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
14529155	DAVID CABELL GRAY MD	INTERNAL MEDICINE	AJOVY	MIGRAINE PRODUCTS	G43.009	Criteria Not Met	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these reasons: 1) Records did not show that you have had at least four (4) migraine days per month for the last three (3) months or longer. 2) More information is needed to know if this drug will be used together with a botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be used together with a botulinum toxin product, records must show that you have had at least a three (3) month trial of Ajovy alone AND a three (3) month trial of a botulinum toxin product alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 fremanezumab (AJOVY) have not been met. From the information we have received, the member does not meet number(s) 2, 4, and 5 of our prior authorization criteria for Ajovy. 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 had four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (A) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (B) vasoactive agent (such as propranolol, metoprolol, etc.), OR (C) antidepressant (such as amitriptyline, venlafaxine, etc.); AND 4) Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR 5) Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following are met: (A) Member has failed at least three (3) months of individual therapy with Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin). 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.		
14530460	CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.9 - Unspecified hemorrhoids	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: Proctofoam HC. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.		
14531388	ERIN RENEE BURGE FNP	NURSE PRACTITIONER	IMCIVREE	ANTI-OBESITY/ANOREXIANTS	E66.09	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.		
14548762	JOANA LYNN HICKS NP	NURSE PRACTITIONER	ZEPBOUND	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.		
14561917	LINDA ELIZAB NELSON PA-C	PHYSICIAN ASSISTANT	SKYRIZI	TARGETED IMMUNOMODULATORS	L40.9 - Psoriasis, unspecified	Criteria Not Met	Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons: 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 risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) 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.		
14563391	DALIA ELIAS EL BEJJANI MD	INFECTIOUS DISEASES	CEFAZOLIN SODIUM	CEPHALOSPORINS	M00.849	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Cefazolin 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.		
14567605	SARAH NORANNE GEE MD	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	No dx given	Criteria Not Met	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) This drug was not prescribed for Behcet's disease, Plaque Psoriasis, OR Psoriatic Arthritis. (Please note: no diagnosis was provided) Additional criteria applies for each covered diagnosis. 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 apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Otezla. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Behcet's disease (BD), Plaque Psoriasis (PP), OR Psoriatic Arthritis (PsA); AND 2) Additional criteria for each covered diagnosis is met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	Yes	
14570380	LORENA MOSER PNP	ADVANCED PRACTICE NURSE	NORDITROPIN FLEXPRO	ENDOCRINE AND METABOLIC AGENTS - MIS	e23.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Genotropin and Omnitrope. 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.		

14571533	BRIAN DANIEL JAMES MD	EMERGENCY MEDICINE	DESCOVY	ANTIVIRALS	to human immunodeficiency virus [HIV]	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14578115	MICHELLE NICHOLE POZSONYI	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	to human immunodeficiency virus [HIV]	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including DATES OF THERAPY) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14587478	KRISHNA POKALA MD	NEUROLOGY	AIMOVIG	MIGRAINE PRODUCTS	Migraines	Criteria Not Met	Our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the records that we have received, Aimovig was denied for these reasons: 1) More information is needed to know if this drug will be used together with botulinum toxin product (such as Botox, Dysport, Xeomin, etc.). If Aimovig will be used together with botulinum toxin product (such as Botox, Dysport, Xeomin, etc.), records must also show you have had at least a three (3) month trial of Aimovig alone AND a three (3) month trial of botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the information we have received, the member does not meet number(s) 3 or 4 of our prior authorization criteria for Aimovig. 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) Aimovig will NOT be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; OR 4) Aimovig will be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine AND both of the following are met: (A) Member has failed at least three (3) months of individual therapy with Aimovig AND (B) Member has failed at least three (3) months of individual therapy with botulinumtoxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN); AND 5) If Aimovig 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 (AIMOVIG); 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.)
14587577	RAMESH M SINGA MD	ANESTHESIOLOGY	RELISTOR	GASTROINTESTINAL AGENTS - MISC.	K59.00 - Constipation, 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: Movantik and Symproic. 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.

14587753	JAMES SANCHO HAHN MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	e29.1	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone gel 1% was denied for these reasons: 1) More information is needed to know if your low levels of testosterone are age-related. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement therapy; AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14589819	ERIN RENEE BURGE FNP	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	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.
14593163	ALEXANDER JAVIER ALVAREZ MD	ALLERGY & IMMUNOLOGY	AZELASTINE HYDROCHLORIDE	NASAL AGENTS - SYSTEMIC AND TOPICAL	Allergic rhinitis due to pollen	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 ¿nasal antihistamines (azelastine 0.1% (Astelin equivalent) (TRIED), azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua OTC equivalent), fluticasone (Flonase equivalent) (TRIED), triamcinolone (Nasacort OTC equivalent), flunisolide). 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.
14596443	MICHAEL FERNANDO LENIS MD	CARDIOLOGY, INTERVENTIONAL	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	e78.4	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
14599596	MARC EVAN WENZEL MD	ENDOCRINOLOGY, DIABETES & M	OZEMPIC	ANTIDIABETICS	R73.03	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
14603170	JONATHAN ALAN LEE MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	Male erectile dysfunction, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for 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.
14605040	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	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

14607675	PRAVEEN KUMAR SAMPATH MD	GASTROENTEROLOGY	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.09 - Other constipation	Criteria Not Met	Our prior authorization criteria for Motegrity have not been met. From the records that we have received, the following caused the denial of Motegrity. 1) The drug is not being used for chronic idiopathic constipation (CIC). 2) Trulance has not been tried and failed. Prior authorization may be required. 3) Records show you are currently using opioids. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Motegrity have not been met. From the information we have received, the member does not meet number 1, 2, and 3 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
14609004	MARCI ANNE ROY MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.909	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow and Ubrelvy. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14609831	MARK LEROY ANDREWS MD	FAMILY PRACTICE	METFORMIN HYDROCHLORIDE	ANTIDIABETICS	s from other organs, systems and tissues	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 unspecified abnormal level of hormones. 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.
14619770	DANIEL NEIL SKOGLUND MD	PSYCHIATRY	VILAZODONE HYDROCHLORID	ANTIDEPRESSANTS	F33.2	Criteria Not Met	Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone. 1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine) 2) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafaxine) Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of major depressive disorder; AND 2) Member is 18 years of age or older; AND 3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14625269	JENNIFER RENEE MULLICAN PA-C	PHYSICIAN ASSISTANT	EUCRISA	DERMATOLOGICALS	Atopic Dermatitis	Criteria Not Met	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Eucrisa exception policy have not been met. From the records that we have received, the following caused the denial. 1) Records did not show tacrolimus ointment (Protopic equivalent) and pimecrolimus cream (Elidel equivalent) have been tried and failed. 2) Records did not show a very high potency topical steroid (e.g. halobetasol, augmented betamethasone) has been tried and failed. 3) Records did not show Opzelura cream has been tried and failed. Prior authorization may be required and quantity limits may apply. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2,3,4 of the Eucrisa exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Member has a diagnosis of mild to moderate atopic dermatitis; AND 2) Member has tried and failed all formulary topical calcineurin inhibitors (tacrolimus and pimecrolimus); OR Member is less than 2 years of age; AND 3) Member has tried and failed one (1) very high potency topical steroid; OR If a very high potency topical steroid is not clinically appropriate, the highest potency steroid that can appropriately be used must be tried; AND 4) Member has tried and failed Opzelura.

14627168	THOMAS CRAIG BLEVINS MD	ENDOCRINOLOGY, DIABETES & M	NOVOLOG FLEXPEN RELION	ANTIDIABETICS	E10.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Insulin Lispro (NDCs: 00002773701, 66733077301). 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.
14629413	SCOTT DAVID BECKER MD	GASTROENTEROLOGY	REMICADE	TARGETED IMMUNOMODULATORS	K51.90	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. REMICADE 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.
14630307	STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), has not been tried and failed. (We show a paid claim. More information is needed if this does not work for you.) 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent),. 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The 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
14634707	WILLIAM MONNING LOVING MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	ADHD	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), has not been tried and failed. 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 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
14636323	PATIENCE HARRIET READING MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.719	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, 6 fills per year for this use. The higher amount of 48 tablets per 90 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.
14640144	SUSAN BALITE NUNEZ MD	ENDOCRINOLOGY, PEDIATRIC	GENOTROPIN	ENDOCRINE AND METABOLIC AGENTS - MIS	E23.0	Criteria Not Met	Our prior authorization criteria for Somatropin Products have not been met. From the records that we have received, GENOTROPIN was denied for these reasons: 1) More information is needed about your lab tests showing that you have growth hormone deficiency (GHD). 2) Records did not show if you have a defined central nervous system (CNS) pathology that affects your growth. These are problems that change how the brain or spinal cord works. 3) Records did not show a history of irradiation or genetic (inherited) conditions associated with growth hormone deficiency. 4) Records did not show you have two or more other pituitary hormone deficiencies. 5) Records did not show you had at least two signs of growth hormone deficiency as an infant. 5) Records did not show you have a pituitary structure malformation, with at least one pituitary hormone deficiency in addition to slow growth. 6) Records did not show you had low blood sugars, low growth hormone levels, and changes in your pituitary structure noticed on imaging as an infant. 7) Records did not show your bones are still able to grow. 8) Records show that your bones are done growing. 9) Records did not show that your height is less than the 3rd percentile. 10) Records did not show that the amount your height has increased over the last year is less than the 3rd percentile. 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 Somatropin Products have not been met. From the information we have received, the member does not meet number 4,5,6 of our prior authorization criteria for GENOTROPIN. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 17 years of age or younger; AND 2) Prescribed by, or in consultation with, a Pediatric Endocrinology Specialist; AND 3) Member has a diagnosis of growth hormone deficiency (GHD); AND 4) Member meets ONE (1) of the following: (A) Two (2) growth hormone (GH) stimulation tests less than 10 ng/mL (mcg/L); OR (B) One (1) GH stimulation test less than 15 ng/mL AND Insulin-like growth factor 1 (IGF-1) and Insulin-like growth factor binding protein-3 (IGF-BP3) levels below normal (less than 2.5th percentile) as determined by the laboratory reference range for age; OR

14641083	DANA SPRUTE MD	FAMILY PRACTICE	ADAPALENE	DERMATOLOGICALS	L73.8	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, ADAPALENE 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 ADAPALENE. 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
14641414	YVETTE MARIE GUTIERREZ-SCHIEFFER MD	OBSTETRICS & GYNECOLOGY	ESTRADIOL	ESTROGENS	Menopausal and female climacteric states	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol vaginal tablets (TRIED), estradiol cream (Estrace equivalent), Premarin vaginal cream, Estring. 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.
14641542	FAITH ISIOMA OGALA NP	ADVANCED PRACTICE NURSE	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.4	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 quetiapine OR 2 formulary antipsychotic agents (risperidone, aripiprazole, olanzapine, ziprasidone 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.
14642573	DARSHAN NARENDRA SHAH MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.709	Plan Limits Exceeded	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 and 6 fills per year for this use. The higher number of 9 tablets per 16 days is not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, and Emgality, must be used to help prevent migraine headaches. Prior authorization may be required. Quantity limits may apply. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
14643029	ERICA ILENA STEVENS MD	DERMATOLOGY	HUMIRA PEN	TARGETED IMMUNOMODULATORS	L88	Criteria Not Met	Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Humira was denied for these reasons: 1) The drug is not being used for Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Peripheral Ankylosing Spondylitis, Psoriatic Arthritis, Reactive Arthritis, Ankylosing Spondylitis with predominant axial involvement, Crohn's Disease, Ulcerative Colitis, Plaque Psoriasis, Hidradenitis Suppurativa, or Uveitis. Additional criteria apply for each covered diagnosis. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Adalimumab Products have not been met. From the information we have received, the member does not meet numbers 1 and 2 our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Peripheral Ankylosing Spondylitis (AS), Psoriatic Arthritis (PsA), Reactive Arthritis, Ankylosing Spondylitis (AS) with predominant axial involvement, Crohn's Disease (CD), Ulcerative Colitis (UC), Plaque Psoriasis (PP), Hidradenitis Suppurativa (HS), OR non-infectious intermediate, posterior, or pan-Uveitis; AND 2) Additional criteria for covered diagnosis are met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14644705	WILLIAM LOUIS HOLCOMB JR MD	PSYCHIATRY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	None	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) 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). 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.

						Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons: 1) This drug is not being used for atopic dermatitis (eczema), which is a health issue that causes dry, itchy, and red skin, OR for nonsegmental vitiligo, a health issue where patches of skin on both sides of the body lose color (become depigmented). Additional criteria apply for each covered health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs.
14645098	AMY ROMINGER MASON MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS	L28.1 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Opzelura. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of atopic dermatitis (AD) OR nonsegmental vitiligo; AND 2) Additional criteria for covered diagnosis are met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14649110	DHIREN B PATEL DO	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0 Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Claims show you may have tried the generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), but records did not show that this drug did not work for you. 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, and amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered.
14659334	STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	ADHD Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The 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.
14659484	ERIN RENEE BURGE FNP	NURSE PRACTITIONER	IMCIVREE	ANTI-OBESITY/ANOREXIANTS	Other obesity due to excess calories Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER (TRIED), and amphetamine/dextroamphetamine ER (Adderall XR equivalent). 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered.
14664326	SUSAN BALITE NUNEZ MD	ENDOCRINOLOGY, PEDIATRIC	GENOTROPIN	ENDOCRINE AND METABOLIC AGENTS - MIS	E23.0 Criteria Not Met	This request cannot be approved because this drug is being used for weight loss without a documented covered genetic (inherited) health issue. Drugs used for weight loss, with the exception of Imcivree in cases of some specific genetic health issues (prior authorization required and quantity limits apply), 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 Somatropin Products have not been met. From the records that we have received, Genotropin was denied for these reasons: 1) Records did not show that your height is less than the 3rd percentile. 2) Records did not show that the amount your height has increased over the last year is less than the 3rd percentile. 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 Somatropin Products have not been met. From the information we have received, the member does not meet number 6 of our prior authorization criteria for Genotropin. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 17 years of age or younger; AND 2) Prescribed by, or in consultation with, a Pediatric Endocrinology Specialist; AND 3) Member has a diagnosis of growth hormone deficiency (GHD); AND 4) Member meets ONE (1) of the following: (A) Two (2) growth hormone (GH) stimulation tests less than 10 ng/mL (mcg/L); OR (B) One (1) GH stimulation test less than 15 ng/mL AND Insulin-like growth factor 1 (IGF-1) and Insulin-like growth factor binding protein-3 (IGF-BP3) levels below normal (less than 2.5th percentile) as determined by the laboratory reference range for age; OR (C) One (1) GH stimulation test less than 10 ng/mL for child with defined central nervous system (CNS) pathology; OR (D) Member has a history of irradiation; OR (E) Member has genetic conditions associated with GHD; OR (F) Multiple pituitary hormone deficiencies exist (at least two other deficiencies in addition to GHD); OR (G) Random growth hormone level less than 7 ng/ml in the first week of life in neonates; OR (H) Member is an infant with a combination of at least TWO (2) of the following: (i) history of hypoglycemia, (ii) hyperbilirubinemia, (iii) poor growth, (iv) midline defects, (v) microphallus, (vi) low IGF-1 AND IGF-BP3, (vii) multiple pituitary hormone deficiencies such as thyroid stimulation hormone and adrenocorticotropic hormone deficiencies, or (viii) abnormal cranial magnetic resonance imaging (MRI); OR (I) Member has ALL three (3) of the following: (i) auxological criteria, AND (ii) hypothalamic-pituitary defect (such as major congenital malformation, tumor, or irradiation), AND (iii) deficiency of at least one (1) additional pituitary hormone; OR

14664378	HEATHER DARLENE DONAGHEY APN	ADVANCED PRACTICE NURSE	DRONABINOL	ANTIEMETICS	R63.4	Criteria Not Met	Our prior authorization criteria for dronabinol (MARINOL) have not been met. From the records that we have received, dronabinol was denied for these reasons: 1) The drug is not being used for nausea and vomiting related to cancer treatments. 2) Records did not show you have tried and failed at least one other drug for nausea and vomiting related to cancer treatments. Records showing the other drug you tried were not received. Other drugs we cover that can help with nausea and vomiting are ondansetron, promethazine, prochlorperazine, and others. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dronabinol (MARINOL) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for dronabinol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of anorexia associated with weight loss in patients with acquired immune deficiency syndrome (AIDS); OR 2) Prescribed for nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments. Please list at least one antiemetic tried and the doses and dates of the trial. (Documentation is required for approval.) Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14673518	TISA DONYELLE COLLINS-DOUGLAS	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	Z20.6	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14676573	STEPHANIE ANN SHAW MD	ENDOCRINOLOGY, DIABETES & M	TIROSINT-SOL	THYROID AGENTS	E03.9 Hypothyroidism, unspecified	Criteria Not Met	Our prior authorization criteria for levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the records that we have received, Tirosint-Sol was denied for these reasons: 1) Records did not show that you cannot swallow tablets. 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 levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Tirosint-Sol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for ONE (1) of the following: (A) Hypothyroidism; OR (B) Pituitary thyrotropin (Thyroid-Stimulating Hormone, TSH) suppression; AND 2) Member is unable to swallow oral tablets. 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
14678143	ANDREW PLUMMER MD	OPHTHALMOLOGY	TAFLUPROST	OPHTHALMIC AGENTS	H40.1132	Criteria Not Met	Our prior authorization criteria for Ophthalmic Prostaglandins have not been met. From the records that we have received, TAFLUPROST was denied for these reasons: 1) Records did not show that other drugs called bimatoprost, latanoprost, and travoprost eye drops did not work for you. 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 Ophthalmic Prostaglandins have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for TAFLUPROST. The reason for denial is explained to the member above. The criteria are listed here. 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latanoprost ophthalmic solution; AND (C) travoprost ophthalmic solution (TRAVATAN Z). 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.
14684755	PAUL HIEN LE 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.
14685472	DAWN CAROLINE PEASE APN	NURSE PRACTITIONER	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MIS	M81.0	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. PROLIA 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.

14686308	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	DEXCOM G6 RECEIVER	MEDICAL DEVICES	dx type 2 DM	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, DEXCOM G6 RECEIVER was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.	
14686540	LOUIS JOSEPH LUX MD	INTERNAL MEDICINE	HYSINGLA ER	ANALGESICS - OPIOID	C51.411	Plan Limits Exceeded	The requested amount of HYSINGLA ER TAB 20 MG 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 HYSINGLA ER TAB 20 MG 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.	Yes
14686916	PRIYA MATHEW PHILIP MD	FAMILY PRACTICE	ZEPBOUND	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.	
14687089	MARC EVAN WENZEL MD	ENDOCRINOLOGY, DIABETES & M	NOVOLOG FLEXPEN	ANTIDIABETICS	E10.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (NDCs: 00002773701, 66733077301) OR Humalog. 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.	
14693289	STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER (TRIED), amphetamine/dextroamphetamine ER (Adderall XR equivalent). 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 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	
14695452	CAROLINE ANN CAMOSY MD	PEDIATRICS	FLUTICASONE PROPIONATE/SA	ANTIASTHMATIC AND BRONCHODILATOR A	derate persistent asthma, uncomplicated	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for member younger than 12 years old for asthma. 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.	
14696867	ANDREW CARL KONTAK MD	CARDIOLOGY	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.5 - Hyperlipidemia, unspecified	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) This drug is not being used for primary hyperlipidemia. This is a health issue that causes high levels of lipids, or fat, in the blood. 2) 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. 3) 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. 4) Records show that a statin drug, such as atorvastatin or rosuvastatin, is working to lower your cholesterol. 5) 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) 1,2,3,4 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	

14698154	IVAN SRDANOVIC PMHNPBC	ADVANCED PRACTICE NURSE	TRINTELLIX	ANTIDEPRESSANTS	F32.9	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2,3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14703278	IRIS SOFIA WINGROVE MD	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY	G47.419 - Narcolepsy without cataplexy	Criteria Not Met	Our prior authorization criteria for Sunosi have not been met. From the records that we have received, the following caused the denial of Sunosi. 1) Records did not show that you have had fewer symptoms of excessive daytime sleepiness since starting this medication. 2) Documentation of improvement was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (documentation is required to be submitted for an approval); AND 2) If prescribed for Excessive Daytime Sleepiness due to Obstructive Sleep Apnea, the medication will continue to be used in conjunction with positive airway pressure therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14706125	AMANDA KAY WATERMAN	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	Z68.34	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.
14709176	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	OZEMPIC	ANTIDIABETICS	E28.2	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
14710086	ZHAN YANG NP	NURSE PRACTITIONER	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.70	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 2 formulary antipsychotic agents (risperidone, aripiprazole, olanzapine, ziprasidone, quetiapine, and others). *Please note, if member is stable on medication, please provide length of use and we may be able to approve. 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
14711758	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	isorder, predominantly hyperactive type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (TRIED) (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER . Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

14716678	DIANA NATHALIE ANDINO MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.709	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, emgality, ajovy . 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.
14720852	NEERAJ MANCHANDA MD	NEUROLOGY	WAKIX	ADHD/ANTI-NARCOLEPSY	EDS	Criteria Not Met	Our prior authorization criteria for pitolisant (WAKIX) have not been met. From the records that we have received, the following caused the denial of Wakix. 1) Sleep studies were not received. 2) Sunosi has not been tried and failed. Prior authorization may be required. Quantity limits may apply. 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 pitolisant (WAKIX) have not been met. From the information we have received, the member does not meet number 3 and 5 of our prior authorization criteria for Wakix (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 Neurologist or board-certified sleep medicine specialist; AND 2) Member has a diagnosis of excessive daytime sleepiness with narcolepsy; AND 3) Documentation of a full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep of less than (<) 8 minutes and two (2) or more sleep onset rapid eye movement (REM) sleep periods is provided with the request (documentation is required to be submitted for an approval); AND 4) A trial of ONE (1) of the following was ineffective, contraindicated, or not tolerated: armodafinil (NUVIGIL) OR modafinil (PROVIGIL); AND 5) A trial of solriamfetol (SUNOSI) 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
14721069	JOSEPH CASIMIR SWIDER DO	PSYCHIATRY	SPRAVATO 84MG DOSE	ANTIDEPRESSANTS	urrent severe without psychotic features	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Spravato 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.
14722147	PRIYA MATHEW PHILIP 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.
14723198	ELIZABETH HAVEY MILLER MD	DERMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	L20.9	Criteria Not Met	Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these reasons: 1) Records show this drug is being used together with biologic therapy. 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 upadacitinib (RINVOQ) have not been met. From the information we have received, the member does not meet number(s) 7 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 12 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema); AND 4) Indicate ONE (1) of the following: (A) Greater than or equal to 10% body surface area (BSA) affected and percent BSA is provided OR (B) Less than 10% BSA affected, but member has involvement of sensitive areas (documentation required to be submitted for an approval); AND 5) A medium to very high potency topical steroid AND a topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required to be submitted for an approval); AND 6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentation is required to be submitted for an approval); AND 7) Rinvoq will NOT be used in combination with another targeted immunomodulator product for atopic dermatitis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14723887	TRICIA LYNN WINTERS PA	PHYSICIAN ASSISTANT	VTAMA	DERMATOLOGICALS	L40.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All 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. 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.

14723977	AMARA SAYED DO	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L20.9	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) This drug is not being used for ongoing (chronic) plaque psoriasis. Plaque psoriasis is a health issue where skin cells build up and form itchy, dry patches and scales. 2) Records did not show that another drug called a topical steroid (e.g betamethasone, triamcinolone) did not work for you. 3) More information is needed to know if this drug will be used together with one of the following drugs: Vtama, Otezla, Sotyktu, or biologic therapy (e.g. adalimumab, Enbrel) for your health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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) 2,4,5 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.
14724465	SAIMA KANWAL JEHANGIR MD	OBSTETRICS & GYNECOLOGY	MYFEMBREE	ESTROGENS	abnormal uterine bleeding	Criteria Not Met	Our prior authorization criteria for relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. From the records that we have received, Myfembree was denied for these reasons: 1) The drug is not being used for heavy menstrual bleeding caused by uterine fibroids (noncancerous growths in the uterus), OR for pain associated with endometriosis (a health issue where tissue that normally grows inside the uterus goes to other areas, such as the ovaries or fallopian tubes). Additional criteria apply for each covered diagnosis. 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/estradiol/norethindrone (MYFEMBREE) have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3 of our prior authorization criteria for Myfembree. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; OR 2) Member has a diagnosis of either Endometriosis or Cyclic pelvic pain suspected to be related to endometriosis; AND 3) Additional criteria for covered diagnosis are met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14726514	ELDA EVELIA VILLARREAL PA-C	PHYSICIAN ASSISTANT	INVOKANA	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Farxiga or Xigduo XR, and Jardiance or Synjardy (XR). 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
14726976	MAYA BADACHHAPE BLEDSOE MD	INTERNAL MEDICINE	SOMATULINE DEPOT	ENDOCRINE AND METABOLIC AGENTS - MIS	E22.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Octreotide, Signifor. 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.
14728756	URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TESTOSTERONE	ANDROGENS-ANABOLIC	R79.89	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism. This is a condition in which the body does not make enough testosterone. 2) More information is needed to know if your low levels of testosterone are age-related. Since the criteria 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement therapy; AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

14729283	ISRAEL CALZADA MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.9	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), has not been tried and failed. 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 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
14729284	JENNY ROSE TOBAT	FAMILY PRACTICE	FREESTYLE LIBRE 14 DAY/SE	MEDICAL DEVICES	E11.9	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, FREESTYLE was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
14731400	DAVID CABELL GRAY MD	INTERNAL MEDICINE	DEXCOM G7 SENSOR	MEDICAL DEVICES	betes mellitus with hyperglycemia (HCC)	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 Dexcom G6 and G7 (covered NDC for the sensors is 08627007701) and Freestyle Libre 2 and 3. 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.
14737560	GHADA HASBANI ABDALLAH OD	OPTOMETRIST	TAFLUPROST	OPHTHALMIC AGENTS	H40.013	Criteria Not Met	Our prior authorization criteria for Ophthalmic Prostaglandins have not been met. From the records that we have received, tafluprost was denied for these reasons: 1) Records did not show that other drugs called bimatoprost, latanoprost (tried), and travoprost eye drops did not work for you. 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 Ophthalmic Prostaglandins have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for tafluprost. The reason for denial is explained to the member above. The criteria are listed here. 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latanoprost ophthalmic solution; AND (C) travoprost ophthalmic solution (TRAVATAN Z). 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.
14738329	MARISA ROCHA GARCIA FNP-C	NURSE PRACTITIONER	ZEPBOUND	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.
14739143	DONALD ROBERT BRODE MD	FAMILY PRACTICE	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray, flunisolide nasal solution, trimcinolone OTC nasal spray, Flonase, nasocort. 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.

14742167	NATHAN WALLACE ANDERSON MD	FAMILY PRACTICE	SEGLUROMET	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Synjardy XR and Xigduo XR. 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.	
14742348	STEPHANIE ANN SHAW MD	ENDOCRINOLOGY, DIABETES & M	TIROSINT-SOL	THYROID AGENTS	E03.9	Criteria Not Met	Our prior authorization criteria for levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the records that we have received, Tirosint-Sol was denied for these reasons: 1) Records did not show that you cannot swallow tablets. 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 levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Tirosint-Sol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for ONE (1) of the following: (A) Hypothyroidism; OR (B) Pituitary thyrotropin (Thyroid-Stimulating Hormone, TSH) suppression; AND 2) Member is unable to swallow oral tablets. 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	Yes
14743883	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the 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) (TRIED), lisdexamfetamine (Vyvanse equivalent (TRIED)), dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
14746883	CYNTHIA LYNN BENTON MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.9	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) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2, 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior	
14747036	TERRY SCOTT PEERY DO	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY	G47.419	Criteria Not Met	Our prior authorization criteria for Sunosi have not been met. From the records that we have received, the following caused the denial of Sunosi. 1) Records did not show that you have had fewer symptoms of excessive daytime sleepiness since starting this medication. 2) Documentation of improvement was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (documentation is required to be submitted for an approval); AND 2) If prescribed for Excessive Daytime Sleepiness due to Obstructive Sleep Apnea, the medication will continue to be used in conjunction with positive airway pressure therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	Yes

14749117	CARTER REID HANSON PA-C	PHYSICIAN ASSISTANT	DESCOVY	ANTIVIRALS	Prep	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization		
14752130	MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	None listed	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) It's unclear what this drug is being used for. Please provide diagnosis. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 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.		
14752408	MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	EMGALITY	MIGRAINE PRODUCTS	G43.119	Criteria Not Met	Our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the records that we have received, Emgality 120mg was denied for these reasons: 1) More information is needed to know if this drug will be used together with a botulinum toxin product (such as Botox, Dysport, Xeomin, etc.). If Emgality will be used together with a botulinum toxin product (such as Botox, Dysport, Xeomin, etc.), records must also show you have had at least a three (3) month trial of Emgality alone AND a three (3) month trial of a botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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) 4 or 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Member has four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.); AND 4) Emgality will NOT be used concomitantly with a botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) for chronic migraine; OR 5) Emgality will be used concomitantly with a botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) 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 a botulinum toxin (BOTOX		
14754072	MAYA BADACHHAPE BLEDSOE MD	INTERNAL MEDICINE	LANREOTIDE ACETATE	ENDOCRINE AND METABOLIC AGENTS - MIS	E22.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Octreotide, Signifor. 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.		Yes
14754830	JOHN ANTHONY QUENG MD	FAMILY PRACTICE	TRETINOIN	DERMATOLOGICALS	- Disorder of pigmentation, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for a cosmetic purpose. 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.		
14754996	KENNETH ALLEN PEREZ DO	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Abnormal weight gain	Plan Exclusion	This request cannot be approved because this drug/product is in a class of drugs/products called anti-obesity or weight loss drugs. Drugs/products of this type are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs/products, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.		

