acute upper respiratory infection, unspecified	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH 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 drugs is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of friel 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 Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) The drug is not being used for Major Depressive Disorder (MOD.) 2) Records did not shown TWO (2) sectories entouring receptable inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or parametrich, have been title and falled. All of the did not shown ONE (1) serotatin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and falled. 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.
14374973 IVAN SRDANOVIC PMHNPBC	Advanced Practice Nurse	TRINTELLIX	ANTIDEPRESSANTS	ADHD	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and falled, or was intolerant to, two selective serotonin reuptake inhibitors (SRIs), AND 3) Patient has tried and falled, or was intolerant to, two selective serotonin reuptake inhibitors (SRIs), SIND 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 apoly to covered drug.
						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 falled. Other drugs that can be used are docemethylphenidate extended release (ER), methylphenidate ER (Concerta, Ritalin LA, or Metadate CD equivalent), amphetamine/disctroamphetamine ER (Addrest XR equivalent), insideamphetamine (Vyanuse equivalent) (herobach belations ER) and others. Please note: ER capsules can be opened and sprinked over applessor. Please book at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14378943 SHERI MICHELLE RAVENSCROFT M	ID Developmental-Behavioral Medicine	QUILLIVANT XR	ADHD/ANTI-NARCOLEPSY	F84.0	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEATH CASE PROVIDES: The 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 beterminations - Exceptions policy are net. From the information we have received, the member does not meet number 2 of the exception policy retirate. The reson for denial is exclusined 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 received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments their with dates of trial and responses, and any other evidence to show the covered drugs are likely to be infertictive or unaffer 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.

		LEVALBUTEROL TARTRATE	ANTIASTHMATIC AND	J20.9 - Acute bronchitis,		Our prior authorization criteria for Step I herapy nave not been met. Step I nerapy means that other drugs will need to be tried and railed first. From the records that we have received, LEVALBUTEROL TARTRATE HFA was denied for these reasons: 1) VENTOLIN HFA has not been tried and failed. Records did not show that you had see 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.
14392092 PAUL DANIEL CALIVIN MD	Family Practice	HFA	BRONCHODILATOR AGENTS	unspecified	Criteria Not Met	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 un formulary for information on what is Our prior authorization criteria for Trintellix have not been met, brom the records that we have received, the following caused the denial of Trintellix. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or parroxetine, have been tried and failed. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.
14396905 MICHAEL ANDREW MUSGROVE MD	Psychiatry	TRINTELLIX	ANTIDEPRESSANTS	F33.2	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, two selective serotronin recuptake inhibitors (SSRIs), AND 3) Patient has tried and failed, or was intolerant to, two selective serotronin recuptake inhibitors (SRIS), 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 Insulin Aspart (Novolog equivalent) or Fiasp. Please look at the formularly to see what drugs are 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	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formularly. An exception to allow coverage of a non-formularly 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 orieria. 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 formularly alternatives have been treceived showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tride 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. 5) Ricca 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.	11.0	Criteria Not Met	Our prior authorization criteria for nintedamia (CFEV) have not been met. From the records that we have received, Ofev was denied for these reasons: 1) Records did not show that you health issue is epitimic worse, or prospessive. 2) More information is needed to know about the specific testing that was done to confirm your health issue. 3) Records did not show the dates and results of a breathing test called fored VIral Capacity (PVC). 4) Records did not show the dates and results of a breathing test called fored VIral Capacity (PVC). 5) Records did not show that changes have been seen on a chest. X-Ray or CT scan. 7) Records did not show that changes have been seen on a chest. X-Ray or CT scan. 7) Records did not show that changes have been seen on a chest. X-Ray or CT scan. 7) Records did not show that changes have been seen on a chest. X-Ray or CT scan. 7) Records did not show that changes have been seen on a chest. X-Ray or CT scan. 7) Records did not show that changes have been seen on a chest. X-Ray or CT scan. 7) Records did not show that conditions the following drugs did not work for your azarbioprine, cyclosporine, mycophenolate mofetil, oral corticosteroids (e.g. more than 20mg of prediscione per day), cyclophosphamide, OR frustimate, OR facrolimus. Prior authorization may 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 prior authorization criteria for offer for chronic Fibrosing Interstitial Lung Disease. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Pulmonologist; AND 2) Member has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype; AND 3) Disease is progressive, as defined by two (2) of the following accounting within the past 12
14420260 SHWOL-HUO DANNY KIANG DO	Dermatology	DUPDENT	DERMATOLOGICALS	L20.89	Criteria Not Met	Covered, Prior authorization may be required and quantity limits may apply to covered drugs. Our prior authorization criteria for dupilipiamb (DUPPENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 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. 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. 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 formularly, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDEN: This request has not been approved because our prior authorization criteria for dupiliumab (DUPDENT) 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 a member does not meet number(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. 1) Member is an eigenst so chromit with, an Allerigist, Immunologist, or Dermatologist; AND 2) Prescribed by, or in consultation with, an Allerigist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chromic moderate-to-severe atopic demmatistis (exzema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (ESA) 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 approvall); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not bolerated is provided with the request (documentation (is req

