Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Denial Reason	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
12616341	HANA JANE PALADICHUK MD	Dermatology	JAKAFI	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	M04.9	Not Covered	The requested amount of JAKAFI TAB 10MG 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 JAKAFI TAB 10MG at 2 tablets per day for this use. The higher number of 2.5 tablets per day is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.		
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent (TRIED)), Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
12686248	SARAH STAYER MILLS MD	Internal Medicine	OXYCONTIN	ANALGESICS - OPIOID	G89.3 - Neoplasm related pain (acute) (chronic)	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 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		
12697642	OM NARAYAN PANDEY MD	Internal Medicine	CABOMETYX	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	C73.0	Not Covered	The requested amount of CABOMETYX TABLET 60MG 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 CABOMETYX TABLET 60MG at 1 tablet per day for this use. The higher amount of 2 tablets per day is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.		
12708980	ADAM MICHAEL DECKER PA	Physician Assistant	LINEZOLID	ANTI-INFECTIVE AGENTS - MISC.	T84.51XA	Criteria Not Met	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, LINEZOLID was denied for this reason: 1) The drug is not prescribed by a(n) Infectious Disease specialist. 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 Restricted to Specialist prior authorization criteria have not been met. From the information we have received, the member does not meet 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The provider's specialty matches the Restricted Specialty requirements per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information		
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended-release (ER) tablet, oxycodone ER tablet, Xtampza ER, Nucynta ER, hydrocodone ER tablet (Hysingla equivalent) or hydrocodone ER capsule (Zohydro equivalent), tramadol ER tablet (TRIED), buprenorphine patch (TRIED), fentanyl patch (Duragesic 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.		
12713445	RAPHAEL XUYAN YE DO	Anesthesiology	BELBUCA	ANALGESICS - OPIOID	chronic pain syndrome	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 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.		
12733461	JOHN PATRICK FARDAL DO	Family Practice	OZEMPIC	ANTIDIABETICS	obesity	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.		
12742286	OM NARAYAN PANDEY MD	Internal Medicine	CABOMETYX	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	C73.00	Not Covered	The requested amount of Cabometyx 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 Cabometyx at 1 tablet per day for this use. The higher amount of 2 tablets per day is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is 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 Enbrel, Humira (TRIED), Taltz (TRIED), Tremfya, Cimzia, Otezla, Orencia, Rinvoq, Skyrizi, Stelara (TRIED), Xeljanz. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
12760967	ROBERT JOHN KOVAL JR MD	Internal Medicine	COSENTYX SENSOREADY PEN	TARGETED IMMUNOMODULATORS	I40.50	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 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		

12770213	ADAM PAUL BARTA MD	Emergency Medicine	TESTOSTERONE PUMP	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 was denied for these reasons: 1) Records show that this drug is being used for age-related low testosterone levels. This is not a covered use on your drug plan. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Initial Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has symptoms of hypogonadism; AND 3) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND 5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 months. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12775381	CRAIG HEWELL COUCH MD	Neurology	NURTEC	MIGRAINE PRODUCTS	G43.009 - 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 your health issue have not been tried and failed. Other drugs that can be used are Ubrelvy(tried) and Reyvow. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12787003	PRAKASH SAMUEL EAPEN MD	Internal Medicine	WEGOVY	ANTI-OBESITY/ANOREXIANTS	e66.01	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
12803412	KAVITHA KUMBUM MD	Gastroenterology	AZATHIOPRINE	MISCELLANEOUS THERAPEUTIC CLASSES	K50.80 - Crohn's disease of both small and large intestine without complications	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are azathioprine tab (IMURAN equiv). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12825663	DEVIKA MARANGATTU MADHAVAN	Endocrinology, Diabetes & Metabolism	INSULIN DEGLUDEC FLEXTOUC	ANTIDIABETICS	Type 2 diabetes mellitus with diabetic neuropathy, 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 failed. Other drugs that can be used are Levemir (tried), insulin glargine, Tresiba, Toujeo. 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
12826159	FEBA THOMAS	Family Practice	OZEMPIC	ANTIDIABETICS	Z68.34 - Body mass index [BMI] 34.0-34.9, adult	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
12839338	TESSA KIMBERLY NOVICK MD	Internal Medicine	LOKELMA	MISCELLANEOUS THERAPEUTIC CLASSES	E87.5 - Hyperkalemia	Criteria Not Met	Our prior authorization criteria for sodium zirconium cyclosilicate (LOKELMA) have not been met. From the records that we have received, Lokelma was denied for these reasons: 1) Records did not show a high blood potassium level (above 5.3mmol/L). 2) Records do not show that you have tried to change your diet to control the blood potassium level. 3) Records do not show that a diuretic (also known as a water pill) has been tried and failed. 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 sodium zirconium cyclosilicate (LOKELMA) have not been met. From the information we have received, the member does not meet number(s) 2 & 3 of our prior authorization criteria for Lokelma. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Nephrologist, Cardiologist, or Endocrinologist; AND 2) Hyperkalemia (greater than (>) 5.3 mmol/L) persists despite dietary management; AND 3) Hyperkalemia (greater than (>) 5.3 mmol/L) persists despite use of diuretics (if appropriate). 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.