14759367	RANI DAS MD	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY		EDS Criteria Not Met	Our prior authorization criteria for Sunosi have not been met. From the records that we have received, the following caused the denial of Sunosi. 1) Sleep studies were not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Sunosi (Initial Therapy) for Excessive Daytime Sleepiness with Narcolepsy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Neurologist or board-certified sleep medicine specialist; AND 2) Member has a diagnosis of excessive daytime sleepiness with narcolepsy; AND 3) Documentation of a full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep of less than (<) 8 minutes and two (2) or more sleep onset rapid eye movement (REM) sleep periods is provided with the request (documentation is required to be submitted for an approval); AND 4) A trial of ONE (1) of the following was ineffective, contraindicated, or not tolerated: armodafinil (NUVIGIL) OR modafinil (PROVIGIL).
14763477	AMARA SAYED DO	DERMATOLOGY	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) This drug is not being used for ongoing (chronic) plaque psoriasis. Plaque psoriasis is a health issue where skin cells build up and form itchy, dry patches and scales. 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) 2 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.
14765207	ERIN JENNIFER MOHLKE	NURSE PRACTITIONER	TRAMADOL HYDROCHLORIDE	ANALGESICS - OPIOID		G89.4 Formulary Alternatives Available	For a member that is new to using an opioid pain reliever, the Opioid Naïve criteria for Step Therapy has not been met. Step Therapy means that another drug will need to be tried and failed first. From the records that we have received, Tramadol extended release (ER) was denied for these reasons: 1) One of these short-acting opioid pain relievers has not been recently tried: morphine sulfate immediate release (IR), oxycodone, oxycodone/acetaminophen, hydrocodone/acetaminophen, hydromorphone, tramadol. Please note: We will only cover up to 7 days for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. Records did not show that you have had recent use of an opioid pain reliever OR have an active cancer diagnosis, a life-ending health issue, or are in hospice care. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Opioid Naive criteria for Step Therapy have not been met. From the information we have received, the member does not meet numbers 1 or 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 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. 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
14766421	WEIWEI CAO PHD	GASTROENTEROLOGY	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOlsease with esophagitis, without bleeding		Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole (tried), pantoprazole (tried), rabeprazole, lansoprazole, esomeprazole (tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14767286	NATHAN WALLACE ANDERSON MD	FAMILY PRACTICE	SEGLUROMET	ANTIDIABETICS		E11.65 Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Synjardy XR and Xigduo XR. 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.

14768759	CYNTHIA LYNN BENTON MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.9 ADHD	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 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
14768769	PRIYA MATHEW PHILIP MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug/product is in a class of drugs/products called anti-obesity, or weight loss, drugs. Drugs/products of this type are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs/products, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
14769136	KEN LIN FNP-C	NURSE PRACTITIONER	TRAMADOL HYDROCHLORIDE	ANALGESICS - OPIOID	low back 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 morphine sulfate immediate release (IR), oxycodone, oxycodone/acetaminophen, hydrocodone/acetaminophen, hydromorphone, tramadol 50mg. 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.
14773090	DAVID CABELL GRAY MD	INTERNAL MEDICINE	NOVOLOG FLEXPEN	ANTIDIABETICS	betes mellitus with hyperglycemia (HCC)	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 Lyumjev OR Insulin Lispro (Humalog/Admelog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
14774883	DANIEL ANTHONY CARRASCO MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	I20.9	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records, such as chart notes, showing this drug is working well have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Dupixent (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 2) Dupixent will NOT be used in combination with another targeted immunomodulator product. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14775633	DAMIAN G LARA MD	FAMILY PRACTICE	UBRELVY	MIGRAINE PRODUCTS	G43.809	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. 2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2, 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second triptan was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

14777865	JAY LELAND VIERNES MD	DERMATOLOGY	TREMFYA	TARGETED IMMUNOMODULATORS	l40.0	Criteria Not Met	Our prior authorization criteria for guselkumab (TREMFYA) have not been met. From the records that we have received, Tremfya was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes that were sent to us are over 1 year old. More recent documentation must be sent to us to show your response to this drug. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for guselkumab (TREMFYA) 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 Tremfya 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.
14778042	CAROLINE ANNE KAUFMAN MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS	lenopausal and female climacteric states	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿estradiol oral tablet, Premarin oral tablet, one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14778387	CELIA BETH SERVIN MD	FAMILY PRACTICE	FLUTICASONE PROPIONATE/SA	ANTIASTHMATIC AND BRONCHODILATOR A	09 - Unspecified asthma, uncomplicated	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Breo Ellipta, Advair HFA or fluticasone/salmeterol breath-actuated inhaler (Advair equivalent), Dulera, budesonide/formoterol (Symbicort 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.
14781880	JOHNNY ZHAO MD	DERMATOLOGY	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) Records show this drug will be used together with Humira. 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 6 years of age or older; AND 4) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis; AND 5) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14785045	MARCIAL ANDRES OQUENDO RINCON M	PEDIATRICS	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show the generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 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
14789645	MICHELLE LE MARKLEY MD	FAMILY PRACTICE	MOUNJARO	ANTIDIABETICS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

14790808	CRAIG HEWELL COUCH MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	g43.009	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. 2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a 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
14791445	PRIYA MATHEW PHILIP 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.
14792005	JOHNNY ZHAO MD	DERMATOLOGY	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) Records show this drug will be used together with one of the following drugs: Vtama, Otezla, Sotyktu, or biologic therapy (e.g. adalimumab, Enbrel) for your health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 6 years of age or older; AND 4) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis; AND 5) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14793625	RAISSA MIJARES BEHM FNP	NURSE PRACTITIONER	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	f32.9	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 our Vraylar exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show aripiprazole (Abilify equivalent) did not work for you. 2) Records did not show at least TWO (2) or more antidepressant drugs did not work for you. (e.g. escitalopram, fluoxetine, sertraline (TRIED), venlafaxine, or 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(s) 2 and 4 of the Vraylar exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Two (2) or more antidepressant medications were ineffective or not tolerated; AND 5) A trial of quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication was ineffective or not tolerated.
14796185	KRISTIE SONTAG DAPP NP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	E28.2	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, Mounjaro was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14801099	BRYAN TODD IRVIN MD	FAMILY PRACTICE	LANTUS SOLOSTAR	ANTIDIABETICS	E11.9	Plan Exclusion	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) Records did not show the biosimilar version(s) of this drug, called INSULIN GLARGINE-YFGN, did not work for you. 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 drug. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are Levemir, Toujeo, Tresiba,Semglee. 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. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 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 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 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

14803121	CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	ORIAHNN	ESTROGENS	frequent menstruation with regular cycle	Criteria Not Met	Our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the records that we have received, Oriahnn was denied for these reasons: 1) A hormonal contraceptive has not been tried and failed. These may include birth control pills, patches, or vaginal rings. 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 elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the information we have received, the member does not meet number(s) 5 of our prior authorization criteria for Oriahnn. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND 2) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND 3) Member has NO known osteoporosis; AND 4) Member is premenopausal; AND 5) A trial of a hormonal contraceptive was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14811609	APRIL WEST FOX MD	SURGERY, COLON & RECTAL	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	other hemorrhoids	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Proctosol HC cream (ANUSOL HC equivalent), lidocaine/hydrocortisone cream (ANAMANTLE equivalent), Proctofoam HC foam, and Analpram-E kit. 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.
14812016	JOHN JOSEPH ZIEBERT MD	GASTROENTEROLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	dx UC	Criteria Not Met	Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these reasons: 1) Records did not show that an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has a diagnosis of moderately to severely active Ulcerative Colitis (UC); AND 3) Member had a trial of an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) that 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.
14812141	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	OZEMPIC	ANTIDIABETICS	E28.2	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
14812958	ZARMEENA VENDAL MD	OPHTHALMOLOGY	TAFLUPROST	OPHTHALMIC AGENTS	H04.123	Criteria Not Met	Our prior authorization criteria for Ophthalmic Prostaglandins have not been met. From the records that we have received, tafluprost ophthalmic solution (ZIOPTAN) was denied for these reasons: 1) Records did not show that other drugs called bimatoprost, latanoprost, and travoprost eye drops did not work for you. 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 Ophthalmic Prostaglandins have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Zioptan. The reason for denial is explained to the member above. The criteria are listed here. 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latanoprost ophthalmic solution; AND (C) travoprost ophthalmic solution (TRAVATAN Z). 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.
14813045	CASEY RENEE MCLEOD	PHYSICIAN ASSISTANT	VITAMIN D3	VITAMINS	E55.9 - Vitamin D deficiency, 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 vitamin D capsules (ergocalciferol). 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.

14813555	URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TESTOSTERONE	ANDROGENS-ANABOLIC	R79.89	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1%(50MG) was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism. This is a condition in which the body does not make enough testosterone. 2) More information is needed to know if your low levels of testosterone are age-related. Since the criteria 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement therapy; AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	Yes
14814909	AMY HERRIN KOWALSKI APN	ADVANCED PRACTICE NURSE	ESTRADIOL	ESTROGENS	N95.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol oral tablet, Premarin oral tablet, one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (TRIED) (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
14817189	ANDREW PAUL BARGER APN	ADVANCED PRACTICE NURSE	CLOMID	ENDOCRINE AND METABOLIC AGENTS - MIS	E29.1 - Testicular hypofunction	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 testosterone cypionate, Androderm patches, testosterone enanthate, testosterone gel, and testosterone solution. 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.	
14821174	BENJAMIN PAUL FIEDLER MD	FAMILY PRACTICE	NOVOLOG FLEXPEN	ANTIDIABETICS	E11.21	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 Lyumjev, Humalog or, Insulin Lispro (Humalog/Admelog 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.	
14821862	MICHAEL JOSEPH REGAN IV MD	EMERGENCY MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight	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 vour health issue.	
14823935	JOHNNY ZHAO MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	PsO	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) Records show this drug will be used together with one of the following drugs: Vtama, Otezla, Sotyktu, or biologic therapy (e.g. adalimumab, Enbrel) for your health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 6 years of age or older; AND 4) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis; AND 5) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	

						Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records showing this drug is working well have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.
14825316	HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	nasal polyps Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Dupixent (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
						Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone. 1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine) 2) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafaxine) Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.
14834878	KARISA RAE STANCIL FNP-C	NURSE PRACTITIONER	VILAZODONE HYDROCHLORID	ANTIDEPRESSANTS	depression Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 3 & 4 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of major depressive disorder; AND 2) Member is 18 years of age or older; AND 3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14842226	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	obesity Plan Exclusion	This request cannot be approved because this drug is being used for obesity (weight loss). Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
						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) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs.
14850623	EMILY WANTLAND HICKS FNP-C	NURSE PRACTITIONER	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.09 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) 1, 3, 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
						Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for these reasons: 1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan, rizatriptan, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply. 2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.
14850835	PATIENCE HARRIET READING MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.719 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2, 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second triptan was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
						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) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs.
14852902	MOHAMMAD BASHASHATI SAGHEZCHI M	GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	CC 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) 1, 3, & 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

14853043	MOHAMMAD BASHASHATI SAGHEZCHI	M GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	CIC	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14853156	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	QELBREE	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are clonidine extended release (ER), guanfacine ER(TRIED), atomoxetine and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or lisdexamfetamine (Vyvanse 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.
14853539	MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	Aging Skin	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
14858282	LIEF ERICSSON FENNO MD	PSYCHIATRY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	opioid dependence	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buprenorphine/naloxone film (Suboxone Film) (TRIED) and Zubsolv sublingual 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.
14860483	DAVID FRANCIS ESCAMILLA MD	FAMILY PRACTICE	HYDROQUINONE	DERMATOLOGICALS	L81.1	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
14862566	CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	ORIAHNN	ESTROGENS	N92.0	Criteria Not Met	Our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the records that we have received, Oriahnn was denied for these reasons: 1) More information is needed to show you are pre-menopausal. This means your body has not gone through the changes of menopause yet. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Oriahnn. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND 2) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND 3) Member has NO known osteoporosis; AND 4) Member is premenopausal; AND 5) A trial of a hormonal contraceptive was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14868464	RABIN KHERADPOUR MD	INTERNAL MEDICINE	KERENDIA	ENDOCRINE AND METABOLIC AGENTS - MIS	E11.8	Criteria Not Met	Our prior authorization criteria for finerenone (KERENDIA) have not been met. From the records that we have received, Kerendia was denied for these reasons: 1) Records did not show you have 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. 2) Records did not show another drug called an angiotensin-converting enzyme (ACE) inhibitor, such as lisinopril, or an angiotensin receptor blocker (ARB), such as valsartan, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for finerenone (KERENDIA) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for 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 any angiotensin-converting enzyme (ACE) inhibitor or any angiotensin receptor blocker (ARB) was ineffective, not tolerated or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

14872963	ANNE CLAIRE ADAMS	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY		F90.9	Criteria Not Met
14876733	LORIE JUNE KMETZ	NURSE PRACTITIONER	AQUEOUS VITAMIN D INFANT:	VITAMINS		E55.9	Plan Exclusion
14877247	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	METFORMIN HYDROCHLORIDE	ANTIDIABETICS	ellitus with other specified complication		Not Covered
14877838	JACQUELINE MARIE KERR MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS		Z68.25	Body mass index
14880594	YEN DANG NIEMAN	OPHTHALMOLOGY	TYRVAYA	OPHTHALMIC AGENTS		h04.123	Not Covered
14883597	LINDSEY ANN HANSEN FNP-BC	NURSE PRACTITIONER	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.		DIC	Criteria Not Met

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) Records did not show the generic version of this drug, called lisdexamfetamine , did not work for you.
2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent).
3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug.
Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 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

This request cannot be approved because this drug/product is in a class of drugs/products called over the counter (OTC) vitamins and minerals. 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.

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 metformin immediate release (IR), metformin extended release (tried) (ER) (Glucophage XR equivalent), sulfonylureas (tried) (glimepiride, glipizide, glyburide), DPP-4 inhibitors (tried) (Januvia, Tradjenta), GLP-1 agonists (tried) (Victoza, Bydureon BCise), meglitinides (nateglinide, repaglinide), thiazolidinediones (pioglitazone), SGLT-2 inhibitors (Farxiga, Jardiance), and alpha-glucosidase inhibitors (acarbose).
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

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

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are cyclosporine ophthalmic emulsion (RESTASIS equiv) (Restricted to Ophthalmology or Optometry Specialist).
Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.

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

Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons:
1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induced constipation (OIC). These are specific health issues that make it difficult to have a bowel movement.
2) More information is needed to show that you do not need frequent dose increases (e.g., weekly) of your opioid pain medication.
3) Records did not show that taking one of the following over-the-counter (OTC) drugs for one month did not work for you: stimulants (e.g., bisacodyl, sennosides), or PEG 3350 (e.g., Miralax), or bulk-forming laxatives (e.g., Metamucil, Citrucel, Fibercon).
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 lubiprostone (AMITIZA) 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 lubiprostone. The reason for denial is explained to the member above. The criteria are listed here.
1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR
2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR
3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND
4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon).
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

14887408	LESLIE SLEDGE GUILLORY FNP	NURSE PRACTITIONER	QUETIAPINE FUMARATE	ANTIPSYCHOTICS/ANTIMANIC AGENTS	dx MDD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are quetiapine XR,quetiapine 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.
14889533	LIZANN BAKER ROGERS	NURSE PRACTITIONER	INSULIN ASPART FLEXPEN	ANTIDIABETICS	E11.21	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 humalog, insulin lispro, lyumjev.. 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.
14893067	ATHIRA UNNIKRISHNAN MD	HEMATOLOGY & ONCOLOGY	TAGRISSO	ANTINEOPLASTICS AND ADJUNCTIVE THERA	NSCLC	Criteria Not Met	Our prior authorization criteria for osimertinib (TAGRISSO) have not been met. From the records that we have received, Tagrisso was denied for these reasons: 1) Records did not show that you had surgery to remove cancer cells. 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 osimertinib (TAGRISSO) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Tagrisso. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist; AND 2) Member has a diagnosis of non-small cell lung cancer (NSCLC); AND 3) Prescribed as adjuvant therapy after surgical tumor resection; AND 4) Documentation of EGFR exon 19 deletion or exon 21 L858R mutation is provided with the 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.
14895991	PRIYA MATHEW PHILIP MD	FAMILY PRACTICE	RYBELSUS	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for obesity (weight loss). Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
14897115	MARCO ANTONIO VEGA MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	ADHD	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show the generic version of this drug, called lisdexamfetamine, did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, & 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
14904489	BRIANNA LAREE HURTADO NP	NURSE PRACTITIONER	TIROSINT	THYROID AGENTS	hypothyroidism	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 levothyroxine and Synthroid. 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.

14904889	LISA ALANE DAMURA	ADVANCED PRACTICE NURSE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2,3 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
14909716	CHRISTOPHER CHANG MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ed abnormal findings of blood chemistry	Criteria Not Met	Our prior authorization criteria for Pulmonary Arterial Hypertension have not been met. From the records that we have received, the following caused the denial of SILDENAFIL TABLET 20MG. 1) The drug was not prescribed by, or together with, a heart or lung specialist. 2) The drug is not being used for Pulmonary Arterial Hypertension (PAH). This is a health issue where you would have high blood pressure in the blood vessels that go from the heart to the lungs. 3) Records did not show that your condition has been confirmed by a right heart catheterization. This is a test that checks how well your heart is pumping and is used to diagnose your health issue. 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 Pulmonary Arterial Hypertension have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Cardiologist or Pulmonologist; AND 2) Member has Pulmonary Arterial Hypertension (PAH) as diagnosed by right heart catheterization. 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
14911420	CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	BIMATOPROST	DERMATOLOGICALS	sis of unspecified eye, unspecified eyelid	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
14912785	MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	Dx.L90.8	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin 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. 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
14916018	SAMMY LERMA III MD	FAMILY PRACTICE	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20	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 buprenorphine/naloxone sublingual film (SUBOXONE equivalent) and Zubsolv sublingual 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.
14916745	ROGER EARL CAGLE MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	F32.A	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix: 1) The drug is not being used for Major Depressive Disorder (MDD). 2) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, have been tried and failed. 3) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and failed. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 1, 2, and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

14917934 LAURA MARIE KENNEDY MD	FAMILY PRACTICE	INVOKANA	ANTIDIABETICS	DM2 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 or Xigduo XR, and Jardiance or Synjardy (XR). 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
14921789 DEBORAH LYNN EKERY MD	CARDIOLOGY	PRALUENT	ANTIHYPERLIPIDEMICS	e78.5 Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Repatha (TRIED), Nexletol, Nexlizet. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14930470 SANDEEP BADYAL MD	FAMILY PRACTICE	LINZESS	GASTROINTESTINAL AGENTS - MISC.	k58.1 Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14938374 NATALIA MILLIKEN NP-C	ADVANCED PRACTICE NURSE	DESCOVY	ANTIVIRALS	HIV PrEP Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14939293 DIANA NATHALIE ANDINO MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	g43.009 Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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. 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.

14940437	FRANK JOSEPH SUPPA DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	HIV PrEP	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14941485	JAMES FINAS HOLLEMAN III MD	INTERNAL MEDICINE	FINASTERIDE	DERMATOLOGICALS	plasia with lower urinary tract symptoms	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
14943691	MATTHEW SCOTT HILL DO	FAMILY PRACTICE	DEXCOM G7 SENSOR	MEDICAL DEVICES	r73.03	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
14946771	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	obesity	Criteria Not Met	Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induced constipation (OIC). These are specific health issues that make it difficult to have a bowel movement. 2) More information is needed to show that you do not need frequent dose increases (e.g., weekly) of your opioid pain medication. 3) Records did not show that taking one of the following over-the-counter (OTC) drugs for one month did not work for you: stimulants (e.g., bisacodyl, sennosides), or PEG 3350 (e.g., Miralax), or bulk-forming laxatives (e.g., Metamucil, Citrucel, Fibercon). 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 lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3, & 4 of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon). 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
14947161	BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	E78.2 - Mixed hyperlipidemia	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 Vascepa, omega-3 acid ethyl ester caps (Lovaza equivalent), one statin (e.g. rosuvastatin)(TRIED), one fibrate (e.g. fenofibrate), and niacin ER (Niaspan ER 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.
14949047	KARISA RAE STANCIL FNP-C	NURSE PRACTITIONER	VILAZODONE HYDROCHLORID	ANTIDEPRESSANTS	depression	Criteria Not Met	Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone. 1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine) 2) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafaxine) Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 3 & 4 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of major depressive disorder; AND 2) Member is 18 years of age or older; AND 3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14952495	TERA CHRISTINA BROOKS MD	FAMILY PRACTICE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	ere) obesity due to excess calories (HCC)	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

14954730	ALYSON DANELLE GARCIA MD	OBSTETRICS & GYNECOLOGY	BONJESTA	ANTIEMETICS	O21.9	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 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. 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.
14959171	ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	e34.9	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone gel was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism. This is a condition in which the body does not make enough testosterone. Since the criteria 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement therapy; AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14960482	TRICIA LYNN WINTERS PA	PHYSICIAN ASSISTANT	ZORYVE	DERMATOLOGICALS	PsO	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) Records show this drug will be used together with one of the following drugs: Vtama, Otezla, Sotyktu, or biologic therapy (e.g. adalimumab, Enbrel) for your health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 6 years of age or older; AND 4) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis; AND 5) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14961306	MOHAMMAD BASHASHATI SAGHEZCHI IV	GASTROENTEROLOGY	TRULANCE	GASTROINTESTINAL AGENTS - MISC.	chronic constipation	Criteria Not Met	Our prior authorization criteria for Trulance have not been met. From the records that we have received, the following caused the denial of Trulance: 1) The drug is not prescribed to treat Chronic Idiopathic Constipation (CIC) OR Irritable Bowel Syndrome with Constipation (IBS-C). 2) Records did not show that you have tried and failed a one (1) month trial (minimum) of one of the following Over-the-Counter (OTC) types of medications: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trulance have not been met. From the information we have received, the member does not meet number 1 & 2 of our prior authorization criteria for Trulance. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of an adult with ONE (1) of the following: Chronic Idiopathic Constipation (CIC) OR Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A one-month trial (minimum) of ONE (1) of the following was ineffective, contraindicated, or not tolerated: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Since criteria have not been met, we are unable to approve coverage for this drug at this time.
14964314	KERI LEE PINNOCK MD	GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.04	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 plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

14966317	ADAM WESLEY SPJUTE MD	ANESTHESIOLOGY	OXYCONTIN	ANALGESICS - OPIOID	chronic pain syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent). 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.
14973947	MELVIN LEON COOPER JR NP	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20-Opioid Dependence	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Suboxone film/Zubsolv. 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.
14975890	LINDSEY DIEGUEZ NP	NURSE PRACTITIONER	ZEPBOUND	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.
14985685	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	DULOXETINE HYDROCHLORIDI	ANTIDEPRESSANTS	ssive disorder, single episode, moderate	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 duloxetine capsule (CYMBALTA equivalent), in 20mg, 30mg, and 60mg strengths. Note that two of the 20mg capsules may be taken together to achieve a dose of 40mg. 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.
14985729	MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	ZORYVE	DERMATOLOGICALS	L40.0-psoriasis	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) This drug was not prescribed by, or together with, a doctor who specializes in your health issue. 2) This drug is not being used for ongoing (chronic) plaque psoriasis. Plaque psoriasis is a health issue where skin cells build up and form itchy, dry patches and scales. 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) 1, 2 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 6 years of age or older; AND 4) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis; AND 5) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14991167	VICTORIA KATHLEEN GACA MD	INTERNAL MEDICINE	VYVANSE	ADHD/ANTI-NARCOLEPSY	t hyperactivity disorder, unspecified type	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The 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

14991879	LAUREN DAVENPORT EASTERWOOD FNP	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 40.0-44.9, adult	Plan Exclusion	This request cannot be approved because this drug is being used for weightloss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
14992262	MELANI INOKA DAYAL APN	ADVANCED PRACTICE NURSE	LEVOCETIRIZINE DIHYDROCHL	ANTIHISTAMINES	j30.2-Other seasonal allergic rhinitis	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 loratadine, fexofenadine, cetirizine, levocetirizine. All available over-the-counter (OTC). 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.
14992403	DARSHAN NARENDRA SHAH MD	NEUROLOGY	BOTOX	NEUROMUSCULAR AGENTS	g81.11	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Botox is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
14992782	MICHAEL RIE MD	FAMILY PRACTICE	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	) - Male erectile dysfunction, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
14999122	LINDSEY DIEGUEZ NP	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15001942	URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	r79.89	Formulary Alternatives Available	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, TADALAFIL TABLET 5MG was denied for these reasons: 1) One of these drugs has not been tried and failed: doxazosin tablet, prazosin capsule, terazosin capsule, dutasteride capsule, finasteride 5mg tablet, alfuzosin tablet, silodosin capsule, or tamsulosin capsule. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15005492	CARTER REID HANSON PA-C	PHYSICIAN ASSISTANT	DESCOVY	ANTIVIRALS	Z72.52 - High risk homosexual behavior	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15007512	JONATHAN NICHOLAS POSEY MD	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	e28.2	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
15007727	GRAHAM MILLER BLOCK MD	INTERNAL MEDICINE	VICTOZA	ANTIDIABETICS	I10 - Essential (primary) hypertension	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. 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
15009135	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	QSYMIA	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.

15010643	EMILY WANTLAND HICKS FNP-C	NURSE PRACTITIONER	LINZESS	GASTROINTESTINAL AGENTS - MISC.	k59.09	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 1, 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15019782	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	Z68.41	Criteria Not Met	Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induced constipation (OIC). These are specific health issues that make it difficult to have a bowel movement. 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 lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 1 or 2 or 3 of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon). 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
15025822	SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0 Psoriasis vulgaris	Criteria Not Met	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes were not sent to us to show your response to this drug. 3) More information is needed to know if this drug is being used together with biologic therapy. 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 apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 2, 3, and 4 of our prior authorization criteria for Otezla for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval); AND 4) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15050303	SHERI MICHELLE RAVENSCROFT MD	DEVELOPMENTAL-BEHAVIORAL P	QUILLIVANT XR	ADHD/ANTI-NARCOLEPSY	r46.3	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), lisdexamfetamine (Vyvanse equivalent). Please note: capsules may be opened and sprinkled on applesauce or mixed with orange juice. See package inserts for more details. 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.
15060193	ALYSSA RODANICHE PA	PHYSICIAN ASSISTANT	PROAIR RESPICLICK	ANTIASTHMATIC AND BRONCHODILATOR A	mild intermittent asthma, uncomplicated	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are albuterol HFA inhaler (PROAIR, PROVENTIL equivalent), and VENTOLIN HFA INHALER. 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.