						be required and quantity limits may apply to covered drugs.
14420456 BONNIE LEIGH POPE APRN	Nurse Practitioner	Jakafi	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	D89.811	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request his not been approve 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. 1) Prescribed for a diagnosis of moderate to severe chronic graft-versus-host disease (GVHD) after allogenic hematopoietic stem cell transplant; AND 2) Prescribed by, or in consultation with, an Oncologist, Hematologist, or Transplant Specialist; AND 3) Member is 12 years of age or older; AND 4) Member is refractory to corticosteroida alone. 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 vilazodone (Vilbryd) have not been met. From the records that we have received, the following caused the denial of vilazodone. 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, escatalopram. (FIERD), fluxouten, parcewher)
						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
14421291 MICHAEL ANDREW MUSGROVE MD	Psychiatry	VILAZODONE HYDROCHLORIDE	ANTIDEPRESSANTS	F33.2	Criteria Not Met	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(s) 3 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria rae listed here. 1) Member has a diagnosis of major depressive disorder; ANID 2) Member is 18 years of age or older; ANID 3) Member must try and fall at least 2 selective servotinin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluovetine, paroxetine); ANID 4) Member must try and fall at least 3 restrontin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venisfaxine). 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 apoly to covered drug.
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. Tour doctor or health care provider may be able to suggest other teatments for you 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 ventrion in FA inhaler, platered if FA inhaler (Proviered in FA inhaler) and the province of th
14437059 AHMAD BILAL TABBARA FNP-C	Nurse Practitioner	ALBUTEROL SULFATE HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	345.909 - Unspecified asthma, uncomplicated	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formularly. An exception to allow coverage of a non-formularly 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. 2. All formularly alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be triad. 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 you rebath issue have not been tried and falled. Other drugs that can be used are docytely, polyethytem glycol (PEC) 3350(electrolytes (Colyte equivalent), PEG 3350(electrolytes Z(Nulytely equivalent), sodium/potassium/magnesium solution (Suprep equivalent), PEG 3350 solution (Polyoripe equivalent), econique experiment of the formulary to see what drugs are 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	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because this drug is not no 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 free. 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 drugs is melically 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.
14453719 ELIZABETH HAVEY MILLER MD	Dermatology	LEVICYN	DERMATOLOGICALS	L30.4	Plan Exclusion	This request has not been approved because this product uses approved by the United States Food and Drug Administration (FDA) as a medical device. Medical devices are more-furg products that are meant to help diagnose and trost 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 be 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 remarked. Claimstife limits war annot her convended druse.
						Our prior authorization criteria for nintedanib (OFEV) have not been met. From the records that we have received, Ofev was denied for these reasons: 1) Records did not show that one of the following drugs did not work for you: azathiopine, cyclosponne, mycophenolate moletat, oral conticosteroids (e.g., more than 20mg of predinisone per day), cyclopospanie, QR ritutumina, OR tratifiumis, From authorization may be required and quity 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.
14454964 RAJESH ANAND SHETTY MD	Pulmonary Disease	OFEV	RESPIRATORY AGENTS - MISC.	184.9	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEATH CARE PROVIDER: This request has not been approved because our prior authorization criteria for initedanib (CPEV) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Offer for Chronic Fibrosing Interstitial Lung Disease. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Pulmonologist, AND 2) Member has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype; AND 3) Disease is progressive, as defined by two (2) of the following occurring within the past 12 months with no atternative explanation: (A) Worsening respiratory symptoms, or (0) Absolute decline in forced wild capacty (PKC) of greater than or equal to 5% predicted within one (1) year of follow-up, and Fibrosing and the provided of the provide