12867699	ESTEFANIA QUINTERO MOJICA RN	Nurse Practitioner	OZEMPIC	ANTIDIABETICS	prediabetes	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
12882076	KATELYN MARIE MURRAY	Physician Assistant	OZEMPIC	ANTIDIABETICS	Obesity	Not Covered	Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
12901662	JOE THANH NGUYEN MD	Family Practice	DEXCOM G6 TRANSMITTER	MEDICAL DEVICES	E11.40 - T2DM	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of DEXCOM G6. 1) Records do not show that you are using insulin. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for DEXCOM G6. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (A) Member has demonstrated hypoglycemia unawareness; OR (B) Undetected hypoglycemia poses an occupational safety risk; OR (C) Member has suboptimal diabetes control and meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (CGM) use based upon a professional CGM trial; OR (E) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information
12902275	ASHA RENE LALL MD	Family Practice	MEMANTINE HYDROCHLORIDE	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	G90.50 - Complex regional pain syndrome I, unspecified	Not Covered	The requested amount of memantine is more than 2.5 times the recommended highest daily dose for the drug. We will still cover 20 mg per day per day for this use. The higher dose of 40-60 mg per day per day is not an approved dose for your health issue. In order for the higher amount per day to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
12950910	HECTOR SANCHEZ MD	Family Practice	LANTUS SOLOSTAR	ANTIDIABETICS	Type 2 diabetes mellitus without complications (HCC)	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-yfgn or semglee, have not been tried and failed. A biosimilar is a biological product that is approved by the United States Food and Drug Administration (FDA) to be highly similar to, and have no clinically meaningful differences from, the original product. 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Levemir, Toujeo and Tresiba. 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the biosimilar drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The biosimilar form(s) of the drug have been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the biosimilar drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered, Prior authorization may be required, Quantity limits may apply to covered drugs.
12953305	ALEXANDRIA ANNE HARRIS PA-C	Physician Assistant	HUMIRA PEN	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons: 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. 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) 3 of our prior authorization criteria for Humira 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). 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.
12954958	BRIAN DAVID VAILLANT MD	Neurology	AVASTIN	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	c714.9	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Avastin injection is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.

12965697	HONG-PHUC NGUYEN	Nurse Practitioner	QULIPTA	MIGRAINE PRODUCTS	G43.909 - Migraine, unspecified, not intractable, without status migrainosus	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Aimovig, Ajovy and Emgality(tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information
12981284	JOE THANH NGUYEN MD	Family Practice	DEXCOM G6 TRANSMITTER	MEDICAL DEVICES	e11.65	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of Dexcom. 1) Records do not show that you are using insulin. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Dexcom. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (A) Member has demonstrated hypoglycemia unawareness; OR (B) Undetected hypoglycemia poses an occupational safety risk; OR (C) Member has suboptimal diabetes control and meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (CGM) use based upon a professional CGM trial; OR (E) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information
12988061	LAWRENCE SAMUEL BAYLISS APN	Nurse Practitioner	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.4	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 hydrocortisone cream (Proctocort equivalent), hydrocortisone enema (Cortenema equivalent), lidocaine/hydrocortisone cream (ANAMANTLE equivalent, Analpram-E Kit, 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 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
13017406	ELISABETH ANNE CLAYTON MD	Allergy & Immunology	CINRYZE	HEMATOLOGICAL AGENTS - MISC.	D84.1	Not Covered	The requested amount of Cinryze 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 Cinryze at 16 vials per 28 days for this use. The higher amount of 24 vials per 28 days is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered. "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) The drug was not prescribed by, or together with, a Rheumatology Specialist. This is a doctor who works with health problems of the joints, muscles, tendons, and bones. 2) Records did not show that you have tried and failed triamcinolone put on the affected areas of the skin, or that you have tried and failed a whole body therapy (e.g. colchicine or azathioprine tablets), OR that you have medical reasons why BOTH of these treatments cannot be used. 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.
13024572	HANA JANE PALADICHUK MD	Dermatology	OTEZLA	TARGETED IMMUNOMODULATORS	M35.2 - Behcet's disease	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) 1 and 4 of our prior authorization criteria for Otezla for Behcet's disease (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Rheumatology Specialist; AND 2) Member has a diagnosis of Behcet's disease (BD); AND 3) Diagnosis is confirmed by the presence of recurrent (at least 3 episodes in any 12-month period) oral ulcerations AND at least two (2) of the following: (A) recurrent genital ulceration, (B) eye lesions, (C) skin lesions, (D) positive pathergy test; AND 4) A trial of ONE (1) of the following was ineffective, not tolerated, or BOTH treatments are contraindicated: (A) topical triamcinolone or (B) one systemic therapy (e.g. colchicine or azathioprine) for Behcet's oral ulcers. 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