15060503	ERIC TODD MEEHAN	PSYCHIATRY, CHILD & ADOLESCE	MOUNJARO	ANTIDIABETICS	R73.03 - Prediabetes	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNJARO was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. 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
15065593	KOHLBE THOMAS PA-C	PHYSICIAN ASSISTANT	NURTEC	MIGRAINE PRODUCTS	G43.909-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 for migraine prevention are Aimovig, Ajovy, Emgality and Qulipta. Other drugs that can be used for acute migraine treatment are Reyvow, Ubrelvy and Zavzpret. 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.
15066148	MEGAN CONTELLO PASSE APN	NURSE PRACTITIONER	ENBREL SURECLICK	TARGETED IMMUNOMODULATORS	M05.79	Criteria Not Met	Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reasons: 1) Records did not show that you have tried and failed methotrexate at a dose of at least 20mg/week for at least 8 weeks. If you are not able to take methotrexate at this dose, records should be sent to us to show that you have had side effects to lower doses of methotrexate OR that you have a contraindication to this drug and cannot take it. 2) Sulfasalazine, hydroxychloroquine, or leflunomide have not been tried and failed. 3) Records did not show that you failed to respond after 3 months or failed to reach goal after 6 months of methotrexate and other disease-modifying antirheumatic drug (DMARD) treatment. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for etanercept (ENBREL) have not been met. From the information we have received, the member does not meet number(s) 3, 4, 5 of our prior authorization criteria for Enbrel for Rheumatoid Arthritis. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) Member has tried one (1) or more conventional disease-modifying antirheumatic drugs (DMARDs) alone (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, corticosteroids) or in combination; AND 4) Member has tried methotrexate at a dose of greater than or equal to 20 mg/week for at least 8 weeks, AND one of the following is met: (A) The dates of utilization of methotrexate at a dose of greater than or equal to 20mg/week is provided; OR (B) Dose-limiting side effects with methotrexate treatment are submitted; OR (C) A contraindication to methotrexate is indicated (Note: a contraindication to methotrexate does NOT cancel the requirement of a 3-6 month trial of conventional DMARDs); AND 5) Indicate ONE (1) of the following: (A) Member had no response after 3 months of DMARD treatment, while using methotrexate at a dose of greater than or equal to 20 mg/week for 8 weeks during that 3 month period. No response is defined as no change in the Simple Disease Activity Index (SDAI) or Clinical Disease Activity Index (CDAI) score; OR (B) Member did not reach goal at 6 months. Goal at 6 months is defined as remission (SDAI score of 0.0-3.3, CDAI score of 0.0-2.8) or low disease activity (SDAI score of 3.4-11.0, CDAI score of 2.9-10.0); AND 6) Dates and doses of conventional DMARD therapy are provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15071439	AZIM GHAFARI SHEKARCHI MD	INTERNAL MEDICINE	SOLOSEC	AMEBICIDES	N76.0 - Acute vaginitis	Criteria Not Met	Our prior authorization criteria for secnidazole (SOLOSEC) have not been met. From the records that we have received, Solosec was denied for these reasons: 1) Records did not show that your health issue meets three (3) of the four (4) Amsel's criteria. These are signs or symptoms that help your doctor identify your health issue, such as white discharge on the vaginal walls, more than 20% cue cells, vaginal fluid pH level greater than 4.5, and fishy odor. 2) Records do not show that you have had three (3) or more episodes of this health issue in the past year. 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 secnidazole (SOLOSEC) have not been met. From the information we have received, the member does not meet number 1,2 of our prior authorization criteria for Solosec. The reason for denial is explained to the member above. The criteria are listed here. 1) The drug is prescribed for the treatment of a woman with bacterial vaginosis as determined by THREE (3) of the FOUR (4) Amsel's Criteria: (A) Homogeneous, thin, white discharge that smoothly coats the vaginal walls; (B) More than 20% cue cells (e.g., vaginal epithelial cells studded with adherent coccobacilli) on microscopic examination; (C) pH of vaginal fluid greater than 4.5; (D) A fishy odor of vaginal discharge before or after addition of 10% potassium hydroxide (KOH) (i.e., the whiff test); AND 2) Member has experienced greater than or equal to 3 episodes in the past year; AND 3) Trials of TWO (2) of the following were ineffective, contraindicated, or not tolerated: metronidazole, clindamycin, tinidazole. 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.
15072425	LIZANN BAKER ROGERS	NURSE PRACTITIONER	HUMALOG	ANTIDIABETICS	DM2	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) Records did not show the biosimilar version(s) of this drug, called insulin lispro injection, did not work for you. 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 drug. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are Lyumjev, Humalog (Mix, Kwikpen or Pen Injection). 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. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The biosimilar form(s) 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 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/

15074159	FRANK JOSEPH SUPPA DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	Prep	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15075313	JOHN MICHAEL MCINTYRE FNP-C	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	E13.69	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 (E11 diagnosis code). 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
15075347	CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	Atopic dermatitis	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Chart notes showing that this drug is working well for you have not been received. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of moderate to severe atopic dermatitis at baseline; AND 2) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 3) Dupixent will NOT be used in combination with another targeted immunomodulator product. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15078322	URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	ed abnormal findings of blood chemistry	Formulary Alternatives Available	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, TADALAFIL was denied for these reasons: 1) One of these drugs has not been tried and failed: doxazosin tablet, prazosin capsule, terazosin capsule, dutasteride capsule, finasteride 5mg tablet, alfuzosin tablet, silodosin capsule, or tamsulosin capsule. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15081058	EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ED	Plan Exclusion	This request cannot be approved because this drug is being used for Erectile Dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15083413	JESSICA LONG DARNUTZER NP-C	NURSE PRACTITIONER	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

15085111	REY XIMENES MD	ANESTHESIOLOGY	MORPHINE SULFATE ER	ANALGESICS - OPIOID	G89.4-Chronic pain syndrome	Formulary Alternatives Available	For a member that is new to using an opioid pain reliever, the Opioid Naive criteria for Step Therapy has not been met. Step Therapy means that another drug will need to be tried and failed first. From the records that we have received, MORPHINE 30mg ER was denied for these reasons: 1) One of these short-acting opioid pain relievers has not been recently tried: morphine sulfate immediate release (IR), oxycodone, oxycodone/acetaminophen, hydrocodone/acetaminophen, hydromorphone, tramadol. Please note: We will only cover up to 7 days for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. Records did not show that you have had recent use of an opioid pain reliever OR have an active cancer diagnosis, a life-ending health issue, or are in hospice care. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Opioid Naive criteria for Step Therapy have not been met. From the information we have received, the member does not meet numbers 1 or 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 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. 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	Yes
15085365	AARON ALAN LAVIANA MD	UROLOGY	LINEZOLID	ANTI-INFECTIVE AGENTS - MISC.	N30.80	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 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	
15090092	TRICIA LYNN WINTERS PA	PHYSICIAN ASSISTANT	CLINDAMYCIN PHOSPHATE/TR	DERMATOLOGICALS	L70.8-acne	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin(TRIED) or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline(TRIED), minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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	
15092699	DIANE LOISE BRINKMAN MD	OBSTETRICS & GYNECOLOGY	ESTRADIOL	VAGINAL AND RELATED PRODUCTS	95.2-Postmenopausal atrophic vaginitis	Plan Limits Exceeded	The requested amount of ESTRADIOL 10MCG 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 ESTRADIOL 10MCG tablet at 8 tablets per 28 days (18 tablets on first fill) for this use. The higher amount of 40 per 93 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.	
15092728	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	E66.01-obesity	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.	
15094491	JONATHAN EDWARD MACCLEMENTS MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	Z68.38-Body mass index	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.	
15096543	CATHERINE CELESTE LEWIS NP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	ncounter for issue of repeat prescription	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.	
15102443	YVETTE MARIE GUTIERREZ-SCHIEFFER MC	OBSTETRICS & GYNECOLOGY	INTRAROSA	VAGINAL AND RELATED PRODUCTS	35.2 - Postmenopausal atrophic vaginitis	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 estradiol vaginal tablets, estradiol cream (Estrace equivalent)(TRIED), Premarin vaginal cream and Estring. 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.	
15105258	CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	AD	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent: 1) Chart notes showing that this drug is working well for you have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of moderate to severe atopic dermatitis at baseline; AND 2) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 3) Dupixent will NOT be used in combination with another targeted immunomodulator product. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15109466	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for Weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	

15116311	CHRISTA DRURY JONES	NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	R73.03 - 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
15117130	DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES & M	WEGOVY	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15121135	FARHEEN YOUSUF MD	ENDOCRINOLOGY, DIABETES & M	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for Weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15122110	SHAWN ROBERT AGENBROAD-ELANDER	NURSE PRACTITIONER	TRINTELLIX	ANTIDEPRESSANTS	F32.9	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Trintellix, The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15123054	JAMES JOHN TEET DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	Z20.6	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15127672	KRISHNA POKALA MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.709	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 (TRIED), Ajovy, Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15132544	NAWALAGE RAVI NAYANADUL COORAY	FAMILY PRACTICE	LYRICA	ANTICONVULSANTS	M54.9 - Dorsalgia, unspecified	Plan Limits Exceeded	The requested amount of Lyrica 25mg is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Lyrica 25mg at 3 capsules per day for this use. The higher amount of 4 capsules 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.
15133775	JONATHAN NICHOLAS POSEY MD	INTERNAL MEDICINE	PULMICORT FLEXHALER	ANTIASTHMATIC AND BRONCHODILATOR A	Mild intermittent asthma, uncomplicated	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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, fluticasone inhaler. 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

15137953	AMY HERRIN KOWALSKI APN	ADVANCED PRACTICE NURSE	DIVIGEL	ESTROGENS	¿N95.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol oral tablet, Premarin oral tablet, one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent)(tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15140347	MARSAL SANCHES MD	PSYCHIATRY	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	f31.81	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 2 formulary antipsychotic agents (risperidone, aripiprazole, olanzapine, ziprasidone, quetiapine, 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.
15142901	MOHAMMAD BASHASHATI SAGHEZCHI M	GASTROENTEROLOGY	KRISTALOSE	LAXATIVES	- Irritable bowel syndrome with diarrhea	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 lactulose solution. 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.
15143067	SARA JANE PAVITT MD	NEUROLOGY	ALMOTRIPTAN MALATE	MIGRAINE PRODUCTS	G43.709	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 rizatriptan, sumatriptan (TRIED), eletriptan, naratriptan, zolmitriptan. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15143732	JORDAN DAVID HARTMAN MD	FAMILY PRACTICE	IVERMECTIN	DERMATOLOGICALS	Other acne	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for demodex acne. 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.
15147981	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	e669	Plan Exclusion	This request cannot be approved because this drug is being used for obesity. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

15151574	LISA ALANE DAMURA	ADVANCED PRACTICE NURSE	VILAZODONE HYDROCHLORID	ANTIDEPRESSANTS	f33.2	Criteria Not Met	Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone: 1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine) Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of major depressive disorder; AND 2) Member is 18 years of age or older; AND 3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15154496	MICHAEL WILLIAM LATTANZI MD	HEMATOLOGY & ONCOLOGY	NUBEQA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	C61 - Malignant neoplasm of prostate	Criteria Not Met	Our prior authorization criteria for darolutamide (NUBEQA) have not been met. From the records that we have received, Nubeqa was denied for these reasons: 1) Records did not show that another drug called abiraterone (Zytiga) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for darolutamide (NUBEQA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Nubeqa. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC); AND 2) Prescribed by, or in consultation with, an Oncologist; AND 3) A trial of abiraterone (ZYTIGA) was ineffective, not tolerated, or is 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.	Yes
15156994	FAUSTIN MURHUBUBA BAHIZI	PHYSICIAN ASSISTANT	MOUNJARO	ANTIDIABETICS	R73.03	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNJARO was denied for this reason: 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	
15157490	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	VILAZODONE HYDROCHLORID	ANTIDEPRESSANTS	F33.9	Criteria Not Met	Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone: 1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram, fluoxetine (TRIED), paroxetine). Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of major depressive disorder; AND 2) Member is 18 years of age or older; AND 3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15157622	ERIN JENNIFER MOHLKE	NURSE PRACTITIONER	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) 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 (TRIED), 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)(Paid claim seen), buprenorphine patch (Butrans equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. 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.	
15165710	JOE THANH NGUYEN MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	Male erectile dysfunction	Plan Exclusion	This request cannot be approved because this drug is being used for Erectile Dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	
15167771	JOE HIDROGO III DO	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.909	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. 2) Two triptan medications (e.g. sumatriptan(tried), rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a 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	

15172310	MELANIE MARIE PICKETT MD	DERMATOLOGY	SODIUM SULFACETAMIDE/SUL	DERMATOLOGICALS	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(tried), adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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
15172885	MOLLY THOMPSON CAMPA	DERMATOLOGY	STELARA	TARGETED IMMUNOMODULATORS	L40.0	Criteria Not Met	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) At least one (1) of the following treatments has not been tried and failed: (A) 15 sessions of light therapy, OR (B) methotrexate 15mg per week, OR (C) acitretin. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ustekinumab (STELARA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Stelara for Plaque Psoriasis (Initial Coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin; AND 4) If the 90mg dose is requested, member's weight is greater than 100kg and is provided with the request.
15173061	HOLLIE ANN HALL ARNP-C	NURSE PRACTITIONER	ADDYI	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	F52.0 - Hypoactive sexual desire disorder	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.
15179154	CHRISTA DRURY JONES	NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	r73.03	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
15179694	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.9	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15184926	SONIA YOUSUF III MD	RHEUMATOLOGY	HUMIRA	TARGETED IMMUNOMODULATORS	M05.79	Criteria Not Met	Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Humira was denied for these reasons: 1) Records did not show that you have tried a conventional disease-modifying antirheumatic drug (DMARD), such as methotrexate, sulfasalazine, hydroxychloroquine, and/or leflunomide, for at least three (3) months. 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 Products have not been met. From the information we have received, the member does not meet number(s) 3,4,5,6 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) Member has tried one (1) or more conventional disease-modifying antirheumatic drugs (DMARDs) (e.g., methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, corticosteroids) alone or in combination for at least three (3) months; AND 4) Member meets ONE (1) of the following: (A) has tried methotrexate at a dose of greater than or equal to 20 mg/week for at least eight (8) weeks, AND the dates of utilization of methotrexate at a dose of greater than or equal to 20mg per week are provided; OR (B) Member had dose-limiting side effects with methotrexate, AND dose-limiting side effects are specified; OR (C) Member has a contraindication to methotrexate, AND contraindication is specified (Note: a contraindication to methotrexate does NOT cancel the requirement of a three (3)-month trial of other conventional DMARDs); AND 5) Member meets ONE (1) of the following: (A) Member had no response after three (3) months of DMARD treatment, which included methotrexate at a dose of greater than or equal to 20 mg per week for eight (8) weeks during that 3-month period. No response is defined as no change in the Simple Disease Activity Index (SDAI) or Clinical Disease Activity Index (CDAI) score; OR (B) Member did not reach goal at six (6) months. Goal at six (6) months is defined as remission (SDAI score of 0.0-3.3, CDAI score of 0.0-2.8) or low disease activity (SDAI score of 3.4-11.0, CDAI score of 2.9-10.0); AND 6) Dates and doses of conventional DMARD therapy are provided.
15188741	STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90	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) 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. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 3 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

15195089	HANA AUBRECHTOVA MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.719	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. 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.
15198256	JENNA GRAY	PHYSICIAN ASSISTANT	TRI-LUMA	DERMATOLOGICALS	) - Disorder of pigmentation, unspecified	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
15203174	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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)(tried), lisdexamfetamine (Vyvanse 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.
15203617	BRAD ERIC VENGHAUS MD	INTERNAL MEDICINE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Criteria Not Met	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) Records did not show the generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 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
15203635	LUCY MARIBEL AMIEVA NP	NURSE PRACTITIONER	LUMRYZ	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	G47.419	Criteria Not Met	Our prior authorization criteria for Lumryz have not been met. From the records that we have received, Lumryz was denied for these reasons: 1) Documentation of your overnight and daytime sleep studies was not received. 2) Records did not show that another drug called armodafinil or modafinil did not 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 Lumryz 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 Lumryz. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Neurologist or board-certified sleep medicine specialist; AND 2) Member has a diagnosis of excessive daytime sleepiness with narcolepsy; AND 3) Documentation of full nocturnal polysomnogram and multiple sleep latency test is provided, and the records show BOTH of the following: (A) Mean onset to sleep of less than eight (8) minutes, AND (B) Two (2) or more sleep onset rapid eye movement (REM) sleep periods (documentation is required to be submitted for an approval); AND 4) A trial of ONE (1) of the following was ineffective, contraindicated, or not tolerated: armodafinil (NUVIGIL) or modafinil (PROVIGIL); AND 5) A trial of solriamfetol (SUNOSI) 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
15206287	CHELLYANNE COLLEEN HINDS PA	PHYSICIAN ASSISTANT	MAVYRET	ANTIVIRALS	B18.2	Criteria Not Met	Our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the records that we have received, Mavyret was denied for these reasons: 1) Records do not show a recent viral level. This must be from within the past 6 months. 2) More information is needed to know how long this drug will be used for. 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 glecaprevir/pibrentasvir (MAVYRET) have not been met. From the information we have received, the member does not meet number(s) 3 and 5 of our prior authorization criteria for Mavyret. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Member has a diagnosis of Hepatitis C Virus (HCV); AND 3) Current viral level (HCV-RNA titer and date) is provided and must be from within the past 6 months (documentation is required for an approval); AND 4) Member does NOT have decompensated cirrhosis (Child-Pugh B or C); AND 5) Member had no prior treatment with direct-acting antiviral(s) (DAA) for HCV AND duration of therapy will be eight (8) weeks; OR 6) Member was previously treated for HCV with a sofosbuvir-based regimen and ALL of the following are met: (A) Member does NOT have genotype 3, and (B) Member has no prior treatment with a NS3/4A protease inhibitor and (C) Duration of therapy will be 16 weeks. 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.

15207397	RUMI AHMED KHAN MD	INTERNAL MEDICINE	YUPELRI	ANTIASTHMATIC AND BRONCHODILATOR A	J45.50	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 severe persistent asthma. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.
15208810	CHELLYANNE COLLEEN HINDS PA	PHYSICIAN ASSISTANT	MAVYRET	ANTIVIRALS	hep c	Criteria Not Met	Our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the records that we have received, Mavyret was denied for these reasons: 1) The drug is not prescribed by, or together with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist. These are doctors who specialize in your health issue. 2) Records do not show a recent viral level. This must be from within the past 6 months. 3) More information is needed to make sure you do NOT have decompensated cirrhosis. This is when healthy liver tissue has been replaced with scarred liver tissue and your liver is no longer working well. 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 glecaprevir/pibrentasvir (MAVYRET) have not been met. From the information we have received, the member does not meet number(s) 1, 3, and 4 of our prior authorization criteria for Mavyret. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Member has a diagnosis of Hepatitis C Virus (HCV); AND 3) Current viral level (HCV-RNA titer and date) is provided and must be from within the past 6 months (documentation is required for an approval); AND 4) Member does NOT have decompensated cirrhosis (Child-Pugh B or C); AND 5) Member had no prior treatment with direct-acting antiviral(s) (DAA) for HCV AND duration of therapy will be eight (8) weeks; OR 6) Member was previously treated for HCV with a sofosbuvir-based regimen and ALL of the following are met: (A) Member does NOT have genotype 3, and (B) Member has no prior treatment with a NS3/4A protease inhibitor and (C) Duration of therapy will be 16 weeks. 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.
15210497	SAGAR SHAILESH PARIKH MD	PAIN MEDICINE	NURTEC	MIGRAINE PRODUCTS	G43.119	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 formulary alternatives have been tried and failed. Other drugs that can be used are Aimovig, Emgality, and Ajovy. 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.
15212589	ALLISON LEIGH ANDERSON MD	OBSTETRICS & GYNECOLOGY	ESTROGEL	ESTROGENS	lenopausal and female climacteric states	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿estradiol oral tablet, Premarin oral tablet, one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15213778	BRET MICHAEL BELLARD MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are dexmethylphenidate ER capsule (Focalin XR equivalent), amphetamine/dextroamphetamine ER capsule (Adderall XR equivalent), and methylphenidate ER tablet or capsule. 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. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The 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

15214613	JENNIFER STREET SUMMERS MD	OBSTETRICS & GYNECOLOGY	BREXAFEMME	ANTIFUNGALS	Chronic candidiasis of vulva and vagina	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fluconazole, and terconazole cream or suppository. 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.
15222031	DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEXCOM G6 SENSOR	MEDICAL DEVICES	Type II diabetes	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G6 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15224933	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	ere) obesity due to excess calories (HCC)	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15226161	ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	ENBREL SURECLICK	TARGETED IMMUNOMODULATORS	m05.79	Criteria Not Met	Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reasons: 1) Records did not show that you have tried and failed methotrexate at a dose of at least 20mg/week for at least 8 weeks. If you are not able to take methotrexate at this dose, records should be sent to us to show that you have had side effects to lower doses of methotrexate OR that you have a contraindication to this drug and cannot take it. 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 etanercept (ENBREL) have not been met. From the information we have received, the member does not meet number(s) 6 of our prior authorization criteria for Enbrel for Rheumatoid Arthritis. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) Member has tried one (1) or more conventional disease-modifying antirheumatic drugs (DMARDs) alone (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, corticosteroids) or in combination; AND 4) Member has tried methotrexate at a dose of greater than or equal to 20 mg/week for at least 8 weeks, AND one of the following is met: (A) The dates of utilization of methotrexate at a dose of greater than or equal to 20mg/week is provided; OR (B) Dose-limiting side effects with methotrexate treatment are submitted; OR (C) A contraindication to methotrexate is indicated (Note: a contraindication to methotrexate does NOT cancel the requirement of a 3-6 month trial of conventional DMARDs); AND 5) Indicate ONE (1) of the following: (A) Member had no response after 3 months of DMARD treatment, while using methotrexate at a dose of greater than or equal to 20 mg/week for 8 weeks during that 3 month period. No response is defined as no change in the Simple Disease Activity Index (SDAI) or Clinical Disease Activity Index (CDAI) score; OR (B) Member did not reach goal at 6 months. Goal at 6 months is defined as remission (SDAI score of 0.0-3.3, CDAI score of 0.0-2.8) or low disease activity (SDAI score of 3.4-11.0, CDAI score of 2.9-10.0); AND 6) Dates and doses of conventional DMARD therapy are provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15226945	ALBERTO GLENDALYZ MD	GERIATRIC MEDICINE	UBRELVY	MIGRAINE PRODUCTS	g43.109	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. 2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a 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
15227201	MARC EVAN WENZEL MD	ENDOCRINOLOGY, DIABETES & M	NOVOLOG FLEXPEN	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog 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.

15227553	TINA CHADHA BUNCH MD	RHEUMATOLOGY	HYDROCODONE BITARTRATE/A	ANALGESICS - OPIOID	Arthropathic psoriasis, unspecified (HCC)	Plan Limits Exceeded	We have received a request for 60 tablets for a 30 day supply for hydrocodone/acetaminophen. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a 7 day supply for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. For members who do not show recent use of an opioid pain reliever, more than a 7 day supply for this first fill can be approved if records are sent in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.	
15229415	RUMI AHMED KHAN MD	INTERNAL MEDICINE	DUPIXENT	DERMATOLOGICALS	J45.5	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records did not show your blood eosinophil count is at least 150 cells per microliter (eosinophils are a type of white blood cell that helps the body fight infections) OR that you need to take a type of drug called an oral steroid (such as prednisone) every day. 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 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Pulmonologist; AND 3) Member has a diagnosis of moderate or severe asthma; AND 4) Member has one of the following: (A) eosinophilic asthma with a baseline blood eosinophil concentration greater than or equal to 150 cells per microliter, and the baseline blood eosinophil concentration is provided, OR (B) oral corticosteroid dependent asthma requiring daily doses of greater than or equal to 5 mg prednisone (or equivalent); AND 5) Member has a history of greater than or equal to 2 asthma exacerbations requiring treatment with systemic corticosteroids or emergency department visit or hospitalization for treatment of asthma within the past year despite adherent utilization of either an inhaled corticosteroid (ICS) with one additional asthma controller medication or maximally tolerated inhaled corticosteroid/long-acting beta agonist (ICS/LABA) combination product; AND 6) Prescriber attests to ALL of the following: (A) Member adherence to controller medications, AND (B) Member is a non-smoker or is adherent to an attempt at smoking cessation, AND (C) Member will NOT be using Dupixent in combination with another targeted immunomodulator product used for asthma. 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	Yes
15230938	ERIN JENNIFER MOHLKE	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	f11.20	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER (tried), 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) (tried), buprenorphine patch (Butrans equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. 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.	
15231530	REDDIAH BABU MUMMANENI MD	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY	g47.411	Criteria Not Met	Our prior authorization criteria for Sunosi have not been met. From the records that we have received, the following caused the denial of Sunosi. 1) Records did not show that you have had fewer symptoms of excessive daytime sleepiness since starting this medication. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (documentation is required to be submitted for an approval); AND 2) If prescribed for Excessive Daytime Sleepiness due to Obstructive Sleep Apnea, the medication will continue to be used in conjunction with positive airway pressure therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15233623	DANIEL ANTHONY CARRASCO MD	DERMATOLOGY	IVERMECTIN	DERMATOLOGICALS	Jnspecified blepharitis right lower eyelid	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 blepharitis right lower eyelid. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.	

15233908	ITAMAR BIRNBAUM MD	CARDIOLOGY	PRALUENT	ANTIHYPERLIPIDEMICS	i25.10	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Repatha, Nexletol, Nexlizet. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15235612	MAYA BADACHHAPE BLEDSOE MD	INTERNAL MEDICINE	MYCAPSSA	ENDOCRINE AND METABOLIC AGENTS - MIS	Acromegaly	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 octreotide injections (Sandostatin equivalent) and Somavert injections. 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.
15240420	TRICIA LYNN WINTERS PA	PHYSICIAN ASSISTANT	CLINDAMYCIN PHOSPHATE/TR	DERMATOLOGICALS	I70.8	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 (tried) or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (tried) (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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.
15244832	VENKATESH BABU SEGU MD	ENDOCRINOLOGY, DIABETES & M	OMNIPOD 5 DEXCOM G7G6 PC	MEDICAL DEVICES	DM2	Plan Limits Exceeded	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 The requested amount of omnipod 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 omnipod at 10 pods per 30 days for this use. The higher amount of 15 pods per 30 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.
15249172	AJAY ZACHARIAH MD	FAMILY PRACTICE	MOUNJARO	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.
15251720	MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	BIMZELX	TARGETED IMMUNOMODULATORS	PP	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 an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA), Taltz, Tremfya, Cimzia, Otezla(tried), Skyrizi, Stelara. 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.
15251990	DANIEL ANTHONY CARRASCO MD	DERMATOLOGY	IVERMECTIN	DERMATOLOGICALS	Jnspecified blepharitis right lower eyelid	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 unspecified blepharitis of right upper and lower eyelids. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.