Our prior authorization criteria for Jakafi have not been met. From the records that we have received, the following caused the denial of Jakafi. 1) Records did not show that corticosteroids (e.g. prednisone) have been tried and failed.

Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

14467545 ARPY JITENDRA KOTHARI PA	Physician Assistant	WINLEVI	DERMATOLOGICALS	L70.8 - Other acne	Not 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 - Exception policy are met. From the information we have received, the member does not meet number 2 of the exception policy or there. The reason for definal 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 melically necessary. These should include relevant medical history and lab results, past treatments tried with desser of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Precorption 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 Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as settraline, chalopram, eschalopram, fluoxetine, or paroxetine, have been treat and fatient. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and fatied. 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.
14472813 SUSANNA-RACHEL SALOME SEAY PMHINP	Advanced Practice Nurse	TRINTELLIX	ANTIDEPRESSANTS	F33.1	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR FEALTH CARE PROVIDER: 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. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and fieled, or was intellerant to, two selective sentonin reuptake inhibitors (SSRIs), AND 3) Patient has tried and fieled, or was intellerant to, pose sertonin-in-orgenipelprine reuptake inhibitors (SSRIs), 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 demethylphenialed excembly denialed excembly plenialed excembly plenialed excembly plenialed excembly plenialed (ER) capsule (TRIED), amphetamine/dextroamphetamine ER capsule (TRIED), methylphenidate ER tablet or capsule, dextroamphetamine ER capsule, and isideoamfetamine capsule or chowale tablet (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.
14474379 JAMES COCHRAN ANDERSON IV MI	D Pediatrics	JORNAY PM	ADHD/ANTI-NARCOLEPSY	F90.2 - Attention-deficit hyperactivity disorder, combined type	d Not 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 - Exception policy are net. From the information we have received, the member does not meet number 2 of the exception policy or there. 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 timeled States Food and Drug Administration (FDA.) 2) All formulary alternatives have been trived 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 includer 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.
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 formous salitate and others. Resea note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.
14477961 VIKTORYIA V DZISKA PA-C	Physician Assistant	ACETAMINOPHEN EXTRA STREN	ANALGESICS - NONNARCOTIC	R51.9	Not Covered	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 trevalment orthors. midth be fruit for vour health is case. 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 accelerationpoten tables, capable, and oral solution (Tylenol equivalents). Please note other drugs are not reward by write mercrination or in the media. Please refer to the formulary for condition in the provider of the continuous success official control (USA) Step I herapy nave not been met. Step I herapy 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: 1) Records did not show that you are using insulin. 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.
14498094 ADRIANA AZAR PRATT MD	Family Practice	DEXCOM G7 SENSOR	MEDICAL DEVICES	E11.59 - Type 2 diabetes mellitu with other circulatory complications	is Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 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 isted here. 1) Member is currently using insulin. 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
						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 definial. I all covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are simulation (TRIO) (80mg not covered), pravastatin, alovastatin, lovastatin, drugstatin capsule. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14504687 DAVID J ESCAMILLA	Pharmacology	SIMVASTATIN	ANTIHYPERLIPIDEMICS	E78.00 - Pure hypercholesterolemia, unspecifie	Not 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 net. From the information we have received, the member does not meet number 2 of the exception policy or them. The reason for denial is explained to the member above. The orities from the policy are issed here. 2) All formulary alternatives have been the dor medical reasons have been provided winy 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:

Jul Covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical indiamyfring. IRIED) or enythromycin, tretinoin (TRIED), adapatene (Differin equivalent) or adapatene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, aufinechozace/letrimathorpim, cephalecian).

Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.

Endocrinology, Diabetes & OZEMPIC Metabolism 14513824 MARC EVAN WENZEL MD 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:

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 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.