13024856	JASDEEP KAUR SANDHU	Psychiatry	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	ADD	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 dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), Vyvanse (tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13050968	NELLA GEMMA STOUT	Nurse Practitioner	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.00 - Constipation, unspecified	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called Trulance did not work for you. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A trial of plecanatide (TRULANCE) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13086853	SIMONA MARIANA SCUMPIA MD	Endocrinology, Diabetes & Metabolism	KERENDIA	ENDOCRINE AND METABOLIC AGENTS - MISC.	E11.65 - Type 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for finerenone (Kerendia) have not been met. From the records that we have received, Kerendia was denied for these reasons: 1) Records did not show you have a diagnosis of Chronic kidney disease (CKD). This is a health issue where your kidneys aren't working as well as they should to filter blood and remove extra water and chemicals from your body. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for finerenone (Kerendia) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Kerendia. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of BOTH Type 2 Diabetes AND Chronic Kidney Disease (CKD); AND 2) A trial of dapagliflozin (Farxiga) was not tolerated or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13088050	SARAH MARGARET MCCRAY FNP	Nurse Practitioner	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J44.9	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 that can be used are Incruse Ellipta, Anoro Ellipta, Stiolto Respimat, Lonhala Magnair (step therapy requires trial of Incruse Ellipta). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13091835	SHANNON MARIE BRASLAVSKY	Nurse Practitioner	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.09 - Other obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13100106	SARAH MARGARET MCCRAY FNP	Nurse Practitioner	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J44.9	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 that can be used are Incruse Ellipta, Anoro Ellipta, Stiolto Respimat, and Lonhala Magnair (step therapy requires trial of Incruse Ellipta). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called Trulance did not work for you. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13110081	MASI KHAJA MD	Gastroenterology	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 linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A trial of plecanatide (TRULANCE) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13148988	HONG-PHUC NGUYEN	Nurse Practitioner	QULIPTA	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 are Aimovig, Ajovy, and Emgality(TRIED). Prior authorization may be required and quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information
13154897	RACHAEL NAMBUSI MD	Family Practice	OZEMPIC	ANTIDIABETICS	E66.9 - Obesity, unspecified	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
13168909	DEVIKA MARANGATTU MADHAVAN	Endocrinology, Diabetes & Metabolism	VICTOZA	ANTIDIABETICS	Prediabetes	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, VICTOZA was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
13170218	MASI KHAJA MD	Gastroenterology	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.00	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called Trulance did not work for you. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of ONE (1) of the following: Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A trial of plecanatide (TRULANCE) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13198066	ROBERT JOHN KOVAL JR MD	Internal Medicine	DICLOFENAC SODIUM	DERMATOLOGICALS	M25.541 - Pain in joints of right hand	Criteria Not Met	Our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the records that we have received, diclofenac 3% gel was denied for these reasons: 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for diclofenac 3% gel. The reason for denial is explained to the member above. The criteria are listed here. 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.
13203568	NIKITHA GANGASANI MD	Internal Medicine	STELARA	TARGETED IMMUNOMODULATORS	K50.90	Not Covered	The requested amount of STELARA INJECTION 45MG/ML is greater than the quantity limit for the drug for Crohn's Disease. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover STELARA INJECTION 45MG/ML at 2 injections (90mg) every 56 days for this health issue. The higher number of 90mg per 28 days is not an approved dose for your health issue. For the higher quantity to be approved, records must show that you have tried and failed Stelara dosed every 8 weeks and other drugs called Skyrizi and Entyvio did not work for you. Please note that Skyrizi intravenous (IV) and Entyvio IV are medical injectable drugs that must be given by a health care provider and are not covered under your pharmacy benefit. These drugs may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.