15253820	KENNETH ALLEN PEREZ DO	FAMILY PRACTICE	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOI	K21.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole, pantoprazole, esomeprazole, lansoprazole, and rabeprazole. 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.
15253970	ASHLEY HEATHER WHATLEY NP	NURSE PRACTITIONER	JATENZO	ANDROGENS-ANABOLIC	F64.9	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 ¿testosterone cypionate, testosterone enanthate, testosterone gel packet or pump 1% (Androgel equivalent)-(tried), testosterone gel packet or pump 1.62% (Androgel equivalent), testosterone solution (Axiron equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 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
15254890	LORENA CARBAJAL CARBALLO MD	INTERNAL MEDICINE	INVOKANA	ANTIDIABETICS	ıthy wout macular edema, bilateral(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 or Xigduo XR, and Jardiance or Synjardy (XR). 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
15255615	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is in a class of drugs called Weight Loss medications. Drugs of this type 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.
15257617	DANIEL ANTHONY CARRASCO MD	DERMATOLOGY	SEYSARA	TETRACYCLINES	L70.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All 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 or adapalene/benzoyl peroxide, and one (1) oral antibiotic (e.g., doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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. Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes were not sent to us to show your response to this drug. 3) More information is needed to know if this drug is being used together with biologic therapy. 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.
15260425	SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 2, 3, and 4 of our prior authorization criteria for Otezla for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval); AND 4) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15262853	ROBERT JAMES DOUGHERTY JR MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	N95.1	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone gel was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism in a male. This is a health issue where the body does not make enough testosterone. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for testosterone gel. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request.
15266340	KETA PANDIT	ENDOCRINOLOGY, DIABETES & M	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.2	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 this drug has worked well for you and that you should continue taking it. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Repatha have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Repatha. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is being monitored, has benefited from therapy, and it is appropriate to continue therapy with evolocumab (REPATHA). 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
15271102	WILLIAM MONNING LOVING MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show the generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The 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
15278638	CRAIG HEWELL COUCH MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.109	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy, and Zavzpret. 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.
15279422	GREG MICHAEL THAERA MD	NEUROLOGY	GILENYA	MULTIPLE SCLEROSIS AGENTS	G35	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) Records did not show the generic version of this drug, called fingolimod 0.5mg capsule (Gilenya equivalent), did not work for you. 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. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 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

15280456	SHAGUFTA R LAKHANI FNP-C	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	G43.909	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) Chart notes showing your health records and past treatments were not received. 2) More information is needed to know if this drug is being used to prevent migraine headaches, to treat migraine headaches when they happen, or both. 3) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used to prevent migraine headaches are Aimovig, Ajovy, and Emgality. Other drugs that can be used to treat migraines when they happen are Ubrelvy, Reyvow, and Zavzpret. 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 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.
15282122	MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	ACCRUFER	HEMATOPOIETIC AGENTS	D50.9	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 ferrex 150 forte capsule, folbee tablet, Multigen Folic tablet, Multigen Plus tablet, tricon capsule and other formulary alternatives. 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.
15283990	KATIE JO DIXON FNP-C	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	09 - Other obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is in a class of drugs called Weight Loss medications. Drugs of this type 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.
15284944	EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	N52.9	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15285216	STEVEN CURTIS CROW MD	FAMILY PRACTICE	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	G43	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 migraine. 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 ibuprofen, naproxen, diclofenac tablet, rizatriptan, sumatriptan, naratriptan, Reyvow, Ubrelvy, 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 numbers 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.
15287812	REUBEN JEREMIAH ELOVITZ MD	INTERNAL MEDICINE	UBRELVY	MIGRAINE PRODUCTS	G43.009	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. 2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a 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
15299304	MARTIN CHRISTOPHER MOLINA MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	ADHD	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show the generic version of this drug, called lisdexamfetamine, did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The 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

15299326	BRIANNA LAREE HURTADO NP	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	PrEP	Not Covered	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15304808	DARUSH RAHMANI DO	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	2.9-SYSTEMIC LUPUS ERYTHEMATOSUS	Criteria Not Met	Our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta SC was denied for these reasons: 1) Records did not show a positive test for anti-double stranded DNA (anti-dsDNA), low levels of complement (C3 or C4) proteins, or a positive test for anti-smith antibodies. These are lab tests used to help diagnose or identify systemic lupus erythematosus (SLE). SLE is a health issue where the immune system attacks its own tissues and organs, causing widespread inflammation. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Benlysta SC. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) and is receiving standard therapy; AND 2) Prescribed by, or in consultation with, a Rheumatologist or Dermatologist; AND 3) Documentation of ONE (1) of the following is provided with the request (documentation is required to be submitted for an approval): (A) anti-double stranded DNA (anti-dsDNA) positive; OR (B) low complement (C3 or C4) proteins; OR (C) positive for anti-smith antibodies; AND 4) Trials of TWO (2) of the following are ineffective, contraindicated or not tolerated: (A) azathioprine, (B) hydroxychloroquine, (C) methotrexate, (D) mycophenolate mofetil, or (E) chronic corticosteroid treatment at greater than or equal to 7.5mg of prednisone daily, or equivalent; AND 5) Member does NOT have severe active central nervous system (CNS) lupus; AND 6) Medication will NOT be given in combination with other biologics
15306048	TRICIA LYNN WINTERS PA	PHYSICIAN ASSISTANT	CLINDAMYCIN PHOSPHATE/TR	DERMATOLOGICALS	Acne	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin (TRIED) or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent) (TRIED), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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
15306268	CLAYTON WARREN ADAMS MD	ANESTHESIOLOGY	BUPRENORPHINE	ANALGESICS - OPIOID	G89.4-Chronic pain syndrome	Formulary Alternatives Available	For a member that is new to using an opioid pain reliever, the Opioid Naive criteria for Step Therapy has not been met. Step Therapy means that another drug will need to be tried and failed first. From the records that we have received, BUPRENORPHINE patch was denied for these reasons: 1) One of these short-acting opioid pain relievers has not been recently tried: morphine sulfate immediate release (IR), oxycodone, oxycodone/acetaminophen, hydrocodone/acetaminophen, hydromorphone, tramadol. Please note: We will only cover up to 7 days for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. Records did not show that you have had recent use of an opioid pain reliever OR have an active cancer diagnosis, a life-ending health issue, or are in hospice care. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Opioid Naive criteria for Step Therapy have not been met. From the information we have received, the member does not meet numbers 1 or 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 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. 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
15308003	ATHIRA UNNIKRISHNAN MD	HEMATOLOGY & ONCOLOGY	NUBEQA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	none-Sensitive Prostate Cancer (mHSPC)	Criteria Not Met	Our prior authorization criteria for darolutamide (NUBEQA) have not been met. From the records that we have received, Nubeqa was denied for these reasons: 1) Records did not show that another drug called abiraterone (Zytiga) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for darolutamide (NUBEQA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Nubeqa. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC); AND 2) Prescribed by, or in consultation with, an Oncologist; AND 3) A trial of abiraterone (ZYTIGA) was ineffective, not tolerated, or is 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.

15309538	MARIAN YVETTE WILLIAMS-BROWN MD	OBSTETRICS & GYNECOLOGY	LENVIMA 20 MG DAILY DOSE	ANTINEOPLASTICS AND ADJUNCTIVE THERA		C54.1	Criteria Not Met	Our prior authorization criteria for lenvatinib (LENVIMA) have not been met. From the records that we have received, the following caused the denial of Lenvima. 1) Records did not show that your cancer got worse (progressed) with or after another cancer treatment. 2) More information is needed to know if Lenvima will be used together with another cancer drug called Keytruda. 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 lenvatinib (LENVIMA) have not been met. From the information we have received, the member does not meet numbers 5, 7 of our prior authorization criteria for Lenvima. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist; AND 2) Member has a diagnosis of advanced endometrial carcinoma; AND 3) Disease is NOT microsatellite instability-high (MSI-H); AND 4) Disease is NOT mismatch repair deficient (dMMR); AND 5) Disease has progressed following prior systemic therapy; AND 6) Member is NOT a candidate for curative surgery or radiation; AND 7) Member will use this drug in combination with pembrolizumab (KEYTRUDA). 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	Yes
15311003	NAWALAGE RAVI NAYANADUL COORAY I	FAMILY PRACTICE	DEXCOM G6 SENSOR	MEDICAL DEVICES		dx E13.69	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, DEXCOM G6 MIS SENSOR was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.	
15314262	CHRISTOPHER JAMES O'CONNOR PA	PHYSICIAN ASSISTANT	BUPRENORPHINE HCL	ANALGESICS - OPIOID		dx f11.20	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 buprenorphine/naloxone tabs/films. 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.	
15318739	JACQUELYN MARIE RODRIGUEZ NP	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20-Opioid dependence		Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: Trial of buprenorphine/naloxone required (Suboxone film/Zubsolv 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.	
15319669	DANIEL NEIL SKOGLUND MD	PSYCHIATRY	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	F90.0-ADHD		Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent). 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.	

15325792	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	LIDOCAINE 5%	ANORECTAL AND RELATED PRODUCTS	B02.9 - Zoster 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 lidocaine ointment, lidocaine patch, gabapentin, amitriptyline, nortriptyline, pregabalin. 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.
15330529	HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY	XOLAIR	ANTIASTHMATIC AND BRONCHODILATOR A	Other urticaria	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Xolair 150 mg Subcutaneous Solution (Reconstituted) 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.
15330548	DONALD DAVIS COLE III MD	FAMILY PRACTICE	SYMBICORT	ANTIASTHMATIC AND BRONCHODILATOR A	derate persistent asthma, uncomplicated	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) Records did not show the generic version of this drug, called budesonide/formoterol (Symbicort equivalent), did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are Breo Ellipta(TRIED), Advair HFA(TRIED) or fluticasone/salmeterol(TRIED), Dulera. 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, 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
15331849	LUCY MARIBEL AMIEVA NP	NURSE PRACTITIONER	LUMRYZ	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	G47.419	Criteria Not Met	Our prior authorization criteria for sodium oxybate ER suspension (LUMRYZ) have not been met. From the records that we have received, LUMRYZ was denied for these reasons: 1) Records of your daytime nap study did not show that the average length of time it took you to fall asleep was shorter than 8 minutes. 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 sodium oxybate ER suspension (LUMRYZ) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for LUMRYZ. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Neurologist or board-certified sleep medicine specialist; AND 2) Member has a diagnosis of excessive daytime sleepiness with narcolepsy; AND 3) Documentation of full nocturnal polysomnogram and multiple sleep latency test is provided, and the records show BOTH of the following: (A) Mean onset to sleep of less than eight (8) minutes, AND (B) Two (2) or more sleep onset rapid eye movement (REM) sleep periods (documentation is required to be submitted for an approval); AND 4) A trial of ONE (1) of the following was ineffective, contraindicated, or not tolerated: armodafinil (NUVIGIL) or modafinil (PROVIGIL); AND 5) A trial of solriamfetol (SUNOSI) 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.
15334821	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	QELBREE	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are atomoxetine (tried) and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or lisdexamfetamine (Vyvanse 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.

15339167	DANIEL NEIL SKOGLUND MD	PSYCHIATRY	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	F90.0-ADHD.	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent). 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.
15346498	FAUSTIN MURHUBUBA BAHIZI	PHYSICIAN ASSISTANT	OZEMPIC	ANTIDIABETICS	r73.03	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
15351295	AMANDA BOUY BALCH WHNP	NURSE PRACTITIONER	TESTOSTERONE	ANDROGENS-ANABOLIC	R68.82	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Testosterone gel 1% was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism in a male. This is a health issue where the body does not make enough testosterone. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Testosterone gel 1%. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request.
15354649	ISELA ARRIETA WERCHAN MD	PSYCHIATRY	LUCEMYRA	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	F11.23	Criteria Not Met	Our prior authorization criteria for Lucemyra have not been met. From the records that we have received, the following caused the denial of Lucemyra: 1) You have not tried and failed clonidine during the current opioid withdrawal attempt. 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 Lucemyra have not been met. From the information we have received, the member does not meet 3 of our prior authorization criteria for Lucemyra. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has diagnosis of mitigation of opioid withdrawal symptoms, AND 2) Prescribed by, or in consultation with, a physician specializing in pain management or addiction treatment, AND 3) Trial and failure of clonidine due to lack of efficacy or intolerable adverse effects for the current opioid withdrawal attempt, OR 4) Member has been prescribed this medication as a continuation of inpatient facility treatment for the completion of a total up to 7 days of treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15356026	KELLY HETHERINGTON SIMPSON	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	AD	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Chart notes showing details of your health issue, such as how much of your body is affected and what other treatments you have tried, were not received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15362018	MARY ANN MARTINEZ MD	DERMATOLOGY	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	psoriasis	Criteria Not Met	Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons: 1) Chart notes were not sent to us to show this drug is working well for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) 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.
15364636	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	QUILLICHEW ER	ADHD/ANTI-NARCOLEPSY	f90.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. Please note: Extended release capsules can be opened and sprinkled over applesauce and lisdexamfetamine capsules and chewtabs (Vyvanse equivalent) can be opened and dissolved in water. 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
15366416	JESSLYN JIAEN LU MD	ENDOCRINOLOGY, DIABETES & M	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug/product is in a class of drugs/products called anti-obesity, or weight loss, drugs. Drugs/products of this type are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs/products, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15374025	NEERAJ MANCHANDA MD	NEUROLOGY	WAKIX	ADHD/ANTI-NARCOLEPSY	EDS	Criteria Not Met	Our prior authorization criteria for pitolisant (WAKIX) have not been met. From the records that we have received, the following caused the denial of Wakix. 1) Records did not show you have had less symptoms of excessive daytime sleepiness since starting this medication. 2) Documentation of improvement was not received. 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 pitolisant (WAKIX) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Wakix (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation of a reduction in symptoms of excessive daytime sleepiness is provided with the 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.
15375183	CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	L20.84	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records did not show that at least TWO (2) of the following treatments did not work for you: topical steroids (triamcinolone (tried)), topical calcineurin inhibitors (such as tacrolimus or pimecrolimus), light therapy, azathioprine, cyclosporine, methotrexate, and mycophenolate mofetil. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15382283	PREETHI ILANGOVAN MD	ENDOCRINOLOGY, DIABETES & M	OMNIPOD 5 DEXCOM G7G6 PC	MEDICAL DEVICES	E10.69	Plan Limits Exceeded	The requested amount of Omnipod 5 G6 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 Omnipod 5 G6 at 10 pods per month for this use. The higher amount of 30 pods per month is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.
15384959	JOHN ROBERTSON JEFFERSON MD	NEUROLOGY	PREGABALIN	ANTICONVULSANTS	M79.2	Plan Limits Exceeded	The requested amount of PREGABALIN is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover PREGABALIN at 3 capsules per day for this use. The higher number of 4 capsules 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.
15385339	ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	ACTEMRA ACTPEN	TARGETED IMMUNOMODULATORS	M05.79	Plan Limits Exceeded	The requested amount of ACTEMRA 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 ACTEMRA at 2 injections per 28 days for this use. The higher number of 4 injections per 28 days is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.

15398109	JAMES JOHN TEET DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	Z20.6	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15399148	AFREEN KHAN MD	FAMILY PRACTICE	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.9	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 lidocaine/hydrocortisone cream (Anamantle equivalent), Proctofoam HC foam, Analpram-E kit, proctosol HC cream (Anusol HC 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.
15401480	KAREN SPURGEON WELCH MD	FAMILY PRACTICE	STELARA	TARGETED IMMUNOMODULATORS	L40.9	Criteria Not Met	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) The drug is not prescribed by a Dermatologist. This is a doctor that works with health problems in the skin, hair, and nails. 2) Records did not show that this drug is working well for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ustekinumab (STELARA) have not been met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of our prior authorization criteria for Stelara for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval); AND 4) If the 90mg dose is requested, member's weight is greater than 100kg and is provided with the request. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15401741	ANDREW ALAN COLLINS MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.009	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy, Zavzpret. 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.
15403387	KATIE JO DIXON FNP-C	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	E66.09	Plan Exclusion	This request cannot be approved because this drug is being used for Weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

15405225	KELLY HETHERINGTON SIMPSON	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	atopic derm	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records show you may not be able to use topical steroids (such as betamethasone-TRIED), topical calcineurin inhibitors (such as tacrolimus or pimecrolimus), light therapy, azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil, but more information is needed to know why each of these treatments are not right for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15405777	STEPHANIE BROOKE KNIGHT NP	NURSE PRACTITIONER	AIMOVIG	MIGRAINE PRODUCTS	G43.909	Criteria Not Met	Our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the records that we have received, Aimovig was denied for these reasons: 1) Records did not show that you have had fewer or less severe migraine headaches since starting this drug. 2) More information is needed to know if this drug will be used together with botulinum toxin product (such as Botox, Dysport, Xeomin, etc.). If Aimovig will be used together with botulinum toxin product (such as Botox, Dysport, Xeomin, etc.), records must also show you have had at least a three (3) month trial of Aimovig alone AND a three (3) month trial of botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) alone. 3) Records did not show that before starting this drug, you had at least 4 migraine days per month for 3 months or longer. 4) More information is needed to show that you have tried and failed (after using for at least 3 months) other drugs from at least ONE of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.). 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 erenumab (AIMOVIG) have not been met. From the information we have received, the member does not meet number(s) 2, 3, 4, 5 of our prior authorization criteria for Aimovig. 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) Aimovig will NOT be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; OR
15406865	SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0	Criteria Not Met	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that your health issue is causing significant functional disability for you. More information is needed to show how your health issue is impacting your day-to-day life. 2) Records did not show at least one of the following treatments did not work for you: 15 sessions of light therapy, OR methotrexate 15mg per week, OR acitretin. 3) Chart notes were not sent to us to show the details of your health issue and how previous treatments worked for you. 4) More information is needed to know if this drug is being used together with biologic therapy, such as adalimumab. 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 apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 2, 3, and 4 of our prior authorization criteria for Otezla. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Plaque psoriasis (PsO) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin; AND 4) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15407194	YUE DENG MD	INTERNAL MEDICINE	DEXCOM G6 RECEIVER	MEDICAL DEVICES	e11.9	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, DEXCOM G6 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.

15408827	JULIE ANN REARDON MD	FAMILY PRACTICE	TIROSINT-SOL	THYROID AGENTS	E03.9	Criteria Not Met	Our prior authorization criteria for levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the records that we have received, Tirosint-Sol was denied for these reasons: 1) Records did not show that you cannot swallow tablets. 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 levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Tirosint-Sol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for ONE (1) of the following: (A) Hypothyroidism; OR (B) Pituitary thyrotropin (Thyroid-Stimulating Hormone, TSH) suppression; AND 2) Member is unable to swallow oral tablets. 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
15411312	CHRISTA DRURY JONES	NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	R73.03	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
15414906	STARLING CORBETT REID MD	INTERNAL MEDICINE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15415781	KATHRYN MARIE LANDHERR MD	OBSTETRICS & GYNECOLOGY	ESTROGEL	ESTROGENS	lenopausal and female climacteric states	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿estradiol oral tablet, Premarin oral tablet, one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15416160	BHAVIM ARUNN DESAI MD	FAMILY PRACTICE	XYWAV	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	Narcolepsy with Cataplexy	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 Sodium Oxybate oral solution, Wakix, Lumryz, Sunosi. 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.
15426261	MORGAN JANELLE MCCARTY DO	DERMATOLOGY	SOTYKTU	DERMATOLOGICALS	I40.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Enbrel, Humira, Taltz, Tremfya, Cimzia, Otezla (tried), Skyrizi, Stelara. 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.
15427821	JENNIFER LYNNE TRAVIESO MD	OBSTETRICS & GYNECOLOGY	MYFEMBREE	ESTROGENS	D25.9	Criteria Not Met	Our prior authorization criteria for relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. From the records that we have received, Myfembree was denied for these reasons: 1) More information is needed to show you do not have osteoporosis. This is a health issue where bones become weak and brittle. 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/estradiol/norethindrone (MYFEMBREE) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Myfembree. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND 2) Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND 3) Member has NO known osteoporosis; AND 4) Member is premenopausal; AND 5) A trial of a hormonal contraceptive was ineffective, contraindicated, or not tolerated.

15428274	JONATHAN EDWARD MACCLEMENTS MD	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.	
15429515	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	ALLOPURINOL	GOUT AGENTS	M10.9 - Gout, 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: allopurinol (Zyloprim equivalent). Please note: the 200mg tablets are not covered, but the same dose can be achieved by taking two (2) 100mg 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.	
15430460	VANESSA AILEEN FRASSATI APN	ADVANCED PRACTICE NURSE	QELBREE	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are atomoxetine (TRIED) and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or lisdexamfetamine (Vyvanse 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.	
15430683	MELODI EYVANAKI ESMAILI OD	OPTOMETRIST	VYZULTA	OPHTHALMIC AGENTS	H40.1131	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 latanoprost (tried), travoprost (Travatan Z equivalent), tafluprost (Zioptan equivalent) and bimatoprost (Lumigan equivalent)-(tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	Yes
15431529	AJAY ZACHARIAH MD	FAMILY PRACTICE	MOUNJARO	ANTIDIABETICS	E66.9	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	
15432292	PETER JEFFREY GEMBOL FNP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	E10.9	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, Mounjaro was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	
15433610	LAURELIN NICOLE MULLINS NP	NURSE PRACTITIONER	VENLAFAXINE HYDROCHLORIC	ANTIDEPRESSANTS	depression	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 venlafaxine extended release (ER) capsules (Effexor XR equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization	

15434060	STANLEY SUCHY WANG MD	CARDIOLOGY	EDARBYCLOR	ANTIHYPERTENSIVES	i10	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 angiotensin II receptor blockers (ARBs) (irbesartan, losartan, valsartan, olmesartan, telmisartan, candesartan) along with chlorthalidone or hydrochlorothiazide (HCTZ). Additionally, other combination medications are available on formulary including losartan/HCTZ, valsartan/HCTZ, olmesartan/HCTZ, irbesartan/HCTZ. 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.
15438185	MARJAN ABEDI LINNELL MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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) (TRIED), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15440771	HANA AUBRECHTOVA MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	migraine	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 TWO (2) triptan drugs (such as sumatriptan-TRIED, rizatriptan, or others) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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 for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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.
15444403	CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	D23.30	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, TRETINOIN 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. 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.
15448263	KYLE MATTHEW SUIRE DO	FAMILY PRACTICE	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	t 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) This drug is being used for migraine. This is not an approved use. More information is needed to know if you have a diagnosis of tension or muscle contraction headaches. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.
15452713	CARSON PAUL HIGGS MD	FAMILY PRACTICE	UREA	DERMATOLOGICALS	L30.9 - Dermatitis, unspecified	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 on what is covered. Prior authorization 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 Ureacin, Rea-Lo, Gordon's Urea 40 and others. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.

15453482	KEN LIN FNP-C	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID		f11.20	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. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.
15455509	SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES		M32.9	Criteria Not Met	Our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta SC was denied for these reasons: 1) Records did not show a positive test for anti-double stranded DNA (anti-dsDNA), low levels of complement (C3 or C4) proteins, or a positive test for anti-smith antibodies. These are lab tests used to help diagnose or identify systemic lupus erythematosus (SLE). SLE is a health issue where the immune system attacks its own tissues and organs, causing widespread inflammation. 2) More information is needed to know if you have severe active central nervous system (CNS) lupus. This is when your health issue is active in your brain and spinal cord. 3) More information is needed to know if Benlysta will be taken together with another biologic drug for your health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the information we have received, the member does not meet number(s) 3, 5, and 6 of our prior authorization criteria for Benlysta SC. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) and is receiving standard therapy; AND 2) Prescribed by, or in consultation with, a Rheumatologist or Dermatologist; AND 3) Documentation of ONE (1) of the following is provided with the request (documentation is required to be submitted for an approval): (A) anti-double stranded DNA (anti-dsDNA) positive; OR (B) low complement (C3 or C4) proteins; OR (C) positive for anti-smith antibodies; AND 4) Trials of TWO (2) of the following are ineffective, contraindicated or not tolerated: (A) azathioprine, (B) hydroxychloroquine, (C) methotrexate, (D) mycophenolate mofetil, or (E) chronic corticosteroid treatment at greater than or equal to 7.5mg of prednisone daily, or equivalent; AND 5) Member does NOT have severe active central nervous system (CNS) lupus; AND 6) Medication will NOT be given in combination with other biologics.
15459829	NEERAJ MANCHANDA MD	NEUROLOGY	AIMOVIG	MIGRAINE PRODUCTS		migraine	Criteria Not Met	Our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the records that we have received, Aimovig was denied for these reasons: 1) Records did not show you have tried and failed (after using for at least 3 months) other drugs from at least ONE of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.). 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 erenumab (AIMOVIG) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Aimovig. 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 four (4) or more migraine days per month for at least the previous three (3) months; AND 3) 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.); AND 4) Aimovig will NOT be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; OR 5) Aimovig will be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine AND both of the following are met: (A) Member has failed at least three (3) months of individual therapy with Aimovig, AND (B) Member has failed at least three (3) months of individual therapy with botulinumtoxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN).
15460360	JAY JOHNSON BAILEY	NURSE PRACTITIONER	FROVATRIPTAN SUCCINATE	MIGRAINE PRODUCTS		G43.909	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 rizatriptan, sumatriptan, eletriptan, naratriptan, zolmitriptan. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization

15468371	SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	m32.9	Criteria Not Met	Our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta SC was denied for these reasons: 1) Records did not show a positive test for anti-double stranded DNA (anti-dsDNA), low levels of complement (C3 or C4) proteins, or a positive test for anti-smith antibodies. These are lab tests used to help diagnose or identify systemic lupus erythematosus (SLE). SLE is a health issue where the immune system attacks its own tissues and organs, causing widespread inflammation. 2) More information is needed to know if you have severe active central nervous system (CNS) lupus. This is when your health issue is active in your brain and spinal cord. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the information we have received, the member does not meet number(s) 3, 5 of our prior authorization criteria for Benlysta SC. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) and is receiving standard therapy; AND 2) Prescribed by, or in consultation with, a Rheumatologist or Dermatologist; AND 3) Documentation of ONE (1) of the following is provided with the request (documentation is required to be submitted for an approval): (A) anti-double stranded DNA (anti-dsDNA) positive; OR (B) low complement (C3 or C4) proteins; OR (C) positive for anti-smith antibodies; AND 4) Trials of TWO (2) of the following are ineffective, contraindicated or not tolerated: (A) azathioprine, (B) hydroxychloroquine, (C) methotrexate, (D) mycophenolate mofetil, or (E) chronic corticosteroid treatment at greater than or equal to 7.5mg of prednisone daily, or equivalent; AND 5) Member does NOT have severe active central nervous system (CNS) lupus; AND 6) Medication will NOT be given in combination with other biologics. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15470191	SONIA YOUSUF III MD	RHEUMATOLOGY	TERIPARATIDE	ENDOCRINE AND METABOLIC AGENTS - MIS	M81.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Tymlos and teriparatide 620 mcg/2.48 mL. 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.
15476433	ATHIRA UNNIKRISHNAN MD	HEMATOLOGY & ONCOLOGY	GILOTRIF	ANTINEOPLASTICS AND ADJUNCTIVE THERA	C43.11	Criteria Not Met	Our prior authorization criteria for afatinib (GILOTRIF) have not been met. From the records that we have received, Gilotrif was denied for these reasons: 1) Records did not show your cancer has spread to other parts of your body (is metastatic). 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 afatinib (GILOTRIF) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Gilotrif. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist; AND 2) Member has a diagnosis of metastatic non-small cell lung cancer (NSCLC); AND 3) Afatinib (Gilotrif) will be used as first-line treatment; AND 4) Member has the presence of a non-resistant epidermal growth factor receptor (EGFR) mutation. 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
15478286	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	AZSTARYS	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15482708	ATHIRA UNNIKRISHNAN MD	HEMATOLOGY & ONCOLOGY	GILOTRIF	ANTINEOPLASTICS AND ADJUNCTIVE THERA	c34.11	Criteria Not Met	Our prior authorization criteria for afatinib (GILOTRIF) have not been met. From the records that we have received, Gilotrif was denied for these reasons: 1) This drug is not being used for non-small cell lung cancer (NSCLC). This is a specific type of lung cancer. 2) Records did not show your cancer has spread to other parts of your body (is metastatic). 3) More information is needed to know if you have tried other drugs for this health issue. 4) Records did not show that you have a specific genetic change (mutation) that is needed for this drug to work. 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 afatinib (GILOTRIF) have not been met. From the information we have received, the member does not meet number 2, 3, and 4 of our prior authorization criteria for Gilotrif. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncologist; AND 2) Member has a diagnosis of metastatic non-small cell lung cancer (NSCLC); AND 3) Afatinib (Gilotrif) will be used as first-line treatment; AND 4) Member has the presence of a non-resistant epidermal growth factor receptor (EGFR) mutation. 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
15483920	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

15486504	DUSTIN ALLEN FONTENOT PA-C	PHYSICIAN ASSISTANT	CLOMID	ENDOCRINE AND METABOLIC AGENTS - MIS	E29.1 - Testicular hypofunction	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 testosterone cypionate, testosterone enanthate, testosterone gel packet or pump 1% (Androgel equivalent), testosterone gel packet or pump 1.62% (Androgel equivalent), testosterone solution (Axiron equivalent). 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.
15486688	MAYA BADACHHAPE BLEDSOE MD	INTERNAL MEDICINE	SANDOSTATIN LAR DEPOT	ENDOCRINE AND METABOLIC AGENTS - MIS	E22.0 - Acromegaly and pituitary gigantism	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Sandostatin LAR 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.
15487456	CLAYTON WARREN ADAMS MD	ANESTHESIOLOGY	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	G43.909	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 migraines. 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 ibuprofen, naproxen, diclofenac tablet, rizatriptan, sumatriptan, naratriptan, Reyvow, Ubrelvy, and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.
15487470	CRYSTAL MELANIE BOWDEN-MCKAY MD	GASTROENTEROLOGY	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOI	K20.0 - Eosinophilic esophagitis	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole (TRIED), pantoprazole, esomeprazole (TRIED), lansoprazole, and rabeprazole. 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.
15491794	SARAH ALI MD	FAMILY PRACTICE	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.00	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 1, 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15491926	ANNE CLAIRE ADAMS	FAMILY PRACTICE	DICLOFENAC SODIUM	DERMATOLOGICALS	M79.644	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.
15492434	NATHAN WALLACE ANDERSON MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weightloss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

15493221	RUMI AHMED KHAN MD	INTERNAL MEDICINE	AIRSUPRA	ANTIASTHMATIC AND BRONCHODILATOR A	09 - Unspecified asthma, uncomplicated	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are albuterol HFA inhaler (Proair, Proventil equivalent) or Ventolin HFA inhaler. 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.
15500242	CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	FERRETTS	HEMATOPOIETIC AGENTS	Iron deficiency	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 ferrex 150 forte cap, folbee tablets, Multigen Folic tab, Multigen Plus tab, Multigen tab, tricon capsules, and Nephron FA 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.
15503432	CLAYTON WARREN ADAMS MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	Z51.81	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 buprenorphine/naloxone SL film/tablet (SUBOXONE equivalent, Zubsolv. 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.
15506605	ANDREA GEORGE MD	ENDOCRINOLOGY, DIABETES & M	OZEMPIC	ANTIDIABETICS	R73.03-prediabetes	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, OZEMPIC was denied for this reason: 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
15507743	TAMIKA DANIELLE LATTA MD	FAMILY PRACTICE	NOVOLIN N	ANTIDIABETICS	E11.65-type 2 DM	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are HUMULIN N. 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.

15508268	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	QUILLICHEW ER	ADHD/ANTI-NARCOLEPSY	ADHD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. Please note: Extended release capsules can be opened and sprinkled over applesauce and lisdexamfetamine capsules and chewtabs (Vyvanse equivalent) can be opened and dissolved in water. 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
15509948	ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	DICLOFENAC EPOLAMINE	DERMATOLOGICALS	0-Bilateral primary osteoarthritis of knee	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 Bilateral primary osteoarthritis of knee. 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 diclofenac 1% gel (Voltaren equivalent), diclofenac 1.5% solution, and 4 oral nonsteroidal anti-inflammatory drugs (NSAIDs) (eg. ibuprofen(TRIED), 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 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.
15510605	DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEXCOM G6 SENSOR	MEDICAL DEVICES	T2D	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G6 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15510791	DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEXCOM G7 SENSOR	MEDICAL DEVICES	T2D	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G7 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15512168	GREG MICHAEL THAERA MD	NEUROLOGY	OCREVUS	MULTIPLE SCLEROSIS AGENTS	G35 - Multiple sclerosis	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. ocrevus 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.
15512855	JONATHAN ANDREW FIGG MD	INTERNAL MEDICINE	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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)(TRIED), lisdexamfetamine (Vyvanse 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.
15514262	JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	schizophrenia	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Invega Sustenna 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.
15515947	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.01	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.

15518036	LAURELIN NICOLE MULLINS NP	NURSE PRACTITIONER	VENLAFAXINE HYDROCHLORIC	ANTIDEPRESSANTS	sive disorder, single episode, 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 venlafaxine extended release (ER) capsules (Effexor XR equivalent). Please note: there is a previous paid claim for this but more information is needed if this did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 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.
15520102	JONATHAN ANDREW FIGG MD	INTERNAL MEDICINE	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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) (TRIED), and lisdexamfetamine (Vyvanse 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.
15521938	AJAY ZACHARIAH MD	FAMILY PRACTICE	MOUNJARO	ANTIDIABETICS	E66.9	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15522650	RICARDO GARCIA JR MD	FAMILY PRACTICE	SALICYLIC ACID	DERMATOLOGICALS	B07.0 - Plantar wart	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 Compound W and others. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.
15523415	LORIE JUNE KMETZ	NURSE PRACTITIONER	SUBLOCADE	ANALGESICS - OPIOID	F11.21	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Sublocade 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.
15524445	WILLIAM LOUIS HOLCOMB JR MD	PSYCHIATRY	TRINTELLIX	ANTIDEPRESSANTS	F33	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15527294	JENNA GRAY	PHYSICIAN ASSISTANT	TRUE METRIX BLOOD GLUCOS	DIAGNOSTIC PRODUCTS	e 2 diabetes mellitus with hyperglycemia	Not Covered	This product is not on our list of covered products, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered product can be approved. The conditions in our Not Covered Diabetic Glucose Meters and Supplies exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show that your continuous glucose monitor (CGM) has a built-in blood glucose meter. 2) Records did not show that you use the built-in blood glucose meter in your continuous glucose monitor (CGM). 2) All covered blood glucose testing products have not been tried and failed. Other products that can be used are Accu-Chek, Onetouch, and Freestyle test strips meters and supplies. Quantity limits may apply. Please look at the formulary to see what products are covered. Prior authorization may be required and quantity limits may apply to covered products. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this product is not on formulary. An exception to allow coverage of a non-formulary product may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 or 3 of the Not Covered Diabetic Glucose Meters and Supplies exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Member is using an insulin pump and ALL of the following are met: (a) Name of the insulin pump is provided, AND (b) Member's glucose meter has connectivity with the insulin pump, AND (c) Names of the glucose meter and test strips are provided, AND (d) Member uses the connectivity feature; OR 2) Member is using a continuous glucose monitor (CGM) and ALL of the following are met: (a) Name of the CGM is provided, AND (b) Member's CGM has a built-in blood glucose meter, AND (c) Member utilizes the built-in blood glucose meter, AND (d) Test strips name is provided; OR 3) ALL of the covered blood glucose testing products have been tried and failed and names of the products tried and failed are provided. Since criteria have not been met, we are unable to approve coverage for this product at this time. Please refer to the formulary for information on what is covered. Prior
15528607	PHOMMALONE MONE NGUYEN NP	NURSE PRACTITIONER	DEXCOM G6 SENSOR	MEDICAL DEVICES	e11.5	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G6 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.

							Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G6 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.
15528857	PHOMMALONE MONE NGUYEN NP	NURSE PRACTITIONER	DEXCOM G6 SENSOR	MEDICAL DEVICES	E11.5	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15534596	SETH MICHAEL HOLLANDER MD	ALLERGY & IMMUNOLOGY	SPIRIVA RESPIMAT	ANTIASTHMATIC AND BRONCHODILATOR A	severe persistent asthma, uncomplicated	Criteria Not Met	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, Spiriva was denied for these reasons: 1) One of these drugs has not been tried and failed: Advair, Breo Ellipta, Dulera, or Symbicort. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15536062	RAMESH M SINGA MD	ANESTHESIOLOGY	ZTLIDO	DERMATOLOGICALS	ostherpetic nervous system involvement	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lidocaine ointment, gabapentin, amitriptyline, nortriptyline, pregabalin (TRIED), and other formulary alternatives. 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.
15536139	JEFFREY NORMAN HIGGINBOTHAM MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	f11.20	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 trial of 1: buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
15537692	ALLISON ANNE URRUTIA MD	OBSTETRICS & GYNECOLOGY	ORILISSA	ENDOCRINE AND METABOLIC AGENTS - MIS	r10.2	Criteria Not Met	Our prior authorization criteria for Orilissa have not been met. From the records that we have received, Orilissa was denied for these reasons: 1) The drug is not prescribed for pain associated with endometriosis. This is a health issue where tissue that normally grows in the uterus goes into other areas of the body such as the ovaries and fallopian tubes. 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 Orilissa have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Orilissa. 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: Endometriosis OR Cyclic pelvic pain suspected to be related to endometriosis; AND 2) Prescribed by, or in consultation with, an OB/GYN or other women's health/reproductive specialist; AND 3) Member does NOT have known osteoporosis; AND 4) Trials of BOTH of the following classes of medications were ineffective, contraindicated, or not tolerated: (A) Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), AND (B) a hormonal contraceptive. 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
15540643	LESLIE LYNN CAMPBELL-ESCALANTE	PHYSICIAN ASSISTANT	RELISTOR	GASTROINTESTINAL AGENTS - MISC.	K59.03	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 Movantik (TRIED) and Symproic. 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.

15541578	AJAY ZACHARIAH MD	FAMILY PRACTICE	VILAZODONE HYDROCHLORID	ANTIDEPRESSANTS		F32.a Criteria Not Met	Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial of vilazodone. 1) Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, escitalopram, fluoxetine, paroxetine) 2) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafaxine) Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for vilazodone. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of major depressive disorder; AND 2) Member is 18 years of age or older; AND 3) Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 4) Member must try and fail at least 1 serotonin-norepinephrine reuptake inhibitor (SNRI) (duloxetine, venlafaxine). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15544466	JEFFREY WILLIAM CHAMP MD	FAMILY PRACTICE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	with other specified complication (HCC)	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 Lyumjev OR insulin lispro (Humalog equivalent) OR Humalog. 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
15544674	ANDREA GEORGE MD	ENDOCRINOLOGY, DIABETES & M	OZEMPIC	ANTIDIABETICS		R73.03 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
15548913	ELIZABETH HAVEY MILLER MD	DERMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS		L20.9 Criteria Not Met	Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these reasons: 1) The drug is not being used for moderate to severe atopic dermatitis (eczema) that affects at least 10% of body surface area (BSA). 2) More information is needed to know if this drug is being used together with biologic therapy. 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 upadacitinib (RINVOQ) have not been met. From the information we have received, the member does not meet number(s) 4 and 7 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 12 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of moderate to severe atopic dermatitis (eczema); AND 4) Indicate ONE (1) of the following: (A) Greater than or equal to 10% body surface area (BSA) affected and percent BSA is provided OR (B) Less than 10% BSA affected, but member has involvement of sensitive areas (documentation required to be submitted for an approval); AND 5) A medium to very high potency topical steroid AND a topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required to be submitted for an approval); AND 6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentation is required to be submitted for an approval); AND 7) Rinvoq will NOT be used in combination with another targeted immunomodulator product for atopic dermatitis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15549551	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight	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.
15550595	CHRISTOPHER TR PARKER DO	RHEUMATOLOGY	ENBREL	TARGETED IMMUNOMODULATORS	NA	Criteria Not Met	Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reasons: 1) This drug was not prescribed for Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Peripheral Ankylosing Spondylitis, Psoriatic Arthritis, Reactive Arthritis, Ankylosing Spondylitis, OR Plaque Psoriasis. Additional criteria apply for each covered diagnosis. 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 etanercept (ENBREL) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Enbrel. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Peripheral Ankylosing Spondylitis (AS), Psoriatic Arthritis (PsA), Reactive Arthritis, Ankylosing Spondylitis (AS), OR Plaque Psoriasis (PP); AND 2) Additional criteria for covered diagnosis are met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

15555034	KELLY CHAMBLISS WITTE	ADVANCED PRACTICE NURSE	DOXEPIN HYDROCHLORIDE	HYPNOTICS/SEDATIVES/SLEEP DISORDER AC		f51.05	Not Covered
15556134	DAMIAN G LARA MD	FAMILY PRACTICE	UBRELVY	MIGRAINE PRODUCTS		g43.809	Criteria Not Met
15557498	CHRISHANTHI MARY SUSAN PERERA MD	INTERNAL MEDICINE	LEVALBUTEROL TARTRATE HFA	ANTIASTHMATIC AND BRONCHODILATOR A		J30.2	Criteria Not Met
15557822	BETH LEE THAI MD	OBSTETRICS & GYNECOLOGY	LUPRON DEPOT (1-MONTH)	ANTINEOPLASTICS AND ADJUNCTIVE THERA		n80.9	Plan Exclusion
15561008	BRIA MILAN HARRIS PA	PHYSICIAN ASSISTANT	INVOKANA	ANTIDIABETICS	ive diabetic retinopathy without macular		Not Covered
15569294	DAVID CABELL GRAY MD	INTERNAL MEDICINE	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOI		r10.12	Not Covered
15569513	STEVEN ALEXANDER MD	CARDIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories		Plan Exclusion

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are doxepin capsule (Sinequan equivalent), ramelteon, zolpidem, zaleplon, trazodone(TRIED) and 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.

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 TWO (2) triptan drugs (such as zolmitriptan(TRIED), sumatriptan, rizatriptan, or others) did not work for you.
Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs.

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 for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here.
1) The medication is prescribed for a diagnosis of acute migraine treatment AND
2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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.

Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, LEVALBUTEROL TARTRATE HFA was denied for these reasons:
1) VENTOLIN HFA has not been tried and failed.
Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here.
1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested.
Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

This drug is not on our list of covered drugs, also known as our formulary. Lupron 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: Farxiga or Xigduo XR, and Jardiance or Synjardy (XR).
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

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole, pantoprazole(TRIED), rabeprazole, lansoprazole, esomeprazole.
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.

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.

15571256	NEERAJ MANCHANDA MD	NEUROLOGY	AIMOVIG	MIGRAINE PRODUCTS	g43.009	Criteria Not Met	Our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the records that we have received, Aimovig was denied for these reasons: 1) Records did not show you have tried and failed (after using for at least 3 months) other drugs from at least ONE of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.). 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 erenumab (AIMOVIG) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Aimovig. 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 four (4) or more migraine days per month for at least the previous three (3) months; AND 3) 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.); AND 4) Aimovig will NOT be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; OR 5) Aimovig will be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine AND both of the following are met: (A) Member has failed at least three (3) months of individual therapy with Aimovig, AND (B) Member has failed at least three (3) months of individual therapy with botulinumtoxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN). 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
15572972	NATHAN HENRY PEKAR MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	F32.9	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15572974	SAMMY LERMA III MD	FAMILY PRACTICE	BUPRENORPHINE HCL	ANALGESICS - OPIOID	z79.899	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 trial of 1: buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
15573209	HEATHER CAROLYN LENZ PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	L98.8	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
15576835	BRIA MILAN HARRIS PA	PHYSICIAN ASSISTANT	INVOKANA	ANTIDIABETICS	E11.69	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 or Xigduo XR, and Jardiance or Synjardy (XR). 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.
15578133	KUSUMA KANAPARTHI MD	INTERNAL MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories	Plan Exclusion	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 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.

15580067	ANITA SHARAN JESUDASS NP	NURSE PRACTITIONER	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG	G47.00 - Insomnia, 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 ramelteon, zolpidem (TRIED), zaleplon (TRIED), trazodone (TRIED), 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.	
15583834	EMILY DIANE HELMS NP	NURSE PRACTITIONER	BELBUCA	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) 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. 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.	
15591432	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	e66.9	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	
15595607	KAYELEIGH ELIZABETH HIGGERSON	HEMATOLOGY & ONCOLOGY, PE	MIDAZOLAM HCL	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG	F41.9 - Anxiety disorder, 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 midazolam injection. 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.	Yes
15598765	BRAD ERIC VENGHAUS MD	INTERNAL MEDICINE	EVEKEO	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for attention-deficit hyperactivity disorder (ADHD) in an adult. 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 amphetamine/dextroamphetamine tablet (Adderall equivalent) (TRIED), methylphenidate. 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 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.	
15601169	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	
15605330	ANDREA GEORGE MD	ENDOCRINOLOGY, DIABETES & M	OZEMPIC	ANTIDIABETICS	R73.03	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.	
15605583	MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	
15618752	SHELBY ELIZABETH THOMAS PA-C	PHYSICIAN ASSISTANT	DICLOFENAC SODIUM	DERMATOLOGICALS	M13.0	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.	

15621448	VAMSI KRISHNA MD	CARDIOLOGY, INTERVENTIONAL	MOUNJARO	ANTIDIABETICS	R73.03	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, Mounjaro was denied for this reason: 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
15631567	ENRIQUE SPINDEL MD	GASTROENTEROLOGY	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.04 - Chronic idiopathic constipation	Criteria Not Met	Our prior authorization criteria for prucalopride (MOTEGRITY) have not been met. From the records that we have received, Motegrity was denied for these reasons: 1) Records did not show that another drug called Trulance did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for prucalopride (MOTEGRITY) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Motegrity. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC); AND 2) A trial of plecanatide (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.
15634407	KEERTHI VEMULAPALLI MD	PSYCHIATRY	BUPROPION HYDROCHLORIDE	ANTIDEPRESSANTS	F33.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are bupropion XL at a dose of 450 mg (150mg + 300mg OR three 150mg 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.
15637779	KEITH EDWARD CAMPBELL PA-C	PHYSICIAN ASSISTANT	CAPLYTA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.91	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 2 formulary antipsychotic agents (risperidone, aripiprazole, olanzapine, ziprasidone, quetiapine, 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.
15638839	PRATIMA VIJAY KUMAR MD	ENDOCRINOLOGY, DIABETES & M	OZEMPIC	ANTIDIABETICS	e 1 diabetes mellitus with hyperglycemia	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
15649869	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	no dx from prescriber	Incomplete/More Information Needed	A member-initiated request for OZEMPIC was submitted. We did not receive records from your doctor showing what health issue this drug is being used for. We tried to reach your doctor for those records but did not get a reply. All requests must have your doctor provide records and information such as diagnosis, medical history, any appropriate lab test results, and other drugs tried, to support why this drug is needed for your health issue(s). The request has not been approved because the documentation submitted did not provide the clinical information from your doctor. The criteria are listed below.
15651689	CHRISHANTHI MARY SUSAN PERERA MD	INTERNAL MEDICINE	LEVALBUTEROL TARTRATE HFA	ANTIASTHMATIC AND BRONCHODILATOR A	R06.2 - Wheezing	Formulary Alternatives Available	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, levalbuterol was denied for these reasons: 1) VENTOLIN HFA has not been tried and failed. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15652565	VANESSA LYNN MADRID	ADVANCED PRACTICE NURSE	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.9	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 2 formulary antipsychotic agents (risperidone, aripiprazole, olanzapine, ziprasidone, quetiapine, 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.
15658679	JULIE DEAUN GRAVES MD	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	Z20.6	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15664338	CHET ALLEN THARPE JR MD	INTERNAL MEDICINE	DESCOVY	ANTIVIRALS	Z20.6	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15665717	DARSHAN NARENDRA SHAH MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.709	Plan Limits Exceeded	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 fill and 6 fills per year for this use. The higher number of 12 fills per year is not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, Emgality, must be used to help prevent migraine headaches AND information must be provided to show that 10 tablets per fill and 6 fills per year did not work for you. 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.
15669352	KAITLIN NICOLE SISSON PA-C	PHYSICIAN ASSISTANT	FENOFIBRATE	ANTIHYPERLIPIDEMICS	E78.1 - Pure hyperglyceridemia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fenofibrate tablet (Tricor equivalent) (tried), fenofibrate capsule (Lofibra equivalent), fenofibric acid DR capsule (Trilipix equivalent), gemfibrozil, omega-3 acid ethyl ester capsule (Lovaza 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.

15670860	LUKE CONNOR JOHNSON PA-C	PHYSICIAN ASSISTANT	FENOFIBRATE	ANTIHYPERLIPIDEMICS	HLD	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 fenofibrate tablet (Tricor equivalent) (TRIED), fenofibrate capsule (Lofibra equivalent), fenofibric acid DR capsule (Trilipix equivalent), gemfibrozil, omega-3 acid ethyl ester capsule (Lovaza 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.
15672541	LUKE PROCHNOW	PHYSICIAN ASSISTANT	TESTOSTERONE PUMP	ANDROGENS-ANABOLIC	E29.1	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Testosterone gel 1.62% was denied for these reasons: 1) Two low testosterone blood levels have not been sent to us. The labs must be drawn in the morning and must be from two different days. 2) The testosterone blood levels provided were not drawn in the morning. 3) Two low testosterone blood levels, drawn on different days, were not provided. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 4 and 5 of our prior authorization criteria for Testosterone gel 1.62%. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request.
15683881	ALICE DIANE FRIEDMAN MD	GASTROENTEROLOGY	STELARA	TARGETED IMMUNOMODULATORS	K51.0	Criteria Not Met	Our prior authorization criteria for subcutaneous ustekinumab (STELARA SC) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes showing this drug is working well for you were not received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 ustekinumab (STELARA SC) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Stelara. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has a diagnosis of moderately to severely active Ulcerative Colitis (UC); AND 3) Member has demonstrated a significant improvement in their condition; AND 4) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs
15686169	JENNIFER MITCHELL MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	F41.9-anxiety	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix: 1) The drug is not being used for Major Depressive Disorder (MDD). 2) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, did not work for you. 3) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 1, 2, 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since 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.
15700538	LAURA MARIE BRYNESTAD ACNP	ADVANCED PRACTICE NURSE	UBRELVY	MIGRAINE PRODUCTS	G43.909	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 TWO (2) triptan drugs (such as sumatriptan, rizatriptan, or others) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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 for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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

15701464	MICHAEL K FLOYD	UROLOGY	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1-Testicular hypofunction	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1.62% was denied for these reasons: 1) Records do not show you are being monitored by your doctor, that this drug is working well for you, and that you should continue taking 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. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for TESTOSTERONE GEL 1.62%. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0) and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement therapy; AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15707214	SHAGUFTA R LAKHANI FNP-C	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	Chronic pain syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER (tried), 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) (tried), buprenorphine patch (Butrans equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. 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.
15710716	JORGE LUIS ARIZMENDI PA-C	PHYSICIAN ASSISTANT	WEGOVY	ANTI-OBESITY/ANOREXIANTS	R73.03 - Prediabetes	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.
15711586	HANA AUBRECHTOVA MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	Migraine	Criteria Not Met	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these reasons: 1) More information is needed to know if this drug will be used together with a botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be used together with a botulinum toxin product, records must show that you have had at least a three (3) month trial of Ajovy alone AND a three (3) month trial of a botulinum toxin product alone. 2) Records did not show that this drug was previously approved by your prescription drug plan. 3) Records did not show that another drug from at least ONE of the following drug classes did not work for you (after using it for at least 3 months): an anticonvulsant (e.g., topiramate, sodium valproate), a vasoactive agent (e.g., propranolol, metoprolol), or an antidepressant (e.g., amitriptyline, venlafaxine). Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 fremanezumab (AJOVY) have not been met. From the information we have received, the member does not meet number(s) 3 or 4 and 5 of our prior authorization criteria for Ajovy. 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) Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR 4) Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following are met: (A) Member has failed at least three (3) months of individual therapy with Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin); AND 5) If Ajovy 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 Ajovy, AND (B) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three (3) month trial from ONE of the following drug classes: (i) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (ii) vasoactive agent (such as propranolol, metoprolol, etc.), OR (iii) antidepressant (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 on what is covered. Prior authorization
15719589	SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	TRETINOIN	DERMATOLOGICALS	wrinkles	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
15725135	JACQUELINE ROSE KARATHRA MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	) - Male erectile dysfunction, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction (ED). Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15737629	SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	TAVABOROLE	DERMATOLOGICALS	B35.1 - Tinea unguium	Formulary Alternatives Available	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, Tavaborole 5% was denied for these reasons: 1) Ciclopirox nail solution and terbinafine tablets have not been tried and failed. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15737947	KATIE JO DIXON FNP-C	NURSE PRACTITIONER	CARVEDILOL PHOSPHATE ER	BETA BLOCKERS	R00.1 - Bradycardia, 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) This drug is being used for bradycardia (slow heart rate). This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.
15742064	RANI DAS MD	NEUROLOGY	HORIZANT	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	G25.81 - Restless legs syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are gabapentin immediate release (IR) (TRIED), pregabalin, pramipexole (TRIED), ropinirole (TRIED), Neupro patch. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 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.
15744096	JULIENNE CALAMLAM PA-C	PHYSICIAN ASSISTANT	ESTRADIOL	ESTROGENS	Z79.890	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 ¿estradiol oral tablet, Premarin oral tablet, estradiol valerate injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15744150	CRYSTAL MELANIE BOWDEN-MCKAY MD	GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.04	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 plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15746337	JENNIFER MITCHELL MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	MDD	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, did not work for you. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15748540	CARMEN ELENA LANDAVERDE MD	HEPATOLOGY/LIVER MEDICINE	OCALIVA	GASTROINTESTINAL AGENTS - MISC.	primary biliary cholangitis	Criteria Not Met	Our prior authorization criteria for obeticholic acid (Ocaliva) have not been met. From the records that we have received, the following caused the denial of Ocaliva. 1) Records did not show your liver lab tests for Alkaline phosphatase (ALP) were at least 2 times higher than normal levels. 2) Records did not show your liver lab tests for Total bilirubin (TBIL) were at least 2 times higher than normal levels. 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 Ocaliva have not been met. From the information we have received, the member does not meet number 4 of our prior authorization criteria for Ocaliva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Hepatologist or Gastroenterologist; AND 2) Member has a diagnosis of primary biliary cholangitis; AND 3) Member is currently taking and has been using ursodiol at 13-15 mg/kg/day for greater than or equal to 1 year with dates of therapy provided; OR Documentation (chart notes) of intolerance to ursodiol is provided with the request (documentation is required to be submitted for an approval); AND 4) Alkaline phosphatase (ALP) greater than or equal to 2 times the upper limit of normal (ULN); OR (B) Total bilirubin (TBIL) greater than or equal to the upper limit of normal (ULN) is provided with the request (include test date, result & reference range; AND 5) Member does NOT have decompensated liver cirrhosis, a prior decompensation event, or compensated liver cirrhosis with portal hypertension.
15751116	JEFFREY NORMAN HIGGINBOTHAM MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	20 - Opioid dependence, uncomplicated	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are trial of 1 of the following: buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
15752112	MICHELLE LE MARKLEY MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	Z79.890	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1.62% was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism in a male. This is a health issue where the body does not make enough testosterone. 2) More information is needed to know if your low levels of testosterone are age-related. 3) Records did not show you have symptoms of low testosterone. 4) Two low testosterone blood levels have not been sent to us. The labs must be drawn in the morning and must be from two different days. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1,3,4,5 of our prior authorization criteria for TESTOSTERONE GEL 1.62%. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request
15754154	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Other obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15760692	LIDYA TESHOME DO	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.909	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 (TRIED), Ajovy, and Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15761814	RITA IFEANYI CHUKWURAH	NURSE PRACTITIONER	OLMESARTAN MEDOXOMIL/AI	ANTIHYPERTENSIVES	I10 - Essential (primary) hypertension	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 ¿amlodipine/olmesartan(recent claim seen) along with hydrochlorothiazide (HCTZ)(recent claim seen) and angiotensin II receptor blockers (ARBs) combined with HCTZ (losartan/HCTZ, valsartan/HCTZ, olmesartan/HCTZ, irbesartan/HCTZ) along with amlodipine. 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.

15763758	SARAH MICHELLE SEEGER PMHNP	ADVANCED PRACTICE NURSE	L-METHYLFOLATE CALCIUM	DIETARY PRODUCTS/DIETARY MANAGEMEN	Polymorphism	Plan Exclusion	Your request for L-METHYLFOLATE has not been approved because it is a medical food/nutritional product. Based on our Pharmacy and Therapeutics (P&T) Committee policy on the coverage of medical foods/nutritional products, these agents are not covered. Please refer to the formulary for specific information on what is covered. Your doctor or health care provider may be able to suggest other treatment options for your condition.
15766723	VICTORIA IAN CHEN	FAMILY PRACTICE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	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.
15774990	RUMI AHMED KHAN MD	INTERNAL MEDICINE	DYMISTA	NASAL AGENTS - SYSTEMIC AND TOPICAL	R09.82	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 postnasal drip. 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.
15780513	SUJAATA RATNA DWADASI MD	GASTROENTEROLOGY	ZEPOSIA	MULTIPLE SCLEROSIS AGENTS	K51.911	Criteria Not Met	Our prior authorization criteria for ozanimod (ZEPOSIA) have not been met. From the records that we have received, Zeposia was denied for these reasons: 1) Records did not show that at least two of the following drugs did not work for you: an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI), Xeljanz, Rinvoq, Stelara. 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 ozanimod (ZEPOSIA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Zeposia. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Prescribed for a diagnosis of moderately to severely active ulcerative colitis (UC); AND 3) Trials of two (2) of the following were ineffective or not tolerated, or trials of all the following are contraindicated: an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI), tofacitinib (XELJANZ/XELJANZ XR), upadacitinib (RINVOQ), and ustekinumab (STELARA). 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
15787954	GAIL CONDE CREAR MD	INTERNAL MEDICINE	QULIPTA	MIGRAINE PRODUCTS	R51.9 - Headache, 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 Aimovig, Ajovy, and Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15788159	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 28.0-28.9, 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.
15791369	SONIA YOUSUF III MD	RHEUMATOLOGY	SIMPONI	TARGETED IMMUNOMODULATORS	I40.50	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 an adalimumab product (adalimumab-fkjp (Hulio equivalent), adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya, Cimzia (TRIED), Otezla, Orencia, Rinvoq, Skyrizi, Stelara, and 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. 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.
15791815	EMILY NADEZHDA STAHL CNS	CLINICAL NURSE SPECIALIST	UBRELVY	MIGRAINE PRODUCTS	not available	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) The drug is not being used to treat a migraine headache when it happens. This is a severe throbbing headache, often on one side of the head. 2) Records did not show that TWO (2) triptan drugs (such as sumatriptan, rizatriptan, or others) did not work for you. Please note one paid claim exists for sumatriptan but your provider did not say whether or not this worked for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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 numbers 1 and 2 of our prior authorization criteria for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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.