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13207280	KEITH HARVEY LAMY MD	Family Practice	PRALUENT	ANTIHYPERLIPIDEMICS	CV disease	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 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.
13209011	RABIN KHERADPOUR MD	Internal Medicine	LORATADINE	ANTIHISTAMINES	Cough, unspecified	Plan Exclusion	This request cannot be approved because this drug/product is in a class of drugs/products called over the counter . Drugs/products of this type are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs/products, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13211038	DEVIKA MARANGATTU MADHAVAN	Endocrinology, Diabetes & Metabolism	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Essential (primary) hypertension	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13216655	ELISABETH ANNE CLAYTON MD	Allergy & Immunology	CINRYZE	HEMATOLOGICAL AGENTS - MISC.	D84.1	Not Covered	The requested amount of Cinryze 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 Cinryze at 16 vials per 28 days for this use. The higher amount of 24 vials is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic pain syndrome . 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 morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13219626	BETTE JEAN PAULSEN NP	Nurse Practitioner	KETAMINE HYDROCHLORIDE	GENERAL ANESTHETICS	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 met. From the information we have received, the member does not meet number 1,2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information
13238584	RACHAEL NAMBUSI MD	Family Practice	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because your plan has chosen this drug/product to be excluded from coverage. Other drugs/products for your health issue may be covered by your plan. Please look at the list of covered drugs/products, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this drug from coverage.
13258969	KAVITHA KUMBUM MD	Gastroenterology	STELARA	TARGETED IMMUNOMODULATORS	CD	Not Covered	The requested amount of STELARA INJECTION 90MG/ML is greater than the quantity limit for the drug for Crohn's Disease. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover STELARA INJECTION 90MG/ML at 1 injection every 56 days for this health issue. The higher number of 1 injection per 28 days is not an approved dose for your health issue. For the higher quantity to be approved, records must show that you have tried and failed Stelara dosed every 8 weeks-(MET) and other drugs called Skyrizi and Entyvio did not work for you. Please note that Entyvio is a medical injectable drug that must be given by a health care provider and is not covered under your pharmacy benefit. These drugs may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
13266737	RACHAEL NAMBUSI MD	Family Practice	TRULICITY	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13267927	LEAH D TATUM MD	Obstetrics & Gynecology	DICLEGIS	ANTIEMETICS	Z32.01 - Encounter for pregnancy test, result positive	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 doxylamine and pyridoxine. These drugs are available over the counter, without a prescription. Additionally, one (1) of the following: meclizine, dimenhydrinate, diphenhydramine (all available over the counter, without a prescription) AND one (1) of the following: metoclopramide, promethazine, prochlorperazine, must be tried and failed. 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.
13270545	SARAH STAYER MILLS MD	Internal Medicine	OXYCODONE HYDROCHLORIDE E	ANALGESICS - OPIOID	G89.3 - Neoplasm related pain (acute) (chronic)	Not Covered	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 The requested amount of oxycodone 20mg ER tablet is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover oxycodone 20mg ER tablet at 2 tablets per day for this use. The higher amount of 3 tablets per day is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.

							Our prior authorization criteria for Motegrity have not been met. From the records that we have received, the following caused the denial of Motegrity. 1) Trulance has not been tried and failed. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13271806	EBERE EILEEN OPARA	Nurse Practitioner	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.04 - Chronic idiopathic constipation	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Motegrity have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Motegrity. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of chronic idiopathic constipation (CIC); AND 2) A trial of Trulance was ineffective, contraindicated, or not tolerated; AND 3) Member is NOT currently using opioids. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13279251	JAMES ALLEN ZACHARY MD	Infectious Diseases	INVOKANA	ANTIDIABETICS	Type 2 diabetes mellitus wout complications(HHS)	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 Farxiga (dapagliflozin) or Xigduo XR (dapagliflozin/metformin), and Jardiance (empagliflozin) or Synjardy XR (empagliflozin/metformin). 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
13301107	RACHAEL NAMBUSI MD	Family Practice	RYBELSUS	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13308745	FEBA THOMAS	Family Practice	OZEMPIC	ANTIDIABETICS	Z68.34 - Body mass index [BMI] 34.0-34.9, adult	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13326348	CHRISTOPHER CHANG MD	Family Practice	OZEMPIC	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13326940	ZAYD NAJDAT NASHAAT MD	Internal Medicine	OZEMPIC	ANTIDIABETICS	Essential (primary) hypertension	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13330033	KHANG DUY NGUYEN MD	Dermatology	KINERET	TARGETED IMMUNOMODULATORS	M35.2 - Behcet's disease	Criteria Not Met	Our prior authorization criteria for Kineret have not been met. From the records that we have received, the following caused the denial of Kineret. 1) The drug is not being used for Active Systemic Juvenile Idiopathic Arthritis, Adult-Onset Still's Disease, Cryopyrin-Associated Periodic Syndromes, Familial Mediterranean Fever, Hyperimmunoglobulin D Syndrome, Mevalonate Kinase Deficiency, Tumor Necrosis Factor Receptor Associated Periodic Syndrome, or Deficiency of Interleukin-1 Receptor Antagonist. 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 Kineret have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Kineret (initial therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatologist; AND 2) Member has a diagnosis of Active Systemic Juvenile Idiopathic Arthritis (SJIA); OR 3) Member has a diagnosis of moderate-to-severe active Adult-Onset Still's Disease (AOSD); OR 4) Member has a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS); AND diagnosis confirmed by presence of a NALP3 gene mutation; OR 5) Member has a diagnosis of Familial Mediterranean Fever (FMF); AND a trial of colchicine was ineffective, contraindicated, or not tolerated; OR 6) Member has a diagnosis of Hyperimmunoglobulin D Syndrome (HIDS) / Mevalonate Kinase Deficiency (MKD); AND Diagnosis confirmed by ONE (1) of the following: (A) Presence of MVK gene mutation; OR (B) Elevated immunoglobulin D (IgD) serum level; OR 7) Member has a diagnosis of Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS); AND diagnosis is confirmed by presence of disease-associated mutations in the TNFRSF1A gene; AND a trial of corticosteroids was ineffective, contraindicated, or not tolerated; OR 8) Member has a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA); AND Prescribed by a provider specializing in, or familiar with, the treatment of DIRA. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
13337769	RACHAEL NAMBUSI MD	Family Practice	SAXENDA	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13361928	CATHIA MENDEZ-VARGAS MD	Geriatric Medicine	EMGALITY	MIGRAINE PRODUCTS	G43.009 - Migraine without aura, not intractable, without status migrainosus	Criteria Not Met	Our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the records that we have received, Emgality was denied for these reasons: 1) You have not tried and failed (after using for at least 3 months) other drugs from at least ONE of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.). 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 galcanezumab (EMGALITY 120mg) have not been met. From the information we have received, the member does not meet number(s) 8 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 migraine; AND 2) Member has experienced a meaningful improvement in frequency and/or severity of migraine; AND 3) Emgality will NOT be used concomitantly with onabotulinumtoxinA (BOTOX) injections for chronic migraine; OR 4) Emgality will be used concomitantly with onabotulinumtoxinA (BOTOX) injections for chronic migraine, AND both of the following are met: (A) Member has failed at least three (3) months of individual therapy with Emgality, AND (B) Member has failed at least three (3) months of individual therapy with onabotulinumtoxinA (BOTOX); AND 5) If Emgality was initiated using manufacturer samples or any other mechanism, all of the following are met: (A) Member had four (4) or more migraine days per month for at least three (3) months prior to starting treatment with erenumab (Emgality); AND (B) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from ONE of the following drug classes: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.). 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