15792046	DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEXCOM G7 SENSOR	MEDICAL DEVICES	ɐ 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G 7 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15793160	AMENZE ANGEL OSA MD	OPHTHALMOLOGY	VYZULTA	OPHTHALMIC AGENTS	H40.1133	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 latanoprost, travoprost (Travatan Z equivalent), tafluprost (Zioptan equivalent) and bimatoprost (Lumigan 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.
15795451	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	BASAGLAR KWIKPEN	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin glargine-yfgn OR Semglee, Levemir, Toujeo, Tresiba. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
15798478	LAURELIN NICOLE MULLINS NP	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	G43.909	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy and Zavzpret. 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.
15806706	VANESSA LYNN MADRID	ADVANCED PRACTICE NURSE	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.9-Bipolar disorder, 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 2 formulary antipsychotic agents (risperidone, aripiprazole, olanzapine, ziprasidone, quetiapine, 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.

15809909	MARIA ROSE BONTRAGER	OPTOMETRIST	OXERVATE	OPHTHALMIC AGENTS	h16.223	Criteria Not Met	Our prior authorization criteria for Oxervate have not been met. From the records that we have received, the following caused the denial of Oxervate. 1) The drug is not prescribed by an Ophthalmologist. 2) The drug is not being used for stage 2 or stage 3 neurotrophic keratitis, a disease that causes damage to the trigeminal nerve and a part of the eye called the cornea. 3) Chart notes showing which eye is affected have not been received. 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 Oxervate have not been met. From the information we have received, the member does not meet number 1, 2, and 5 of our prior authorization criteria for Oxervate. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by an Ophthalmologist; AND 2) Member has a diagnosis of stage 2 or stage 3 neurotrophic keratitis; AND 3) A trial of preservative-free artificial tears was ineffective; AND 4) Member has not received previous treatment with Oxervate in the affected eye(s). 5) Documentation of affected eye(s) is provided with the 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.
15812798	GERMAN ECHEVERRY MD	ANESTHESIOLOGY	ZEPBOUND	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.
15814452	ANDREW ALAN COLLINS MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.009	Plan Limits Exceeded	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 with 6 fills per year for this use. The higher number of 16 tablets per 30 days is not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, Emgality, must be used to help prevent migraine headaches AND information must be provided to show that 10 tablets per 30 days with 6 fills per year did not work for you. 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.
15815308	PATRICK CHRISTOPHER NOLAN MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	ı, 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, Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15816851	MEREDITH LEAH COOK	PHYSICIAN ASSISTANT	IQIRVO	GASTROINTESTINAL AGENTS - MISC.	k74.8	Not Covered	The Navitus Pharmacy and Therapeutics (P&T) Committee has not yet reviewed Iqirvo for this health issue. Our Coverage Determinations - Exceptions policy is used to decide if a drug awaiting P&T review 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 Ocaliva. 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 the Navitus Pharmacy and Therapeutics (P&T) Committee has not yet reviewed Iqirvo for this indication. An exception to allow coverage of a drug awaiting P&T review 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.
15818858	CLAIRE KYLANDER	NURSE PRACTITIONER	INTRAROSA	VAGINAL AND RELATED PRODUCTS	N95.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol vaginal tablets, estradiol cream (Estrace equivalent - TRIED), Premarin vaginal cream and Estring. 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.

15819734	LUKE PROCHNOW	PHYSICIAN ASSISTANT	TESTOSTERONE PUMP	ANDROGENS-ANABOLIC	E29.1	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1.62% PUMP was denied for these reasons: 1) Two low testosterone blood levels have not been sent to us. The labs must be drawn in the morning and must be from two different days. 2) The testosterone blood levels provided were not drawn in the morning. 3) Two low testosterone blood levels, drawn on different days, were not provided. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 4 and 5 of our prior authorization criteria for TESTOSTERONE GEL 1.62% PUMP. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request.
15826733	KATIE LEAGH LAM PA	PHYSICIAN ASSISTANT	ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	e78.1	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our icosapent exception policy have not been met. From the records that we have received, the following caused the denial. 1) This drug is not being used together with diet changes in an adult with high triglyceride levels over 500mg/dL. Triglycerides are a type of fat found in the blood. 2) Records did not show a recent triglyceride level. Triglycerides are a type of fat found in the blood. 3) Records did not show that the following drugs did not work for you or that there are clinical reasons why they cannot be used: omega-3 acid ethyl ester capsule (Lovaza equivalent), one statin (atorvastatin - TRIED), one fibrate (e.g. fenofibrate), niacin ER (Niaspan ER equivalent) and brand name Vascepa. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the icosapent 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 as an adjunct to diet to reduce triglycerides in an adult member with severe hypertriglyceridemia (triglycerides over 500mg/dL). Recent triglyceride levels must be submitted with the request; AND 2) All of the following drugs have been tried and failed: omega-3 acid ethyl ester capsule (Lovaza equivalent), one statin (e.g. rosuvastatin), one fibrate (e.g. fenofibrate), niacin ER (Niaspan ER equivalent) and brand name Vascepa.
15826853	PATRICK CHRISTOPHER NOLAN MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	ı, 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. 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.
15830388	MICHELLE ROSE MEYSTEDT	PHYSICIAN ASSISTANT	UBRELVY	MIGRAINE PRODUCTS	g43.109	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 TWO (2) triptan drugs (such as sumatriptan, rizatriptan, or others) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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 for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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.
15834339	MICHAEL SIK SHIN	EMERGENCY MEDICINE	DESCOVY	ANTIVIRALS	z20.6	Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show you experienced a severe side effect after taking a drug called Truvada for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15835061	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	COMBIPATCH	ESTROGENS	Menopausal and female climacteric states	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol/norethindrone tablet (Activella equivalent), jinteli tablet (Femhrt equivalent), Prempha se/Prempro tablet, and other estrogen combination products (i.e. an estrogen + progestin). 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.
15835931	DARSHAN NARENDRA SHAH MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	G43.709	Criteria Not Met	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these reasons: 1) More information is needed to know if this drug will be used together with a botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be used together with a botulinum toxin product, records must show that you have had at least a three (3) month trial of Ajovy alone AND a three (3) month trial of a botulinum toxin product alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 fremanezumab (AJOVY) have not been met. From the information we have received, the member does not meet number(s) 4 or 5 of our prior authorization criteria for Ajovy. 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 had four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (A) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (B) vasoactive agent (such as propranolol, metoprolol, etc.), OR (C) antidepressant (such as amitriptyline, venlafaxine, etc.); AND 4) Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR 5) Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following are met: (A) Member has failed at least three (3) months of individual therapy with Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin). 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.
15839925	ARJUN MOHANDAS MD	INTERNAL MEDICINE	AIRSUPRA	ANTIASTHMATIC AND BRONCHODILATOR A	Lobar pneumonia, unspecified organism	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 pneumonia. 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 albuterol HFA inhaler (Proair, Proventil equivalent) or Ventolin HFA inhaler. 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 numbers 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.
15840880	NAWALAGE RAVI NAYANADUL COORAY I	FAMILY PRACTICE	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	R51.9	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) This drug is being used for unspecified headaches. 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 ibuprofen, naproxen, diclofenac tablet, rizatriptan, sumatriptan, naratriptan, Reyvow, Ubrelvy, Zavzpret and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.
15843244	CHRISTOPHER GLENN SEEKER MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS	Z79.890	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 ¿estradiol oral tablet, Premarin oral tablet, estradiol valerate injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

15843444	LAWRENCE TSAI MD	UROLOGY	ANDROGEL	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, ANDROGEL was denied for these reasons: 1) The testosterone blood levels provided were not drawn in the morning. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for ANDROGEL. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request.
15845833	STEVEN ANDREW MCDONALD MD	EMERGENCY MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for 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.
15847093	KOREN DINGEMAN WESTON MD	INTERNAL MEDICINE	NURTEC	MIGRAINE PRODUCTS	g43.909	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy and Zavzpret. 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.
15850671	RAMESH M SINGA MD	ANESTHESIOLOGY	NURTEC	MIGRAINE PRODUCTS	G43.909	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, Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15851590	DAVID DEE WEEKS MD	INTERNAL MEDICINE	XIFAXAN	ANTI-INFECTIVE AGENTS - MISC.	R19.7 - Diarrhea, unspecified	Plan Limits Exceeded	The requested amount of Xifaxan 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 Xifaxan at 60 tablets per 30 days for this use. The higher amount of 42 tablets per 14 days is not covered by your plan without more information about your diagnosis. Please look at the list of covered drugs, also known as our formulary, to see what is covered.
15853181	MARTIN CASTILLO PA-C	PHYSICIAN ASSISTANT	RELISTOR	GASTROINTESTINAL AGENTS - MISC.	K59.00-Constipation, 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 Movantik (TRIED) and Symproic. 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.
15854027	HARINDER PREET KAUR MD	FAMILY PRACTICE	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.09	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15858631	LEIGHA ANA SHARP MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L21.8-Other seborrheic dermatitis	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) This drug is not being used for ongoing (chronic) plaque psoriasis. Plaque psoriasis is a health issue where skin cells build up and form itchy, dry patches and scales. 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) 2 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 6 years of age or older; AND 4) Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis; AND 5) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15859650	SARA JANE PAVITT MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.709	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. 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.	
15865808	JENNIFER MITCHELL MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	depressive disorder, recurrent, moderate	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine, did not work for you. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	Yes
15865853	HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczema	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records did not show that at least 10% of your body surface area (BSA) is affected by your health issue. 2) Records did not show that sensitive areas of your body are affected by your health issue. 3) More information is needed to know if this drug is being used together with another immunomodulator drug for your health issue. Immunomodulator drugs help your body respond more appropriately to decrease swelling and itching. 4) Chart notes showing details of your health issue, such as how much of your body is affected and what other treatments you have tried, were not received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 3 and 5 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval); (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.	Yes
15866261	JOSHUA LAMAR MCKAY MD	CARDIOLOGY, INTERVENTIONAL	ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	coronary artery without angina pectoris	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our ICOSAPENT exception policy have not been met. From the records that we have received, the following caused the denial. 1) Records did not show that the following drugs did not work for you or that there are clinical reasons why they cannot be used: omega-3 acid ethyl ester capsule (Lovaza equivalent), one fibrate (e.g. fenofibrate), niacin ER (Niaspan ER equivalent) and Vascepa. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 of the ICOSAPENT 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 cardiovascular risk reduction in an adult member with persistent triglycerides over 150 mg/dL (recent triglyceride levels must be submitted with the request); AND (A) Member has a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) OR a diagnosis of diabetes with 2 additional cardiovascular risk factors; AND (B) Member is receiving concurrent treatment with a maximally tolerated statin; AND 2) All of the following drugs have been tried and failed: omega-3 acid ethyl ester capsule (Lovaza equivalent), one fibrate (e.g. fenofibrate), niacin ER (Niaspan ER equivalent) and Vascepa.	

15867383	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	WEGOVY	ANTI-OBESITY/ANOREXIANTS	09 - Other obesity due to excess calories	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.
15867485	BRIAN JAY SHIMKUS MD	HEMATOLOGY & ONCOLOGY	LUPRON DEPOT (1-MONTH)	ANTINEOPLASTICS AND ADJUNCTIVE THERA	C61	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. LUPRON DEPOT (1-MONTH) 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.
15868401	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	isorder, predominantly hyperactive type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: dexmethylphenidate extended release (ER) (TRIED), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. 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.
15869903	BRIAN JAY SHIMKUS MD	HEMATOLOGY & ONCOLOGY	ERLEADA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	mCSPC	Criteria Not Met	Our prior authorization criteria for Erleada have not been met. From the records that we have received, the following caused the denial of Erleada: 1) Abiraterone (Zytiga) has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Erleada have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Erleada. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncology Specialist; AND 2) Prescribed for a diagnosis of non-metastatic castration-resistant prostate cancer (non-mCRPC) and prostate-surface antigen doubling-time (PSADT) is less than or equal to 10 months; OR 3) Prescribed for a diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) and a trial of abiraterone (Zytiga) 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.
15871276	GEOFFREY FULTON HUGHES NP	NURSE PRACTITIONER	CLOMID	ENDOCRINE AND METABOLIC AGENTS - MIS	-	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 an unknown diagnosis. 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.
15874046	JORDAN DAVID HARTMAN MD	FAMILY PRACTICE	BASAGLAR KWIKPEN	ANTIDIABETICS	betes mellitus with hyperglycemia (HCC)	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 SEMGLEE INJ, INSULIN GLARGINE-YFGN INJECTION (NDCs Covered: 49502025080, 83257001111) Levemir (TRIED), Toujeo, and Tresiba. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15876574	BRIAN JAY SHIMKUS MD	HEMATOLOGY & ONCOLOGY	GAMMAGARD LIQUID	PASSIVE IMMUNIZING AND TREATMENT AG	variable immunodeficiency, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. GAMMAGARD 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.
15880462	STEVEN ANDREW MCDONALD MD	EMERGENCY MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weightloss . Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

15885117	RICKY CHANDRA MEHTA	RHEUMATOLOGY	AZATHIOPRINE	MISCELLANEOUS THERAPEUTIC CLASSES	D86.9 - Sarcoidosis, 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 methotrexate, azathioprine 50mg (can take 2 tablets for 100mg), leflunomide, and mycophenolate mofetil. 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.
15885529	KUSUMA KANAPARTHI MD	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15885692	SHUBHADA SHRIKANT SHRIKHANDE MD	HEMATOLOGY & ONCOLOGY	GRANISETRON HYDROCHLORI	ANTIEMETICS	R11.0 - Nausea	Plan Limits Exceeded	The requested amount of GRANISETRON 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 GRANISETRON at 14 tablets per fill for this use. The higher amount of 20 tablets per fill is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.
15887876	CASEY EDWARD COTON DO	PSYCHIATRY	QELBREE	ADHD/ANTI-NARCOLEPSY	340 - Attention and concentration deficit	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 atomoxetine (TRIED) and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or lisdexamfetamine (Vyvanse 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.
15891574	ANUJA KHUNTI DO	FAMILY PRACTICE	FERROCITE PLUS	HEMATOPOIETIC AGENTS	R53.83 - Other fatigue	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 ferrex 150 forte capsule, folbee tablets, iron polysacch/threonic acid/b12/FA cap, ferrex 28 tablets, 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.
15897252	FARHEEN YOUSUF MD	ENDOCRINOLOGY, DIABETES & M	NOVOLOG FLEXPEN	ANTIDIABETICS	e 2 diabetes mellitus with hyperglycemia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR insulin lispro (Humalog equivalent) OR Humalog. 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
15898196	DAWN DESIMONE PA-C	PHYSICIAN ASSISTANT	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) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are trial of 1: buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
15898242	STEVEN ANDREW MCDONALD MD	EMERGENCY MEDICINE	ZEPBOUND	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.

15903005	EMILY NADEZHDA STAHL CNS	CLINICAL NURSE SPECIALIST	UBRELVY	MIGRAINE PRODUCTS	g43.709	Plan Limits Exceeded	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 and 6 fills per year for this use. The higher number of 16 tablets per 30 days is not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, or Emgality, must be used to help prevent migraine headaches AND information must be provided to show that 10 tablets per 30 days and 6 fills per year did not work for you. 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.	
15905364	BRENT ALAN PORTER MD	INTERNAL MEDICINE	QULIPTA	MIGRAINE PRODUCTS	g43.909	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 the acute treatment of migraines. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Other drugs that can be used for migraine prevention are Aimovig, Ajovy, and Emgality. Other drugs that can be used for acute migraine treatment are Reyvow, Ubrelvy and Zavzpret. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.	
15906665	IRIS SOFIA WINGROVE MD	NEUROLOGY	AUSTEDO	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	g24.01	Criteria Not Met	Our prior authorization criteria for deutetrabenazine (AUSTEDO, AUSTEDO XR) have not been met. From the records that we have received, Austedo (XR) was denied for these reasons: 1) Records did not show that your health issue is causing functional disability for you. More information is needed to show how your health issue is impacting you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for deutetrabenazine (AUSTEDO, AUSTEDO XR) have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Austedo (XR). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with a Psychiatrist or Neurologist; AND 2) Member has a diagnosis of tardive dyskinesia; AND 3) Member has a functional disability due to tardive dyskinesia; AND 4) Member has failed to respond to a change or is unable to switch current antidopaminergic therapy.	Yes
15913412	VAMSI KRISHNA MD	CARDIOLOGY, INTERVENTIONAL	ARCALYST	TARGETED IMMUNOMODULATORS	-Acute nonspecific idiopathic pericarditis	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 colchicine, one glucocorticoid (such as prednisone), and one nonsteroidal anti-inflammatory drug (NSAID) (such as ibuprofen, indomethacin, aspirin). 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.	
15915255	ALLISON LEIGH ANDERSON MD	OBSTETRICS & GYNECOLOGY	MIRABEGRON ER	URINARY ANTISPASMODICS	R35.0 - Frequency of micturition	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 brand name 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.	
15916979	DANIEL ANTHONY CARRASCO MD	DERMATOLOGY	TREMFYA	TARGETED IMMUNOMODULATORS	l40.0	Plan Exclusion	Tremfya is being 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. Please note: all doses so far have been administered by a health care provider. If it will be self-administered moving forward, we need documentation showing this as well as chart notes that document if there is been significant improvement.	Yes

15917007	ESTHER MELAMED MD PHD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	migraine	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy, and Zavzpret. 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.
15918291	RACHEL OLIVIA TAYLOR MCLEOD FNP-C	NURSE PRACTITIONER	ADDYI	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	F52.0 - Hypoactive sexual desire disorder	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.
15926141	KRISTINA KAY BURTON FNP	NURSE PRACTITIONER	XELJANZ	TARGETED IMMUNOMODULATORS	K51.90	Criteria Not Met	Our prior authorization criteria for tofacitinib (XELJANZ) have not been met. From the records that we have received, Xeljanz was denied for these reasons: 1) Records did not show that another drug called an adalimumab product (adalimumab-aaty, adalimumab-adaz, adalimumab-fkjp, Hadlima, Simlandi) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for tofacitinib (XELJANZ) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Xeljanz. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has a diagnosis of moderately to severely active Ulcerative Colitis (UC); AND 3) A trial of an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI) 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.
15929202	ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	E34.9	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone 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 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for testosterone. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0) and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement therapy; AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15935706	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	DEXCOM G7 SENSOR	MEDICAL DEVICES	E11.65	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G7 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15936200	DAVID CABELL GRAY MD	INTERNAL MEDICINE	MOUNJARO	ANTIDIABETICS	E66.09	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15937348	KEVIN BRIAN BROWNE MD	OTOLARYNGOLOGY	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J33.9 - Nasal polyp, 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 budesonide nasal spray (RHINOCORT AQUA equivalent), fluticasone nasal spray (FLONASE equivalent) (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

15939289	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	FREESTYLE LIBRE 3/SENSOR/	MEDICAL DEVICES	E11.65	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Freestyle Libre was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15946440	DONALD ROBERT BRODE MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	N52.9	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15948393	DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES & M	H-E-B IN CONTROL PEN NEED	MEDICAL DEVICES	DM2	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 B-D Pen needles, Novofine Pen needles, B-D insulin syringes. 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
15949505	RANDY WAYNE BRYSON NP	NURSE PRACTITIONER	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) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
15950797	BRENT ALAN PORTER MD	INTERNAL MEDICINE	NURTEC	MIGRAINE PRODUCTS	t 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 Reyvow, Ubrelvy and Zavzpret. 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.
15954121	CRYSTAL MELANIE BOWDEN-MCKAY MD	GASTROENTEROLOGY	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOI	GERD	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 omeprazole (TRIED), pantoprazole, rabeprazole, lansoprazole, esomeprazole (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15955366	SRILAKSHMI VALLABHANENI MD	CARDIOLOGY	OZEMPIC	ANTIDIABETICS	obesity	Plan Exclusion	This request cannot be approved because this drug is being used for Obesity (Weight Loss). Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15956661	RAMESH M SINGA MD	ANESTHESIOLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.909	Plan Limits Exceeded	The requested amount of Nurtec is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Nurtec at 10 tablets per 30 days wth 6 fills per year for this use. The higher number of 16 tablets every 30 days is not a covered amount of this drug per your plan. Covered drugs that may be used for migraine prevention are Aimovig, Ajovy, and Emgality. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Prior authorization and quantity limits may apply to covered drugs.

15958592	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	QUVIVIQ	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG	G47.00	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ramelteon, zolpidem, zaleplon, trazodone (tried), 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
15965402	JOE THANH NGUYEN MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	n52.9	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
15966717	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	DEXCOM G7 SENSOR	MEDICAL DEVICES	e 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G7 sensors was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
15967962	RITA IFEANYI CHUKWURAH	NURSE PRACTITIONER	LINZESS	GASTROINTESTINAL AGENTS - MISC.	table bowel syndrome with constipation	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 3,4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15968692	SAPNA RANI BHAGAT MD	OBSTETRICS & GYNECOLOGY	IMVEXXY MAINTENANCE PACK	VAGINAL AND RELATED PRODUCTS	n95.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol vaginal tablets (Yuvafem, Vagifem equivalents), estradiol cream (Estrace equivalent) (TRIED), Premarin vaginal cream, and Estring. 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.
15969570	MIREYA ADAME APRN	NURSE PRACTITIONER	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	MDD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show aripiprazole (Abilify equivalent) did not work for you. 2) Records did not show that another drug called quetiapine OR olanzapine used with an antidepressant medication did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 and 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND 5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication.

15971916	ELISABETH RUTH BLANK	NURSE PRACTITIONER	AZELASTINE HYDROCHLORIDE	NASAL AGENTS - SYSTEMIC AND TOPICAL	r09.81	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 ¿nasal antihistamines (azelastine 0.1% (Astelin equivalent), azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua equivalent), fluticasone (Flonase equivalent), triamcinolone (Nasacort equivalent), flunisolide). 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.	
15974663	LIDYA TESHOME DO	NEUROLOGY	EMGALITY	MIGRAINE PRODUCTS	g43.909	Criteria Not Met	Our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the records that we have received, Emgality 120mg was denied for these reasons: 1) Records show Emgality will be used together with a botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) but do not show you have had at least a three (3) month trial of Emgality alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Member has four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.); AND 4) Emgality will NOT be used concomitantly with a botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) for chronic migraine; OR 5) Emgality will be used concomitantly with a botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) 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 a botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN)	Yes
15980330	ELISABETH ANNE CLAYTON MD	ALLERGY & IMMUNOLOGY	AZELASTINE HYDROCHLORIDE	NASAL AGENTS - SYSTEMIC AND TOPICAL	j30.89	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 ¿nasal antihistamines (azelastine 0.1% (Astelin equivalent), azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua equivalent), fluticasone (Flonase equivalent), triamcinolone (Nasacort equivalent), flunisolide). 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.	
15985999	MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, test was denied for these reasons: 1) More information is needed to know if your low levels of testosterone are age-related. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for test. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15990481	LIAM MCCOMB	PHYSICIAN ASSISTANT	LINEZOLID	ANTI-INFECTIVE AGENTS - MISC.	L03.116	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 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	

15994240	MELISSA RENEE GABRIELLI	NURSE PRACTITIONER	AUVELITY	ANTIDEPRESSANTS	MDD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are bupropion extended-release (XL), AND one serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g. desvenlafaxine extended release (ER) (Pristiq equivalent), venlafaxine, duloxetine), AND two selective serotonin reuptake inhibitors (SSRI) (e.g. sertraline, citalopram, paroxetine, fluoxetine, escitalopram). 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.
15996074	MICHAEL ALAN FULLER MD	PSYCHIATRY	BUPROPION HYDROCHLORIDE	ANTIDEPRESSANTS	f31.9	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 bupropion XL at a dose of 450 mg (150mg + 300mg OR three 150mg 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.
15998093	PATRICIA SHEA RODRIGUEZ NP	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	R73.03	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
16000529	MARYANN CECELIA GAMBLE	FAMILY PRACTICE	FINASTERIDE	DERMATOLOGICALS	.65.9 - Nonscarring hair loss, 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.
16002601	DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES & M	H-E-B IN CONTROL PEN NEED	MEDICAL DEVICES	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are B-D Pen needles, Novofine Pen needles, B-D insulin syringes. 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
16004565	ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	BASAGLAR KWIKPEN	ANTIDIABETICS	E11.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin glargine-yfgn (TRIED), Levemir, Toujeo, Tresiba. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
16006483	ANDREW ALAN COLLINS MD	NEUROLOGY	BOTOX	NEUROMUSCULAR AGENTS	t intractable, without status migrainosus	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. BOTOX is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.

							Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons: 1) Records did not show that taking one of the following over-the-counter (OTC) drugs for one month did not work for you: stimulants (e.g., bisacodyl, sennosides), or PEG 3350 (e.g., Miralax), or bulk-forming laxatives (e.g., Metamucil, Citrucel, Fibercon). 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.
16013371	RITA IFEANYI CHUKWURAH	NURSE PRACTITIONER	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.		IBS-C	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon). 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
16015375	CLAIRE KYLANDER	NURSE PRACTITIONER	INTRAROSA	VAGINAL AND RELATED PRODUCTS	enopausal and perimenopausal disorder		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: estradiol vaginal tablets, estradiol cream (Estrace equivalent), Premarin vaginal cream and Estring. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16029138	GREG LOUIS WESTMORELAND MD	SURGERY, ORTHOPEDIC	HYMOVIS	MUSCULOSKELETAL THERAPY AGENTS		M17.11	Plan Exclusion	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.
16032432	STACIA CHRISTINE MILES MD	DERMATOLOGY	ADAPALENE	DERMATOLOGICALS	81.4 - Other melanin hyperpigmentation		Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. HYMOVIS 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 request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
16036027	COURTNEY SHAWN KYLE PA-C	PHYSICIAN ASSISTANT	UBRELVY	MIGRAINE PRODUCTS	t intractable, without status migrainosus		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 TWO (2) triptan drugs (such as sumatriptan, rizatriptan, or others) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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 for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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.
16043171	AGEZI CHINWE IGBOKO	NURSE PRACTITIONER	WINLEVI	DERMATOLOGICALS	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 (We show a recent paid claim. More information is needed if this does not work for you.), adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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.
16045779	CLAIRE MCDONOUGH PMHNPBC	ADVANCED PRACTICE NURSE	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS		F33.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show aripiprazole (Abilify equivalent) did not work for you. 2) Records did not show that your current antidepressant treatment is not helping enough for you. 3) Records did not show at least TWO (2) or more antidepressant drugs did not work for you. (e.g. escitalopram, fluoxetine, sertraline, venlafaxine, or others) 4) Records did not show that another drug called quetiapine OR olanzapine used with an antidepressant medication did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2, 3, 4 and 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND 5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication.

16046697	MOLLY THOMPSON CAMPA	DERMATOLOGY	STELARA	TARGETED IMMUNOMODULATORS	PP Criteria Not Met	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) Records show that you may not be able to use light therapy, methotrexate, or acitretin, but more information is needed to show why these treatments are not right for you. 2) Chart notes were not sent to us to show the details of your health issue and how you responded to previous treatments. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ustekinumab (STELARA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Stelara for Plaque Psoriasis (Initial Coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin; AND 4) If the 90mg dose is requested, member's weight is greater than 100kg and is provided with the request. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	Yes
16051212	RENE BADILLO II	PHYSICIAN ASSISTANT	KAPSPARGO SPRINKLE	BETA BLOCKERS	palpitations 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 acebutolol, atenolol, betaxolol, bisoprolol, metoprolol, and nebivolol. 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.	
16053415	TAMILSELVI PERIASAMY MD	INTERNAL MEDICINE	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR A structive pulmonary disease, unspecified Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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. 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.	
16053449	FEROZ OSMANI MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	low back 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) This drug is being used for low back pain. 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 immediate release (IR), oxycodone (currently taking), oxycodone/acetaminophen, hydrocodone/acetaminophen, hydromorphone, tramadol. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 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.	

16054684	ELIZABETH HAVEY MILLER MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	L20.9	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records did not show that at least TWO (2) of the following treatments did not work for you: topical steroids (such as betamethasone) (TRIED), topical calcineurin inhibitors (such as tacrolimus or pimecrolimus), light therapy, azathioprine, cyclosporine, methotrexate, and mycophenolate mofetil. 2) More information is needed to know if this drug is being used together with another immunomodulator drug for your health issue. Immunomodulator drugs help your body respond more appropriately to decrease swelling and itching. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval); (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.		
16054839	CHERYL ANN JOHNSTON PA	PHYSICIAN ASSISTANT	SOLOSEC	AMEBICIDES	Acute vaginitis	Criteria Not Met	Our prior authorization criteria for secnidazole (SOLOSEC) have not been met. From the records that we have received, Solosec was denied for these reasons: 1) Records did not show that your health issue meets three (3) of the four (4) Amsel's criteria. These are signs or symptoms that help your doctor identify your health issue, such as white discharge on the vaginal walls (confirmed), more than 20% cue cells, vaginal fluid pH level greater than 4.5, and fishy odor (confirmed). 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 secnidazole (SOLOSEC) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Solosec. The reason for denial is explained to the member above. The criteria are listed here. 1) The drug is prescribed for the treatment of a woman with bacterial vaginosis as determined by THREE (3) of the FOUR (4) Amsel's Criteria: (A) Homogeneous, thin, white discharge that smoothly coats the vaginal walls; (B) More than 20% cue cells (e.g., vaginal epithelial cells studded with adherent coccobacilli) on microscopic examination; (C) pH of vaginal fluid greater than 4.5; (D) A fishy odor of vaginal discharge before or after addition of 10% potassium hydroxide (KOH) (i.e., the whiff test); AND 2) Member has experienced greater than or equal to 3 episodes in the past year; AND 3) Trials of TWO (2) of the following were ineffective, contraindicated, or not tolerated: metronidazole, clindamycin, tinidazole. 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.		
16070030	SUJAATA RATNA DWADASI 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) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 1, 3, and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization		
16070331	ANUREKHA BONGU CHADHA MD	RHEUMATOLOGY	GAMMAGARD LIQUID	PASSIVE IMMUNIZING AND TREATMENT AG	M33.20	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. GAMMAGARD 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.	Yes	
16075147	RACHEL ELIZABETH DOCKRAY PA-C	PHYSICIAN ASSISTANT	TESTOSTERONE	ANDROGENS-ANABOLIC	1° male hypogonadism	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone gel 1.62% was denied for these reasons: 1) More information is needed to know if your low levels of testosterone are age-related. 2) Two low testosterone blood levels have not been sent to us. The labs must be drawn in the morning and must be from two different days. 3) Two low testosterone blood levels, drawn on different days, were not provided. 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 2, 4, & 5 of our prior authorization criteria for testosterone gel 1.62%. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request.		

16076139	CLAYTON WARREN ADAMS MD	ANESTHESIOLOGY	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	t 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) This drug is being used for migraines. 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: ibuprofen, naproxen, diclofenac tablet, rizatriptan, sumatriptan, naratriptan, Reyvow, Ubrelvy, Zavzpret and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.
16078070	ISELA ARRIETA WERCHAN MD	PSYCHIATRY	LUCEMYRA	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	opioid withdrawal	Criteria Not Met	Our prior authorization criteria for Lucemyra have not been met. From the records that we have received, the following caused the denial of Lucemyra: 1) You have not tried and failed clonidine during the current opioid withdrawal attempt. 2) The drug was not prescribed as a continuation of inpatient facility treatment. 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 Lucemyra have not been met. From the information we have received, the member does not meet 3 or 4 of our prior authorization criteria for Lucemyra. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has diagnosis of mitigation of opioid withdrawal symptoms, AND 2) Prescribed by, or in consultation with, a physician specializing in pain management or addiction treatment, AND 3) Trial and failure of clonidine due to lack of efficacy or intolerable adverse effects for the current opioid withdrawal attempt, OR 4) Member has been prescribed this medication as a continuation of inpatient facility treatment for the completion of a total up to 7 days of treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16080933	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	R73.03	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
16084862	NAWALAGE RAVI NAYANADUL COORAY I	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	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.
16087764	JAMES LUDWIG WISE MD	GASTROENTEROLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	Ulcerative Colitis (UC)	Criteria Not Met	Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these reasons: 1) Records did not show that an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI, HUMIRA) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has a diagnosis of moderately to severely active Ulcerative Colitis (UC); AND 3) Member had a trial an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI, HUMIRA) that 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.
16091895	HALEY NGUYEN OD	OPTOMETRIST	TAFLUPROST	OPHTHALMIC AGENTS	H40.1131	Criteria Not Met	Our prior authorization criteria for Ophthalmic Prostaglandins have not been met. From the records that we have received, tafluprost (Zioptan equivalent) was denied for these reasons: 1) Records did not show that other drugs called bimatoprost, latanoprost (TRIED), and travoprost eye drops did not work for you. 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 Ophthalmic Prostaglandins have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for tafluprost (Zioptan equivalent). The reason for denial is explained to the member above. The criteria are listed here. 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latanoprost ophthalmic solution; AND (C) travoprost ophthalmic solution (TRAVATAN Z). 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
16093998	SAMI MOHAMAD ABOUMATAR MD	NEUROLOGY	FYCOMPA	ANTICONVULSANTS	epilepsy and epileptic syndromes with se	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: topiramate and lacosamide (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.

16094181	AGEZI CHINWE IGBOKO	NURSE PRACTITIONER	WINLEVI	DERMATOLOGICALS	L70.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All 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 (tried), adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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
16096235	PATIENCE HARRIET READING MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.011	Plan Limits Exceeded	The requested amount of Ubrelvy is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Ubrelvy at 10 tablets per 30 days, 6 fills per year for this use. The higher number of more than 6 fills per year is not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Emgality, Ajovy, must be used to help prevent migraine headaches AND information must be provided to show that 10 tablets per 30 days, 6 fills per year did not work for you. 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.
16098414	JOSEPH EDWARD GARCIA MD	SURGERY, GENERAL	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.09	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 1, 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16106902	STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	LOPERAMIDE HYDROCHLORID	ANTIDIARRHEAL/PROBIOTIC AGENTS	K58.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are diphenoxylate/atropine (Lomotil equivalent), Motofen, opium tincture. 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.
16111799	KIMBERLY MICHELLE CATAHAN NP	NURSE PRACTITIONER	SKYRIZI	TARGETED IMMUNOMODULATORS	K51.90	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 an adalimumab product (adalimumab-adaz (Hyrimoz equivalent), adalimumab-fkjp (Hulio equivalent), adalimumab-aaty (Yuflyma equivalent), Hadlima, Humira, Simlandi), Stelara, Rinvoq, Simponi, 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. 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.
16112255	SUJAATA RATNA DWADASI MD	GASTROENTEROLOGY	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	Constipation, unspecified	Criteria Not Met	Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induced constipation (OIC). These are specific health issues that make it difficult to have a bowel movement. 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 lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3 of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon). 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

16113798	ELIZABETH HAVEY MILLER MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	Atopic Dermatitis	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records did not show that at least TWO (2) of the following treatments did not work for you: topical steroids (such as betamethasone) (TRIED), topical calcineurin inhibitors (such as tacrolimus or pimecrolimus), light therapy, azathioprine, cyclosporine, methotrexate, and mycophenolate mofetil. 2) More information is needed to know if this drug is being used together with another immunomodulator drug (e.g. Opzelura) for your health issue. Immunomodulator drugs help your body respond more appropriately to decrease swelling and itching. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 4 & 5 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval); (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.	Yes
16114377	YUE DENG MD	INTERNAL MEDICINE	JUBLIA	DERMATOLOGICALS	B35.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ciclopirox topical nail solution (Penlac equivalent), terbinafine tablet, itraconazole capsule, griseofulvin. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16115930	ROBERT BENJAMIN DICKINSON MD	UROLOGY	GEMTESA	URINARY ANTISPASMODICS	N23.81	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.	
16118310	WILLIAM MARC LEWIS DO	INTERNAL MEDICINE	MOUNJARO	ANTIDIABETICS	id (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	
16123428	GREG MICHAEL THAERA MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	G43.719	Criteria Not Met	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these reasons: 1) Records did not show that you have had fewer or less severe migraine headaches since starting this drug. 2) More information is needed to know if this drug will be used together with a botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be used together with a botulinum toxin product, records must show that you have had at least a three (3) month trial of Ajovy alone AND a three (3) month trial of a botulinum toxin product alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 fremanezumab (AJOVY) have not been met. From the information we have received, the member does not meet number(s) 2, 3, and 4 of our prior authorization criteria for Ajovy. 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) Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR 4) Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following are met: (A) Member has failed at least three (3) months of individual therapy with Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin); AND 5) If Ajovy 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 Ajovy, AND (B) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three (3) month trial from ONE of the following drug classes: (i) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (ii) vasoactive agent (such as propranolol, metoprolol, etc.), OR (iii) antidepressant (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 on what is covered. Prior authorization	

16125629	EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	DEXCOM G7 SENSOR	MEDICAL DEVICES	tes mellitus without complications (HCC)	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G7 Sensor was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
16126388	DIANA NATHALIE ANDINO MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.009	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy and Zavzpret. 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.
16126669	ASAD NAWAZ MD	ANESTHESIOLOGY	BELBUCA	ANALGESICS - OPIOID	M54.12 - Radiculopathy, cervical region	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), 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. 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.
16129672	LINDSAY KAY BRETTMANN MD	INTERNAL MEDICINE	TRETINOIN	DERMATOLOGICALS	Epidermal cyst	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
16135189	SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	M32.9	Criteria Not Met	Our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta SC was denied for these reasons: 1) Records did not show a positive test for anti-double stranded DNA (anti-dsDNA), low levels of complement (C3 or C4) proteins, or a positive test for anti-smith antibodies. These are lab tests used to help diagnose or identify systemic lupus erythematosus (SLE). SLE is a health issue where the immune system attacks its own tissues and organs, causing widespread inflammation. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Benlysta SC. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) and is receiving standard therapy; AND 2) Prescribed by, or in consultation with, a Rheumatologist or Dermatologist; AND 3) Documentation of ONE (1) of the following is provided with the request (documentation is required to be submitted for an approval): (A) anti-double stranded DNA (anti-dsDNA) positive; OR (B) low complement (C3 or C4) proteins; OR (C) positive for anti-smith antibodies; AND 4) Trials of TWO (2) of the following are ineffective, contraindicated or not tolerated: (A) azathioprine, (B) hydroxychloroquine, (C) methotrexate, (D) mycophenolate mofetil, or (E) chronic corticosteroid treatment at greater than or equal to 7.5mg of prednisone daily, or equivalent; AND 5) Member does NOT have severe active central nervous system (CNS) lupus; AND 6) Medication will NOT be given in combination with other biologics
16148673	MARJAN ABEDI LINNELL MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 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) (TRIED), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER . Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16148979	AMY ROMINGER MASON MD	DERMATOLOGY	TRETINOIN	DERMATOLOGICALS	L98.8	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin 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. 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
16154954	CATHERINE CELESTE LEWIS NP	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	L30.9	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, Tretinoin Cream 0.1% 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 0.1%. 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.
16155494	JIHONG KIM NP	NURSE PRACTITIONER	TIOTROPIUM BROMIDE	ANTIASTHMATIC AND BRONCHODILATOR A	J42	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 unspecified chronic bronchitis. 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.
16155871	NEERAJ MANCHANDA MD	NEUROLOGY	XYREM	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	G47.419	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 modafinil(TRIED), armodafinil, Sodium Oxybate oral solution, Wakix(TRIED), Sunosi(TRIED), Lumryz. 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.
16159161	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	LURASIDONE HYDROCHLORID	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F34.81	Plan Limits Exceeded	The requested amount of LURASIDONE TABLET 40MG 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 LURASIDONE TABLET 40MG at 1 tablet per day for this use. The higher number of 2 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.
16166684	WILLIAM MARC LEWIS DO	INTERNAL MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16168129	DARSHAN NARENDRA SHAH MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	G43.709	Criteria Not Met	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these reasons: 1) More information is needed to know if this drug will be used together with a botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be used together with a botulinum toxin product, records must show that you have had at least a three (3) month trial of Ajovy alone AND a three (3) month trial of a botulinum toxin product alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 fremanezumab (AJOVY) have not been met. From the information we have received, the member does not meet number(s) 4 and 5 of our prior authorization criteria for Ajovy. 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 had four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (A) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (B) vasoactive agent (such as propranolol, metoprolol, etc.), OR (C) antidepressant (such as amitriptyline, venlafaxine, etc.); AND 4) Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR 5) Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following are met: (A) Member has failed at least three (3) months of individual therapy with Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin). 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.
16172703	TRAVIS MICHAEL COX MD	HEMATOLOGY & ONCOLOGY	METAFOLBIC	DIETARY PRODUCTS/DIETARY MANAGEMEN	ency of other specified B group vitamins	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.

16173183	GRACE WHITNEY KIMMEL MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS	L80 - Vitiligo	Criteria Not Met
16175273	SHAGUFTA R LAKHANI FNP-C	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4-Chronic Pain Syndrome	Not Covered
16180654	GRACE WHITNEY KIMMEL MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS	L80	Criteria Not Met
16180919	ZAYD NAJDAT NASHAAT MD	INTERNAL MEDICINE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ED	Plan Exclusion
16182030	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	WEGOVY	ANTI-OBESITY/ANOREXIANTS	09 - Other obesity due to excess calories	Plan Exclusion
16185929	JARED KEALY MD	FAMILY PRACTICE	LOPERAMIDE HCL	ANTIDIARRHEAL/PROBIOTIC AGENTS	ve gastroenteritis and colitis, unspecified	Not Covered
16187089	LINDSAY KAY BRETTMANN MD	INTERNAL MEDICINE	TRETINOIN	DERMATOLOGICALS	L72.0	Plan Exclusion
16187462	SHEARREN VONSHAY JOHNSON	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight	Plan Exclusion
16187498	SRIVADEE ORAVIVATTANAKUL MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	ı, intractable, without status migrainosus	Not Covered

Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons:
1) Records did not show that light therapy (phototherapy) did not work for you.
2) Records did not show that a topical steroid (e.g., betamethasone, triamcinolone) OR a topical calcineurin inhibitor (e.g., pimecrolimus cream, tacrolimus ointment) did not work for you.
Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 6 and 7 of our prior authorization criteria for Opzelura. 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) Member has a diagnosis of nonsegmental vitiligo; AND
3) Member is 12 years of age or older; AND
4) Member meets ONE (1) of the following: (A) greater than or equal to 0.5% total body surface area (BSA) of the face is depigmented, or (B) greater than or equal to 3% total BSA on non-facial areas is depigmented; AND
5) The total affected body surface area (BSA) is less than or equal to 10%; AND
6) Phototherapy trial was ineffective, contraindicated, or not tolerated; AND
7) A trial of ONE (1) of the following was ineffective or not tolerated: (A) medium potency or stronger topical corticosteroid, OR (B) topical calcineurin inhibitor, OR (C) member has a contraindication to both.
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

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv.
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.

Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons:
1) Records did not show that a topical steroid (e.g., betamethasone, triamcinolone) OR a topical calcineurin inhibitor (e.g., pimecrolimus cream, tacrolimus ointment) did not work for you.
Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs.

ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 7 of our prior authorization criteria for Opzelura. 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) Member has a diagnosis of nonsegmental vitiligo; AND
3) Member is 12 years of age or older; AND
4) Member meets ONE (1) of the following: (A) greater than or equal to 0.5% total body surface area (BSA) of the face is depigmented, or (B) greater than or equal to 3% total BSA on non-facial areas is depigmented; AND
5) The total affected body surface area (BSA) is less than or equal to 10%; AND
6) Phototherapy trial was ineffective, contraindicated, or not tolerated; AND
7) A trial of ONE (1) of the following was ineffective or not tolerated: (A) medium potency or stronger topical corticosteroid, OR (B) topical calcineurin inhibitor, OR (C) member has a contraindication to both.
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

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

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

This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include loperamide. 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.

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

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

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Ajovy, Emgality, and Aimovig.
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.

16194303	JUSTINE CYNTHIA REILLY MD	OBSTETRICS & GYNECOLOGY	FERROUS SULFATE	HEMATOPOIETIC AGENTS	D64.9	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include ferrous sulfate, ferrous gluconate, and others. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered. **Please note, the formulary does cover ferrex 150 forte capsules, Multigen tablets, Multigen Plus tablets, and other products that contain iron.
16200511	SHEARREN VONSHAY JOHNSON	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight	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.
16201186	EDGAR NOE NAVARRO GARZA MD	PEDIATRICS	SENNA	LAXATIVES	K59.00	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 Senna liquid, Senna-Lax tabets, bisacodyl/tablet/suppository, Miralax, and others. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered. Please note, polyethylene glycol 3350 powder (MIRALAX equivalent) is covered on your formulary.
16203822	ELIZABETH CABRERA MD	DERMATOLOGY	ABSORICA LD	DERMATOLOGICALS	L70.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Isotretinoin (Accutane equivalent - Amnesteem, Claravis, Myorisan, or Zenatane) (Paid claims show you may have tried this drug, but records did not show that it did not work for you). Please note, depending on your plan, certain isotretinoin 30 mg products may not be covered. Additionally, one oral antibiotic (doxycycline (TRIED), minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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
16204228	MATTHEW A BARTOW MD	FAMILY PRACTICE	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MIS	Osteoporosis	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 Osteoporosis. 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.
16206340	ISELA ARRIETA WERCHAN MD	PSYCHIATRY	SUBLOCADE	ANALGESICS - OPIOID	F11.20	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. SUBLOCADE INJ 300/1.5 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.
16211365	LAURELIN NICOLE MULLINS NP	NURSE PRACTITIONER	ZEPBOUND	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.
16215106	KATHRYN ANN ANGER MD	OBSTETRICS & GYNECOLOGY	LINEZOLID	ANTI-INFECTIVE AGENTS - MISC.	N76.0	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 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
16215445	KARISA RAE STANCIL FNP-C	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	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.
16216565	MICHAEL CHRISTOPHER STEFANOWICZ D	FAMILY PRACTICE	PREGABALIN	ANTICONVULSANTS	munodeficiency virus (HIV) disease(HHS)	Plan Limits Exceeded	The requested amount of pregabalin 150mg capsule is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Pregabalin 150mg capsule at 3 capsules per day for this use. The prescribed dose is 4 capsules per day. This drug comes in a 300mg capsule. The same dose can be reached by taking one (1) pregabalin 300mg capsule twice per day. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.
16219052	AMMAR MOIN AHMED MD	DERMATOLOGY	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	PP	Criteria Not Met	Our prior authorization criteria for subcutaneous risankizumab-rzaa (SKYRIZI SC) have not been met. From the records that we have received, Skyrizi was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes showing this drug is working well for you were not received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 risankizumab-rzaa (SKYRIZI SC) 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 Skyrizi. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of plaque psoriasis (PsO) OR palmoplantar psoriasis (PP); AND 3) Member has demonstrated a significant improvement in their condition; AND 4) Documentation (written explanation accepted) of improvement within the past year is 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.
16219993	SHEARREN VONSHAY JOHNSON	NURSE PRACTITIONER	SAXENDA	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight	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.

16221307	LEAH MELLO MD	OBSTETRICS & GYNECOLOGY	COMBIPATCH	ESTROGENS	n95.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol/norethindrone tablet (Activella equivalent), jinteli tablet (Femhrt equivalent), Prempha se/Prempro tablet, and other estrogen combination products (i.e. an estrogen + progestin). 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.
16221586	CARMEN ELENA LANDAVERDE MD	HEPATOLOGY/LIVER MEDICINE	REZDIFFRA	GASTROINTESTINAL AGENTS - MISC.	K76.0, K74.00, R74.8	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 fatty liver . This is not an approved use. 2) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 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.
16221803	CLAIRE KYLANDER	NURSE PRACTITIONER	ADDYI	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	F52.0 - Hypoactive sexual desire disorder	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.
16224332	JORDAN REYES KRIEGER MD	UROLOGY	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	bph	Formulary Alternatives Available	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, Tadalafil was denied for these reasons: 1) One of these drugs has not been tried and failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16227807	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	LURASIDONE HYDROCHLORID	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F41.1	Plan Limits Exceeded	The requested amount of Lurasidone 20mg 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 Lurasidone 20mg at 1 tablet per day for this use. The prescribed dose is 2 tablets per day for 10 days, then 1 tablet per day for 10 days, then discontinue. This drug comes in a 40mg tablet. The same dose can be reached by taking one 40mg tab and one 20mg tab. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.
16238307	ANDRES DARIO PARDO-AGILA MD	FAMILY PRACTICE	CARVEDILOL PHOSPHATE ER	BETA BLOCKERS	betes mellitus with hyperglycemia (HCC)	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 carvedilol tab (COREG 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.
16242738	COLLIN MARSHALL MCKENZIE MD	OBSTETRICS & GYNECOLOGY	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(TRIED), 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.

16245421	STEVEN JONATHAN DELL MD	OPHTHALMOLOGY	VEVYE	OPHTHALMIC AGENTS	H04.123	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are cyclosporine (Restasis equivalent)(TRIED), Xiidra, Miebo, Tyrvaya. 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
16261716	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	AZSTARYS	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extended release (ER) (TRIED), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent). 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.
16262142	JACQUELINE ROSE KARATHRA MD	FAMILY PRACTICE	TRETINOIN	DERMATOLOGICALS	L85.8	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
16266320	MOLLY THOMPSON CAMPA	DERMATOLOGY	AKLIEF	DERMATOLOGICALS	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 (tried) or erythromycin, tretinoin, adapalene (Differin equivalent) (tried) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). 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
16267978	CHERYL ANN JOHNSTON PA	PHYSICIAN ASSISTANT	CLIMARA PRO	ESTROGENS	Hormone replacement therapy	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 estradiol/norethindrone tablet (Activella equivalent), jinteli tablet (Femhrt equivalent), Premphase/Prempro tablet, and other estrogen combination products (i.e. an estrogen + progestin). 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.
16273563	JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	f90.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the 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) (tried), lisdexamfetamine (Vyvanse equivalent) (tried), dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16273720	MATTHEW A BARTOW MD	FAMILY PRACTICE	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MIS	M81.0	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Prolia 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.

16290019	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ed	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16290402	JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	f25.0	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Invega Sustenna 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.
16290827	CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	l40.0	Criteria Not Met	Our prior authorization criteria for subcutaneous risankizumab-rzaa (SKYRIZI SC) have not been met. From the records that we have received, Skyrizi was denied for these reasons: 1) Chart notes showing this drug is working well for you were not received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 risankizumab-rzaa (SKYRIZI SC) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Skyrizi. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of plaque psoriasis (PsO) OR palmoplantar psoriasis (PP); AND 3) Member has demonstrated a significant improvement in their condition; AND 4) Documentation (written explanation accepted) of improvement within the past year is 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.
16292522	MATTHEW A BARTOW MD	FAMILY PRACTICE	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MISsis without current pathological fracture		Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. PROLIA 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.
16297240	FLORENCE OLABISI FALOLA NP	NURSE PRACTITIONER	LINZESS	GASTROINTESTINAL AGENTS - MISC.	CIC	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16300212	ANDRES DARIO PARDO-AGILA MD	FAMILY PRACTICE	CARVEDILOL PHOSPHATE ER	BETA BLOCKERS	betes mellitus with hyperglycemia (HCC)	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 carvedilol immediate-release (IR), labetalol, atenolol, metoprolol IR or extended release (ER), and nebivolol. 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.
16300539	TIERYN BOARINI NP	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 36.0-36.9, 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.
16300548	TIERYN BOARINI NP	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 30.0-30.9, adult	Plan Exclusion	This request cannot be approved because this drug is in a class of drugs called Weight Loss medications. Drugs of this type 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 erenumab (AIMOVIG) have not been met. From the records that we have received, Aimovig was denied for these reasons: 1) More information is needed to know if this drug will be used together with botulinum toxin product (such as Botox, Dysport, Xeomin, etc.). If Aimovig will be used together with botulinum toxin product (such as Botox, Dysport, Xeomin, etc.), records must also show you have had at least a three (3) month trial of Aimovig alone AND a three (3) month trial of botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.	
16300681	CRAIG HEWELL COUCH MD	NEUROLOGY	AIMOVIG	MIGRAINE PRODUCTS		G43.109 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the information we have received, the member does not meet number(s) 3 or 4 of our prior authorization criteria for Aimovig. 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) Aimovig will NOT be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; OR 4) Aimovig will be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine AND both of the following are met: (A) Member has failed at least three (3) months of individual therapy with Aimovig AND (B) Member has failed at least three (3) months of individual therapy with botulinumtoxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN); AND 5) If Aimovig 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 (AIMOVIG); 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	Yes
16310810	JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS		F25.0 Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. INVEGA SUSTENNA 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.	
16312577	AMISA PATEL DO	FAMILY PRACTICE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 28.0-28.9, adult	Plan Exclusion	This request cannot be approved because this drug is in a class of drugs called Weight Loss medications. Drugs of this type 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.	
16314793	RAISSA MIJARES BEHM FNP	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS		Z72.51 Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada). 2) Records were not sent to us to show your bones got weaker while taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada). 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you had a severe side effect after taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada) for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
16315317	RAISSA MIJARES BEHM FNP	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS		Z72.51 Criteria Not Met	Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada). 2) Records were not sent to us to show your bones got weaker while taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada). 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 4) Records were not sent to us to show you had a severe side effect after taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada) for at least 4 weeks. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval); OR (C) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least four (4) to eight (8) weeks of treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
16319978	CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	FERRETTS	HEMATOPOIETIC AGENTS		iron deficiency Plan Exclusion	This request cannot be approved because this drug/product is in a class of drugs/products called over the counter (OTC) vitamins and minerals. 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. Please note: Your pharmacy drug plan covers ferrex 150 forte cap,Multigen Folic tab, Multigen Plus tab, Multigen tab, tricon capsules, and Nephron FA tablets. Check with your provider if these, or other treatment options, might be right for your health issue.	

16320105	RICHARD DOUGLAS SAMBROOK	ADVANCED PRACTICE NURSE	BUPROPION HYDROCHLORIDE	ANTIDEPRESSANTS	MDD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are bupropion XL at a dose of 450 mg (150mg + 300mg OR three 150mg tablets), AND one serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g. desvenlafaxine extended release (ER) (Pristiq equivalent), venlafaxine, duloxetine(TRIED)), AND two selective serotonin reuptake inhibitors (SSRI) (e.g. sertraline, citalopram, paroxetine, fluoxetine, escitalopram(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.
16324323	ALMA DELIA CARTER	PHYSICIAN ASSISTANT	UREA	DERMATOLOGICALS	L21.9	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include urea creams, lotions, gels, ointments, and other urea products. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.
16326440	BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	IVERMECTIN	DERMATOLOGICALS	L71.9 - Rosacea, 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 topical metronidazole, azelaic acid (Finacea equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
16327411	KAITLIN NICOLE SISSON PA-C	PHYSICIAN ASSISTANT	FENOFIBRATE	ANTIHYPERLIPIDEMICS	E78.1 - Pure hyperglyceridemia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fenofibrate capsule (LOFIBRA equivalent, 67mg, 134mg, 200mg), fenofibrate tablet (TRICOR equivalent, 48mg, 54mg, 145mg, 160mg) (TRIED), fenofibric acid DR capsule (TRILIPIX equivalent), gemfibrozil, omega-3 acid ethyl ester capsule (LOVAZA equivalent). 2) Records show you may not be able to take fenofibrate capsule (LOFIBRA equivalent), fenofibric acid DR capsule (TRILIPIX equivalent), gemfibrozil, or omega-3 acid ethyl ester capsule (LOVAZA equivalent), but more information is needed to show why each of these drugs is not right for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 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.
16328764	JAVIER ARMENTA PA-C	PHYSICIAN ASSISTANT	NASONEX	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray (RHINOCORT AQUA equivalent), fluticasone nasal spray (FLONASE equivalent), flunisolide nasal spray, triamcinolone nasal spray (NASACORT 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.