13380975	KIRTI VINAYAK MANJREKAR MD	Internal Medicine	RENAGEL	GASTROINTESTINAL AGENTS - MISC.	N18.6 - End stage renal 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 sevelamer tablet, sevelamer powder pak, SEVELAMER CARBONATE TABLET. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13399621	ALEIDA FERNANDEZ-RUBIO PA-C	Physician Assistant	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 weightloss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
13406037	ROSA MARIA FRAUSTO DE MALDONADO	Nurse Practitioner	CETIRIZINE HCL	ANTIHISTAMINES	J30.9 - Allergic rhinitis, unspecified	Plan Exclusion	This request cannot be approved because your plan has chosen this drug/product to be excluded from coverage. Other drugs/products for your health issue may be covered by your plan. Please look at the list of covered drugs/products, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this drug from coverage.
13427268	MICHELLE LIEBERMAN LUBETZKY MD	Internal Medicine	FERROUS GLUCONATE	HEMATOPOIETIC AGENTS	CKD	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include ferrous sulfate & ferrous gluconate. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered. Please note: Your pharmacy drug plan covers ferrex 150 forte, folbee, Multigen, tricon, and others. Check with your provider if these, or other treatment options, might be right for your health issue.
13430883	HEMALI RAJENDRAKUMAR PATEL MD	Hospitalist	INVOKAMET	ANTIDIABETICS	E11.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Xigduo XR (dapagliflozin/metformin) and Synjardy XR (empagliflozin/metformin). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13445502	STEVEN CURTIS CROW MD	Family Practice	TRETINOIN	DERMATOLOGICALS	Dermatitis, unspecified	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, TRETINOIN CREAM 0.05% was denied for these reasons: 1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. These are health issues of the skin. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Acne Agents have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for TRETINOIN CREAM 0.05%. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of acne vulgaris, acne rosacea, or actinic keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13447280	DEBORAH LYNN EKERY MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.5	Criteria Not Met	Our prior authorization criteria for evolocumab (REPATHA) have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show your low-density lipoprotein-cholesterol (LDL-C) is at least 190mg/dL when you are not on cholesterol-lowering drugs. The LDL-C is a blood test that measures the amount of lipid, or fat, in the blood. 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 evolocumab (REPATHA) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Repatha. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a confirmed diagnosis of primary hyperlipidemia (other than heterozygous or homozygous familial hypercholesterolemia); AND 2) Untreated low-density lipoprotein-cholesterol (LDL-C) is greater than or equal to 190 mg/dL; AND 3) A trial of greater than or equal to eight (8) weeks of ONE (1) of the following high-intensity statin therapies was ineffective or not tolerated: (A) atorvastatin greater than or equal to 40 mg, or (B) rosuvastatin greater than or equal to 20mg, or (C) A combination product containing a high-intensity statin; AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 70 mg/dL while on high-intensity or maximally-tolerated statin therapy, or a combination product containing a high intensity statin. 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) This drug is being used for low testosterone. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone gel (androgel equivalent), testosterone cypionate injection (DEPO-TESTOSTERONE equiv), testosterone solution (AXIRON equiv) and other formulary alternatives. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13495654	RODOLFO GABRIEL GUTIERREZ-MACIAS MD	Family Practice	CLOMIPHENE CITRATE	ENDOCRINE AND METABOLIC AGENTS - MISC.	R79.89 - Other specified abnormal findings of blood chemistry	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 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information
							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 Retacrit. 2) More information is needed to show that you will be injecting this medication at your home. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13538030	MICHELLE LIEBERMAN LUBETZKY MD	Internal Medicine	PROCRIT	HEMATOPOIETIC AGENTS	D64.89 - Other specified anemias	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 and 5 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. 5) The drug will be self-administered at the patient's home. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in the plan benefit summary. 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
							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 ¿testosterone cypionate (on a trial), testosterone enanthate, testosterone gel packet or pump 1% (Androgel equivalent), testosterone gel packet or pump 1.62% (Androgel equivalent), testosterone solution (Axiron equivalent), Androderm patch. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13567091	AARON ALAN LAVIANA MD	Urology	XYOSTED	ANDROGENS-ANABOLIC	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 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
							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 an ophthalmologist or optometrist). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13567847	YEN DANG NIEMAN	Ophthalmology	TYRVAYA	OPHTHALMIC AGENTS	DED	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 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

13573091	CHRISTOPHER CHANG MD	Family Practice	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	F51.01 - Primary insomnia	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 ramelteon, zolpidem (TRIED), zaleplon, trazodone, eszopiclone. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
13640902	KEITH HARVEY LAMY MD	Family Practice	REPATHA PUSHTRONEX SYSTEM	ANTIHYPERLIPIDEMICS	HeFH	Criteria Not Met	Our prior authorization criteria for evolocumab (REPATHA) have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show that at least eight (8) weeks of atorvastatin (40mg per day or more), rosuvastatin (20mg per day or more), or a combination drug with a strong statin did not work for you. 2) Records did not show your low-density lipoprotein (LDL) blood level did not go below 70mg/dL while taking a strong statin or maximally-tolerated statin 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. 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 evolocumab (REPATHA) 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 Repatha. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); AND 2) A trial of greater than or equal to eight (8) weeks of ONE (1) of the following high-intensity statin therapies was ineffective or not tolerated: (A) atorvastatin greater than or equal to 40 mg, or (B) rosuvastatin greater than or equal to 20mg, or (C) A combination product containing a high-intensity statin; AND 3) Low-density lipoprotein (LDL) level remains greater than or equal to 70 mg/dL while on high-intensity or maximally-tolerated statin therapy, or a combination product containing a high intensity statin. 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.
13681805	ARPY JITENDRA KOTHARI PA	Physician Assistant	ZORYVE	DERMATOLOGICALS	L40.0	Criteria Not Met	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) Documentation was not received to show that another drug called a topical steroid (e.g betamethasone, triamcinolone) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for roflumilast (ZORYVE) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Zoryve. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a dermatologist; AND 2) Prescribed for a diagnosis of chronic plaque psoriasis; AND 3) Member is at least 12 years of age or older; AND 4) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval); AND 5) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
13692647	PRAKASH SAMUEL EAPEN MD	Internal Medicine	OZEMPIC	ANTIDIABETICS	E66.01 - Morbid (severe) obesity due to excess calories	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
13699682	JENNIFER LAN NAKAMURA MD	Internal Medicine	RESTASIS	OPHTHALMIC AGENTS	dx E50.7	Criteria Not Met	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, RESTASIS 0.05% OP was denied for this reason: 1) The drug is not prescribed by a(n) Ophthalmology or Optometry . 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 Restricted to Specialist prior authorization criteria 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 provider's specialty matches the Restricted Specialty requirements per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.

						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 teriparatide, Tymlos, and 1 oral bisphosphonate (i.e. alendronate tablets, risedronate tablets, ibandronate tablets). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
13714521	JACQUELINE MARIE KERR MD	Family Practice	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MISC.	M81.0	Not Covered
13743647	JAMES ALLEN ZACHARY MD	Infectious Diseases	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	Male erectile dysfunction, unspecified	Plan Exclusion
13832681	MARY MICAELA RIEGER MD	Maternal & Fetal Medicine	GEMTESA	URINARY ANTISPASMODICS	N32.81 - Overactive bladder	Not Covered
13837420	TOCHI MARIE AMAGWULA MD	Obstetrics & Gynecology	SAXENDA	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight	Plan Exclusion
13956476	RAYMONDA EL KHOURY MD	Internal Medicine	LUPKYNIS	MISCELLANEOUS THERAPEUTIC CLASSES	M32.10	Criteria Not Met
13986883	SUZANNE CLAIRE WETHEROLD MD	Cardiology	BYSTOLIC	BETA BLOCKERS	I47.1 - Supraventricular tachycardia	Not Covered
13996847	MELANIE MARIE PICKETT MD	Dermatology	TALTZ	TARGETED IMMUNOMODULATORS	I40.0	Not Covered
14015770	MELANIE MARIE PICKETT MD	Dermatology	TALTZ	TARGETED IMMUNOMODULATORS	L40.0	Not Covered

This request cannot be approved because this drug is being used for impotence. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Myrbetriq and 3 other drugs for your health issue, such as oxybutynin, trospium, tolterodine, darifenacin, solifenacin.
Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
4) Prescription drug samples were not used to establish treatment.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

Our prior authorization criteria for voclosporin (LUPKYNIS) have not been met. From the records that we have received, Lupkynis was denied for these reasons:
1) More information is needed to show that this drug will be used together with other drugs that work to weaken the immune system to help treat your health issue.
2) More information is needed to show this drug will not be used with Benlysta.
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 voclosporin (LUPKYNIS) 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 Lupkynis for Initial Therapy. The reason for denial is explained to the member above. The criteria are listed here.
1) Prescribed by, or in consultation with, a Rheumatologist or Nephrologist; AND
2) Member has a diagnosis of active lupus nephritis (LN); AND
3) Medication will be used in combination with a background immunosuppressive therapy regimen; AND
4) Medication will NOT be given in combination with belimumab (BENLYSTA).
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 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 nebivolol, has not been tried and failed.
2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.
Please look at the formulary to see what drugs are covered.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
1) The generic form of the drug has been tried and failed; AND
2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND
3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/.
Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.

The requested amount of Taltz 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 Taltz at one injection every 28 days for this use. The higher number of 3 injections every 28 days is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.

The requested amount of TALTZ 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 TALTZ at 1 ml per 28 days for this use. The higher amount of 3 ml per 28 days is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.

14039638	EDWARD LEWIS LAIN MD	Dermatology	SEYSARA	TETRACYCLINES	L70.0 - Acne vulgaris	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), doxycycline(tried), minocycline. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14048237	MARY JANE WARREN APN	Advanced Practice Nurse	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	f51.01	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 ramelteon, zolpidem(tried), zaleplon, trazodone, eszopiclone(tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14115311	SOSLAND RACHEL MD	Urology	GEMTESA	URINARY ANTISPASMODICS	N32.81 - Overactive bladder	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 Myrbetriq and 3 other drugs for your health issue, such as oxybutynin, trospium, tolterodine, darifenacin, solifenacin, fesoterodine extended release (ER) tablet (TOVIAZ equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information
14135754	ALIREZA EBNESHAHIDI MD	Family Practice	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	pain	Criteria Not Met	We have received a request for 30 tablets for a 10 day supply for hydrocodone/acetaminophen. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a 7 day supply for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. For members who do not show recent use of an opioid pain reliever, more than a 7 day supply for this first fill can be approved if records are sent in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.
14140988	AMANDA ISABEL LICEA	Physician Assistant	ORGOVYX	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	C61 - Malignant neoplasm of prostate	Criteria Not Met	Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. Our prior authorization criteria for relugolix (ORGOVYX) have not been met. From the records that we have received, Orgovyx was denied for these reasons: 1) Records did not show that this drug is being used to treat advanced prostate cancer. 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 relugolix (ORGOVYX) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Orgovyx. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist or Urologist; AND 2) Member has a diagnosis of advanced prostate cancer; AND 3) Member requires treatment with androgen deprivation therapy (ADT). 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

14211534	OM NARAYAN PANDEY MD	Internal Medicine	IMBRUVICA	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	C83.10	Criteria Not Met	Our prior authorization criteria for ibrutinib (IMBRUVICA) have not been met. From the records that we have received, Imbruvica was denied for these reasons: 1) Records did not show this drug is being used to treat one of these health issues: Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma, Waldenström Macroglobulinemia, OR Chronic Graft Versus Host Disease. 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 ibrutinib (IMBRUVICA) 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 Imbruvica (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist or Hematologist (or Transplant Specialist, if prescribed for Chronic Graft Versus Host Disease); AND 2) Member has a diagnosis of Chronic Lymphocytic Leukemia (CLL); OR 3) Member has a diagnosis of Small Lymphocytic Lymphoma (SLL); OR 4) Member has a diagnosis of symptomatic Waldenström Macroglobulinemia (WM); OR 5) Member has a diagnosis of active Chronic Graft Versus Host Disease (cGVHD); AND Member requires systemic therapy; AND A trial of systemic glucocorticoid therapy 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.
14218887	ALMA D CARTER PA-C	Physician Assistant	DICLOFENAC SODIUM	DERMATOLOGICALS	pain	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are diclofenac 1% gel (Voltaren equivalent), diclofenac 1.5% solution, and 4 oral nonsteroidal anti-inflammatory drugs (NSAIDs) (eg. ibuprofen, diclofenac, meloxicam, etodolac, naproxen, celecoxib, nabumetone). 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
14232718	JEFFREY NORMAN HIGGINBOTHAM MD	Anesthesiology	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic pain syndrome. This is not an approved use. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 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
14240573	RYAN GILBERT MICHAUD	Anesthesiology	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic pain syndrome. This is not an approved use. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 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
14299233	DIANA CAROLYN COOK MD	Family Practice	OZEMPIC	ANTIDIABETICS	obesity	Plan Exclusion	on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

14313829	OM NARAYAN PANDEY MD	Internal Medicine	IMBRUVICA	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	MCL	Criteria Not Met	Our prior authorization criteria for ibrutinib (IMBRUVICA) have not been met. From the records that we have received, Imbruvica was denied for these reasons: 1) Records did not show this drug is being used to treat one of these health issues: Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma, Waldenström Macroglobulinemia, OR Chronic Graft Versus Host Disease. 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 ibrutinib (IMBRUVICA) have not been met. From the information we have received, the member does not meet number(s) 2, 3, 4, and 5 of our prior authorization criteria for Imbruvica (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist or Hematologist (or Transplant Specialist, if prescribed for Chronic Graft Versus Host Disease); AND 2) Member has a diagnosis of Chronic Lymphocytic Leukemia (CLL); OR 3) Member has a diagnosis of Small Lymphocytic Lymphoma (SLL); OR 4) Member has a diagnosis of symptomatic Waldenström Macroglobulinemia (WM); OR 5) Member has a diagnosis of active Chronic Graft Versus Host Disease (cGVHD); AND Member requires systemic therapy; AND A trial of systemic glucocorticoid therapy 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.
14323329	EMILY WANTLAND HICKS FNP-C	Nurse Practitioner	OZEMPIC	ANTIDIABETICS	Z91.89-Other specified personal risk factors	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
14331509	EMILY WANTLAND HICKS FNP-C	Nurse Practitioner	OZEMPIC	ANTIDIABETICS	Z91.89	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required, and quantity limits may apply to covered drugs.
14353430	BRYANNA MANTILLA	Internal Medicine	ORENCIA	TARGETED IMMUNOMODULATORS	M06.00	Criteria Not Met	Our prior authorization criteria for subcutaneous abatacept (ORENCIA SC) have not been met. From the records that we have received, Orencia SC was denied for these reasons: 1) Records did not show at least TWO (2) of the following drugs did not work for you: an adalimumab product (Humira) (TRIED), Enbrel, Xeljanz, Rinvoq. 2) Records did not show that BOTH of the following drugs did not work for you: an adalimumab product (Humira) (TRIED) AND Actemra. 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for subcutaneous abatacept (ORENCIA SC) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for Orencia SC. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) Trials of TWO (2) of the following were ineffective or not tolerated: (A) an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA), (B) etanercept (ENBREL), (C) tofacitinib (XELJANZ/XELJANZ XR), D) upadacitinib (RINVOQ); OR 4) Trials of BOTH an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) AND tocilizumab (ACTEMRA) were ineffective or not tolerated; OR 5) ALL untried alternatives are contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14366540	LEIGH ANNE ROMERO MD	Family Practice	SYNVISC ONE	MUSCULOSKELETAL THERAPY AGENTS	M17.0	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. SYNVISC ONE is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
14375227	MARINA VLADIMIROVNA MOORE	Neurology	UBRELVY	MIGRAINE PRODUCTS	G43.001	Criteria Not Met	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for these reasons: 1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan, rizatriptan, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second triptan was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14390690	MARINA VLADIMIROVNA MOORE	Neurology	UBRELVY	MIGRAINE PRODUCTS	G43.001	Not Covered	The requested amount of Ubrelvy is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Ubrelvy at 10 tablets per 30 days for this use. The higher number of 16 tablets per 30 days is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.

							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 3 of the following: one topical steroid (such as triamcinolone (TRIED), betamethasone, halobetasol), one topical vitamin D analog (such as calcipotriene, calcitriol), tazarotene, tacrolimus, pimecrolimus, and Zoryve. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14400127	MELANIE MARIE PICKETT MD	Dermatology	VTAMA	DERMATOLOGICALS	PP	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 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
							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 Arnuity Ellipta, Asmanex HFA or twisthaler, Flovent (TRIED - paid claim). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14467048	KARLA LIZETH MARTINEZ COLEMAN MD	Internal Medicine	QVAR REDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J45.40	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 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.
14503187	CRAIG HEWELL COUCH MD	Neurology	TYSABRI	MULTIPLE SCLEROSIS AGENTS	G35 - Multiple sclerosis	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. TYSABRI is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
							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, insulin glargine-yfgn, Levemir (TRIED), Toujeo (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.
14510746	DEVIKA MARANGATTU MADHAVAN	Endocrinology, Diabetes & Metabolism	INSULIN DEGLUDEC FLEXTOUC	ANTIDIABETICS	Type 2 diabetes mellitus with other specified complication	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 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.