16330050	GREG MICHAEL THAERA MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	G43.719	Criteria Not Met	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these reasons: 1) More information is needed to know if this drug will be used together with a botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be used together with a botulinum toxin product, records must show that you have had at least a three (3) month trial of Ajovy alone AND a three (3) month trial of a botulinum toxin product alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 fremanezumab (AJOVY) have not been met. From the information we have received, the member does not meet number(s) 3 or 4 of our prior authorization criteria for Ajovy. 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) Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR 4) Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following are met: (A) Member has failed at least three (3) months of individual therapy with Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin); AND 5) If Ajovy 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 Ajovy, AND (B) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three (3) month trial from ONE of the following drug classes: (i) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (ii) vasoactive agent (such as propranolol, metoprolol, etc.), OR (iii) antidepressant (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 on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16330676	AMANDA KAY WATERMAN	FAMILY PRACTICE	OPZELURA	DERMATOLOGICALS	vitiligo	Criteria Not Met	Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons: 1) This drug was not prescribed by or together with a doctor who specializes in your health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Opzelura. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Dermatologist; AND 2) Prescriber attests to improvement with therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16334941	ANABEL GRAY WINIECKI NP	ADVANCED PRACTICE NURSE	NAPROXEN DR	ANALGESICS - ANTI-INFLAMMATORY	G43.909	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 naproxen (Naprosyn equivalent), ibuprofen, diclofenac tablet, meloxicam, celecoxib, flurbiprofen, 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.
16339658	SHATANIEL TAYLOR NP	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is in a class of drugs called Weight Loss medications. Drugs of this type 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.
16339960	LAURA KATE EASTEP MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS	Z79.890	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) Records did not include your diagnosis. More information is needed to know what health issue is being treated. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿estradiol oral tablet, Premarin oral tablet, estradiol valerate injection (Delestrogen equivalent), estradiol once-weekly patch (Climara equivalent), and estradiol twice-weekly patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.
16346662	CONNOR THOMAS HUGHES MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS	L20.9	Criteria Not Met	Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons: 1) Records did not show that a topical calcineurin inhibitor, such as pimecrolimus cream or tacrolimus ointment, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Opzelura. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Dermatologist, Allergist, or Immunologist; AND 2) Member has a diagnosis of mild to moderate atopic dermatitis (AD); AND 3) Trials of BOTH of the following have been ineffective, contraindicated, or not tolerated: (A) topical corticosteroid, AND (B) topical calcineurin inhibitor. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

16354700	ALLEN LEE DENNIS 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) 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. 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.
16355864	SOROUSH BAHNAMIRI AZADI OD	OPTOMETRIST	AVENOVA	DERMATOLOGICALS	H01.009	Plan Exclusion	This request has not been approved because this product was approved by the United States Food and Drug Administration (FDA) as a medical device. Medical devices are non-drug products that are meant to help diagnose and treat health issues. Medical devices cannot be approved and are excluded from coverage under your pharmacy benefit. This product may be covered under your medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. There also may be over-the-counter (OTC) products that you can buy without a prescription that may treat your health issue. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
16359955	MICHELLE LE MARKLEY MD	FAMILY PRACTICE	XYOSTED	ANDROGENS-ANABOLIC	Z79.890 - Hormone replacement therapy	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 hormone replacement therapy(female). This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone cypionate(tried), testosterone enanthate, testosterone gel packet or pump 1% (Androgel equivalent), testosterone gel packet or pump 1.62% (Androgel equivalent). 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet numbers 1, 2, 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The 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.
16361619	STANLEY SUCHY WANG MD	CARDIOLOGY	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	ED	Formulary Alternatives Available	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, tadalafil 5mg was denied for these reasons: 1) One of these drugs has not been tried and failed: doxazosin, prazosin, terazosin, dutasteride, finasteride 5mg, alfuzosin, silodosin, tamsulosin. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16363716	EDWARD LEWIS LAIN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	AD	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent: 1) Chart notes showing that this drug is working well for you have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of moderate to severe atopic dermatitis at baseline; AND 2) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 3) Dupixent will NOT be used in combination with another targeted immunomodulator product. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16364216	RAJESH MOOLJIBHAI MEHTA MD	GASTROENTEROLOGY	DUPIXENT	DERMATOLOGICALS	K29.70	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent: 1) The drug is not being used for chronic rhinosinusitis with nasal polyps, atopic dermatitis (eczema), asthma, eosinophilic esophagitis, or prurigo nodularis. Please note: Additional criteria apply for each covered health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet numbers 1 and 2 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis, Atopic Dermatitis, Asthma, Eosinophilic Esophagitis, or Prurigo Nodularis; AND 2) Additional criteria for each covered diagnosis are met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

16372657	MOE HEIN AUNG MD	OPHTHALMOLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.701	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, Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16377325	CHRISTINE ANN TREVINO DO	PEDIATRICS	QUILLIVANT XR	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for attention-deficit hyperactivity disorder in a member less than 6 years of age. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.
16377546	SHATANIEL TAYLOR NP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16385341	DANIEL NEIL SKOGLUND MD	PSYCHIATRY	QUVIVIQ	HYPNOTICS/SEDATIVES/SLEEP DISORDER AC	G47.00	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ramelteon, zolpidem(tried), zaleplon(tried), trazodone, eszopiclone(tried), Belsomra, doxepin tablets (Silenor equivalent)-(tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16385680	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AC	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(may not be appropriate), zaleplon(may not be appropriate), trazodone(tried), eszopiclone(tried), Belsomra, doxepin tablets (Silenor 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.
16387394	MARCO ARTURO URIBE JR MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS	N95.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿estradiol oral tablet, Premarin oral tablet, estradiol valerate injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16388006	BILLIE KAREN MARTIN PA-C	PHYSICIAN ASSISTANT	SANTYL	DERMATOLOGICALS	fungating breast mass	Plan Limits Exceeded	The requested amount of Santyl 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 Santyl at 90 grams per 30 days for this use. The higher number of 360 grams per 30 days is not an approved dose for your health issue. For the higher quantity to be approved, medical support must be sent in to show this drug is required for your health issue. 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.

16388196	JOE HIDROGO III DO	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.901	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 TWO (2) triptan drugs (such as sumatriptan, rizatriptan, or others) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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 for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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.
16388262	JOE HIDROGO III DO	NEUROLOGY	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). 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.
16388326	DAWN CAROLINE PEASE APN	NURSE PRACTITIONER	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MIS	M81.0	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Prolia 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.
16389090	JENNEY SONEHUANG VONGPRATHOUM	FAMILY PRACTICE	ALBUTEROL SULFATE HFA	ANTIASTHMATIC AND BRONCHODILATOR A	derate persistent asthma, uncomplicated	Plan Limits Exceeded	The requested amount of ALBUTEROL SULFATE HFA (ProAir Equivalent) 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 ALBUTEROL SULFATE HFA at 2 inhalers (8.5 grams per device) per 30 days for this use. The higher number of 18 grams (package size for Ventolin HFA equivalent) per 30 days is not an approved dose for your health issue. For the higher quantity to be approved, medical support must be sent in to show this drug is required for your health issue. 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.
16389189	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	RAMELTEON	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG	G47.00 - Insomnia, unspecified	Plan Limits Exceeded	The requested amount of RAMELTEON 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 RAMELTEON at 1 tablet per day for this use. The higher number of 2 tablets per day is not an approved dose for your health issue. For the higher quantity to be approved, medical support must be sent in to show this drug is required for your health issue. 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.
16389875	MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	TAVABOROLE	DERMATOLOGICALS	L62.2	Formulary Alternatives Available	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, tavaborole was denied for these reasons: 1) Other drugs that must be tried and failed are ciclopirox nail solution and terbinafine tablets. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16398083	KEN LIN FNP-C	NURSE PRACTITIONER	BOTOX	NEUROMUSCULAR AGENTS	G43.909	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Botox is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
16399138	LAURA KATE EASTEP MD	OBSTETRICS & GYNECOLOGY	ESTRADIOL	ESTROGENS	Z79.890 - Hormone replacement therapy	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 estradiol oral tablet, Premarin oral tablet, estradiol valerate injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16400543	SHATANIEL TAYLOR NP	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

							This product is not on our list of covered products, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered product can be approved. The conditions in our Not Covered Diabetic Glucose Meters and Supplies exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered blood glucose testing products have not been tried and failed. Other products that can be used are Accu-Chek and OneTouch meters and supplies. Quantity limits may apply. Please look at the formulary to see what products are covered. Prior authorization may be required and quantity limits may apply to covered products.
16401025	MEGHAN ELIZABETH HUGHES PA-C	PHYSICIAN ASSISTANT	TRUE METRIX BLOOD GLUCOS	DIAGNOSTIC PRODUCTS	diabetes mellitus without complications	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this product is not on formulary. An exception to allow coverage of a non-formulary product 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 or 2 or 3 of the Not Covered Diabetic Glucose Meters and Supplies exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Member is using an insulin pump and ALL of the following are met: (a) Name of the insulin pump is provided, AND (b) Member's glucose meter has connectivity with the insulin pump, AND (c) Names of the glucose meter and test strips are provided, AND (d) Member uses the connectivity feature; OR 2) Member is using a continuous glucose monitor (CGM) and ALL of the following are met: (a) Name of the CGM is provided, AND (b) Member's CGM has a built-in blood glucose meter, AND (c) Member utilizes the built-in blood glucose meter, AND (d) Test strips name is provided; OR 3) ALL of the covered blood glucose testing products have been tried and failed and names of the products tried and failed are provided. Since criteria have not been met, we are unable to approve coverage for this product at this time. Please refer to the formulary for information on what is covered. Prior
16403613	DONALD ROBERT BRODE MD	FAMILY PRACTICE	MAVYRET	ANTIVIRALS	HCV	Criteria Not Met	Our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the records that we have received, Mavyret was denied for these reasons: 1) The drug is not prescribed by, or together with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist. These are doctors who specialize in your health issue. 2) More information is needed to make sure you do NOT have decompensated cirrhosis. This is when healthy liver tissue has been replaced with scarred liver tissue and your liver is no longer working well. 3) More information is needed to know if you have taken other drugs for hepatitis C in the past. 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 glecaprevir/pibrentasvir (MAVYRET) have not been met. From the information we have received, the member does not meet number(s) 1, 4, and 5 of our prior authorization criteria for Mavyret. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Member has a diagnosis of Hepatitis C Virus (HCV); AND 3) Current viral level (HCV-RNA titer and date) is provided and must be from within the past 6 months (documentation is required for an approval); AND 4) Member does NOT have decompensated cirrhosis (Child-Pugh B or C); AND 5) Member had no prior treatment with direct-acting antiviral(s) (DAA) for HCV AND duration of therapy will be eight (8) weeks; OR 6) Member was previously treated for HCV with a sofosbuvir-based regimen and ALL of the following are met: (A) Member does NOT have genotype 3, and (B) Member has no prior treatment with a NS3/4A protease inhibitor and (C) Duration of therapy will be 16 weeks. 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.
16404440	ZAYD NAJDAT NASHAAT MD	INTERNAL MEDICINE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	N52.9	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16406089	JAMES LUDWIG WISE MD	GASTROENTEROLOGY	BUDESONIDE	ANORECTAL AND RELATED PRODUCTS	K51.90	Criteria Not Met	Our prior authorization criteria for budesonide (UCERIS) have not been met. From the records that we have received, the following caused the denial of budesonide rectal foam. 1) The drug is not being used for mild to moderate ulcerative colitis (UC) that affects the last part of the colon. UC is a health issue that affects your digestive system. 2) Records did not show that another drug called mesalamine did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for budesonide (UCERIS) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for budesonide rectal foam. The reason for denial is explained to the member above. The criteria are listed here. 1) Budesonide rectal foam is requested for a member with active mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge; AND 2) Member has tried and failed or was intolerant to mesalamine. 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.
16407941	KYLA RENEE ASCHENBECK MD	OPHTHALMOLOGY	CEQUA	OPHTHALMIC AGENTS	ɔye syndrome of bilateral lacrimal glands	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 cyclosporine (Restasis equivalent) (TRIED), Xiidra (TRIED), Miebo, and Tyrvaya. 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.

16415015	SUJAATA RATNA DWADASI MD	GASTROENTEROLOGY	AMITIZA	GASTROINTESTINAL AGENTS - MISC.	IBS-C	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) Records did not show the generic version of this drug, called lubiprostone, did not work for you. *Please note, this medication requires a prior authorization* 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are Trulance, Linzess (TRIED). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, 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
16417526	JAZMINE NICOLE ALANIS PA	PHYSICIAN ASSISTANT	INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	f20.9	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Invega Sustenna 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.
16420305	ALLEN LEE DENNIS 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) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are a trial of one of the following: buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
16427397	VASUDHA MANTRAVADI MD	PEDIATRICS	RYALTRIS	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.9 - Allergic rhinitis, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿nasal antihistamines (azelastine 0.1% (Astelin equivalent), azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua equivalent), fluticasone (Flonase equivalent), triamcinolone (Nasacort equivalent), flunisolide). 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.
16427398	TARA AUTUMN CHERRY MD	OBSTETRICS & GYNECOLOGY	CLIMARA PRO	ESTROGENS	N95.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol oral tablet, Premarin oral tablet, estradiol valerate injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16430643	JEFFREY STEVEN ROSENBLOOM MD	OTOLARYNGOLOGY	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J33.1 - Polypoid sinus degeneration	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 budesonide nasal spray (RHINOCORT AQUA equivalent), fluticasone nasal spray (FLONASE equivalent)-(tried), mometasone nasal spray (NASONEX equivalent)-(tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16431238	PATIENCE HARRIET READING MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.719	Plan Limits Exceeded	The requested amount of UBRELVY is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover UBRELVY at 10 tablets per 30 days, 6 fills per year for this use. The higher number of 10 tablets per 30 days, more than 6 fills per year is not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, Emgality, must be used to help prevent migraine headaches AND information must be provided to show that 10 tablets per 30 days, 6 fills per year did not work for you. 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.
16431325	ARPITA VIKRAMBHAI PATEL MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	t 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 Reyvow, Ubrelvy and Zavzpret. 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.
16431501	APRIL WEST FOX MD	SURGERY, COLON & RECTAL	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.9	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 Proctosol HC cream (ANUSOL HC equivalent), lidocaine/hydrocortisone cream (ANAMANTLE equivalent), Proctofoam HC foam, and Analpram-E kit. 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.
16432943	KRISTINA KAREN JULICH MD	NEUROLOGY	JORNAY PM	ADHD/ANTI-NARCOLEPSY	t hyperactivity disorder, unspecified type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER (Concerta, Metadate CD, Ritalin LA), amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16436298	CLAYTON WARREN ADAMS MD	ANESTHESIOLOGY	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	G43.909	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 on what is covered. Prior authorization 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 migraines. 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 ibuprofen, naproxen, diclofenac tablets, rizatriptan, sumatriptan, naratriptan, Reyvow, Ubrelvy, Zavzpret and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.

16438700	ANNA PATRICK LINCOLN MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	disorder, predominantly inattentive type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. 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.
16443081	CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	Chloasma	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, Tretinoin 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. 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.
16449329	AMELIE GARZA NP	NURSE PRACTITIONER	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F32.A	Not Covered	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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Vraylar exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) The drug is not being used as add-on treatment for Major Depressive Disorder. That means that this drug should be used together with an antidepressant to help treat your health issue. 2) Records did not show aripiprazole (Abilify equivalent) did not work for you. 3) Records did not show that your current antidepressant treatment is not helping your health issue enough. 4) Records did not show at least TWO (2) or more antidepressant drugs did not work for you. (e.g. escitalopram, fluoxetine, sertraline, venlafaxine, or others) 5) Records did not show that another drug called quetiapine OR olanzapine used together with an antidepressant medication did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, 3, 4, and 5 of the Vraylar exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Two (2) or more antidepressant medications were ineffective or not tolerated; AND 5) A trial of quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication was ineffective or not tolerated.
16450486	KARTHIK VENKATA GARAPATI MD	GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	table bowel syndrome with constipation	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16450547	MELANIE JOYCE FROGOZO OD	OPTOMETRIST	VEVYE	OPHTHALMIC AGENTS	eye syndrome of bilateral lacrimal glands	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 cyclosporine (Restasis equivalent)(TRIED), Xiidra, Miebo, Tyrvaya. 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
16451918	KAITLIN EILEEN GASTINGER NP	NURSE PRACTITIONER	BIMATOPROST	DERMATOLOGICALS	Nonscarring hair loss, unspecified	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.

16451997	JAMES LUDWIG WISE MD	GASTROENTEROLOGY	BUDESONIDE ER	CORTICOSTEROIDS	of small intestine without complications	Criteria Not Met	Our prior authorization criteria for budesonide (UCERIS) have not been met. From the records that we have received, the following caused the denial of budesonide extended release (ER) tablet. 1) The drug is not being used for mild to moderate ulcerative colitis (UC). This is a health issue that affects your digestive system. 2) Records did not show that another drug called mesalamine did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for budesonide (UCERIS) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for budesonide extended release (ER) tablet. The reason for denial is explained to the member above. The criteria are listed here. 1) Budesonide ER tablet is requested for a member with active mild to moderate ulcerative colitis; AND 2) Member has tried and failed or was intolerant to mesalamine. 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
16457317	ANNA PATRICK LINCOLN MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	disorder, predominantly inattentive type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER (Aptensio XR, Concerta, Metadate CD, Ritalin LA), amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent)(TRIED), and dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16457461	DANA MARIE GARCIA MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	services in other specified circumstances	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.
16466746	BINACA GAGLANI MD	ALLERGY & IMMUNOLOGY	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J32.9 - Chronic sinusitis, 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 budesonide nasal spray (RHINOCORT AQUA equivalent), fluticasone nasal spray (FLONASE equivalent)-(tried), flunisolide nasal spray, triamcinolone nasal spray (NASACORT 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.
16467009	CHRISTINE ANN TREVINO DO	PEDIATRICS	QUILLIVANT XR	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for attention-deficit hyperactivity disorder in a child less than 6 years of age. 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.
16469306	DAMIAN G LARA MD	FAMILY PRACTICE	DEXCOM G7 SENSOR	MEDICAL DEVICES	E11.9	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G7 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
16478488	KATHRYN CHRISTEN SIEMS PA-C	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	plasm of skin of unspecified part of face	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, Tretinoin Cream 0.025% was denied for these reasons: 1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. These are health issues of the skin. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Acne Agents have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Tretinoin Cream 0.025%. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of 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.

16479561	RANI DAS MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.719	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. 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.
16481778	MELISSA ANN FROST PA-C	PHYSICIAN ASSISTANT	ENSTILAR	DERMATOLOGICALS	E85.4	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 a skin issue called macular amyloidosis. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 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.
16484504	MARCO ARTURO URIBE JR MD	OBSTETRICS & GYNECOLOGY	IMVEXXY MAINTENANCE PACK	VAGINAL AND RELATED PRODUCTS	95.2 - Postmenopausal atrophic vaginitis	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 estradiol vaginal tablets, estradiol cream (Estrace equivalent), Premarin vaginal cream and Estring. 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.
16490036	BRANDON SHAUN ALTILLO	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	E66.01	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16491170	ALINDA ROBERTA COX MD	OBSTETRICS & GYNECOLOGY	INTRAROSA	VAGINAL AND RELATED PRODUCTS	N95.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol vaginal tablets, estradiol cream (Estrace equivalent), Premarin vaginal cream and Estring. 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.
16491612	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ED	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

16492272	SRIVADEE ORAVIVATTANAKUL MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	ı, intractable, without status migrainosus	Criteria Not Met	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these reasons: 1) Records did not show that another drug from at least ONE of the following drug classes did not work for you (after using it for at least 3 months): an anticonvulsant (e.g., topiramate, sodium valproate), a vasoactive agent (e.g., propranolol, metoprolol), or an antidepressant (e.g., amitriptyline, venlafaxine). 2) More information is needed to know if this drug will be used together with a botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be used together with a botulinum toxin product, records must show that you have had at least a three (3) month trial of Ajovy alone AND a three (3) month trial of a botulinum toxin product alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 fremanezumab (AJOVY) have not been met. From the information we have received, the member does not meet number(s) 3 and (4 or 5) of our prior authorization criteria for Ajovy. 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 had four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (A) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (B) vasoactive agent (such as propranolol, metoprolol, etc.), OR (C) antidepressant (such as amitriptyline, venlafaxine, etc.); AND 4) Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR 5) Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following are met: (A) Member has failed at least three (3) months of individual therapy with Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin). 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.
16493802	ALBERT JAMES WONG MD	FAMILY PRACTICE	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	Male erectile dysfunction, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16503723	RUBY NOEMI MEYER APRN	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	headache	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 headache. 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 Reyvow, Ubrelvy and Zavzpret. 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 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 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.
16505337	FARHEEN YOUSUF MD	ENDOCRINOLOGY, DIABETES & M	DEXCOM G7 SENSOR	MEDICAL DEVICES	Prediabetes	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 Dexcom G7 sensor (non-sample pack sensors are covered), Dexcom G6 sensor and Freestyle Libre. 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.
16507012	NICHOLAS FRANCIS BASTIAN DO	INTERNAL MEDICINE	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	N52.9	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16514482	RANI DAS MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.719	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(TRIED), 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.

16515212	MICHAEL ALAN FULLER MD	PSYCHIATRY	BUPROPION HYDROCHLORIDE	ANTIDEPRESSANTS		F31.9	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 bupropion XL at a dose of 450 mg (150mg + 300mg OR three 150mg tablets), AND one serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g. desvenlafaxine extended release (ER) (Pristiq equivalent), venlafaxine, duloxetine), AND two selective serotonin reuptake inhibitors (SSRI) (e.g. sertraline, citalopram, paroxetine, fluoxetine, escitalopram). 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.	
16516327	ERNESTO AARON GONZALEZ MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.		N52.9	Criteria Not Met	Our prior authorization criteria for Pulmonary Arterial Hypertension have not been met. From the records that we have received, the following caused the denial of Sildenafil tablet. 1) The drug was not prescribed by, or together with, a heart or lung specialist. 2) The drug is not being used for Pulmonary Arterial Hypertension (PAH). This is a health issue where you would have high blood pressure in the blood vessels that go from the heart to the lungs. 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 Pulmonary Arterial Hypertension have not been met. From the information we have received, the member does not meet number 1, 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Cardiologist or Pulmonologist; AND 2) Member has Pulmonary Arterial Hypertension (PAH) as diagnosed by right heart catheterization. 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.	
16517330	SHAWN ROBERT AGENBROAD-ELANDER	NURSE PRACTITIONER	TRINTELLIX	ANTIDEPRESSANTS		F32.a	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	
16517980	MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	TRINTELLIX	ANTIDEPRESSANTS		MDD	Criteria Not Met	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline(TRIED), citalopram, escitalopram, fluoxetine, or paroxetine, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	
16520465	STEPHANIE BROOKE KNIGHT NP	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20		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 buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.	Yes
16533094	RONALD LEE COX MD	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	K20.0 - Eosinophilic esophagitis		Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records did not show a topical steroid drug, such as swallowed fluticasone, did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 5 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is at least 1 year of age or older; AND 2) Member weight is at least 15 kg; AND 3) Prescribed by, or in consultation with, an allergist or gastroenterologist; AND 4) Member has a diagnosis of eosinophilic esophagitis as documented with BOTH of the following: (A) endoscopic biopsy with greater than or equal to 15 eosinophils/high power field (hpf), and (B) symptoms of esophageal dysfunction (e.g. dysphagia); AND 5) A trial of BOTH a proton pump inhibitor AND a topical corticosteroid was ineffective, not tolerated, or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	

16538315	BRANDON SHAUN ALTILLO	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	E66.01-obesity	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.
16541102	MARTHA NICOLE MENEFEE NP	CLINICAL NURSE SPECIALIST	OTEZLA	TARGETED IMMUNOMODULATORS	L40.50	Criteria Not Met	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) More information is needed to know if this drug is being used together with biologic therapy, such as adalimumab. 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 apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Otezla. 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 Psoriatic Arthritis (PsA); AND 3) A trial of ONE (1) of the following was ineffective or not tolerated: (A) methotrexate; OR (B) sulfasalazine; OR (C) Member has contraindication to BOTH and the contraindication is specified; AND 4) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16541868	SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	COSENTYX UNOREADY	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are adalimumab product (adalimumab-fkjp (Hulio equivalent), adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia, Otezla, Skyrizi, and an ustekinumab product (Stelara) (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. 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.
16544438	OSCAR AARON MOLINA MD	FAMILY PRACTICE	NUZYRA	TETRACYCLINES	of right lower leg with fat layer exposed	Criteria Not Met	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, NUZYRA was denied for this reason: 1) The drug is not prescribed by a(n) Infectious Disease or Pulmonology 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 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
16555937	NANCY ANN DASSO NP	NURSE PRACTITIONER	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J01.00	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray (RHINOCORT AQUA equivalent), fluticasone nasal spray (FLONASE equivalent), flunisolide nasal spray, and triamcinolone nasal spray (NASACORT 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.
16561174	CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	l81.1	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
16567404	SUZANNE SINGERMAN ALBERT FNP-C	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	Migraines	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy, and Zavzpret. 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.

16583246	SARAH MICHELLE SEEGER PMHNP	ADVANCED PRACTICE NURSE	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	MDD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show that another drug called quetiapine OR olanzapine used with an antidepressant medication did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND 5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication.	
16585003	BROCK EVAN HARPER MD	RHEUMATOLOGY	BIMZELX	TARGETED IMMUNOMODULATORS	AS	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 an adalimumab product (TRIED), Enbrel (TRIED), Rinvoq (TRIED), Taltz (TRIED), Cimzia (TRIED), and 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. 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.	
16585199	CHELLYANNE COLLEEN HINDS PA	PHYSICIAN ASSISTANT	MAVYRET	ANTIVIRALS	Chronic viral hepatitis C(HHS)	Criteria Not Met	Our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the records that we have received, Mavyret was denied for these reasons: 1) Records do not show a recent viral level. This must be from within the past 6 months. 2) More information is needed to know if you have taken other drugs for hepatitis C in the past. 3) More information is needed to know if you took another sofosbuvir-based drug regimen for hepatitis C in the past. 4) More information is needed to know if you have taken an NS3/4A protease inhibitor drug for hepatitis C in the past. 5) More information is needed to know how long this drug will be used for. 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 glecaprevir/pibrentasvir (MAVYRET) have not been met. From the information we have received, the member does not meet number(s) 3 and 5 or 6 of our prior authorization criteria for Mavyret. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Member has a diagnosis of Hepatitis C Virus (HCV); AND 3) Current viral level (HCV-RNA titer and date) is provided and must be from within the past 6 months (documentation is required for an approval); AND 4) Member does NOT have decompensated cirrhosis (Child-Pugh B or C); AND 5) Member had no prior treatment with direct-acting antiviral(s) (DAA) for HCV AND duration of therapy will be eight (8) weeks; OR 6) Member was previously treated for HCV with a sofosbuvir-based regimen and ALL of the following are met: (A) Member does NOT have genotype 3, and (B) Member has no prior treatment with a NS3/4A protease inhibitor and (C) Duration of therapy will be 16 weeks. 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	
16586129	MICHAEL RIE MD	FAMILY PRACTICE	ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	E78.2 - Mixed hyperlipidemia	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our icosapent (Vascepa equivalent) exception policy have not been met. From the records that we have received, the following caused the denial. 1) Records did not show that the following drugs did not work for you or that there are clinical reasons why they cannot be used: omega-3 acid ethyl ester capsule (Lovaza equivalent), one statin (e.g. rosuvastatin) (TRIED), one fibrate (e.g. fenofibrate), niacin ER (Niaspan ER equivalent) and brand name Vascepa. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 of the icosapent (Vascepa equivalent) 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 as an adjunct to diet to reduce triglycerides in an adult member with severe hypertriglyceridemia (triglycerides over 500mg/dL). Recent triglyceride levels must be submitted with the request; AND 2) All of the following drugs have been tried and failed: omega-3 acid ethyl ester capsule (Lovaza equivalent), one statin (e.g. rosuvastatin) (TRIED), one fibrate (e.g. fenofibrate), niacin ER (Niaspan ER equivalent) and brand name Vascepa. 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	
16590228	SELINA KAY CHRANE PA	PHYSICIAN ASSISTANT	UBRELVY	MIGRAINE PRODUCTS	Migraines	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 TWO (2) triptan drugs (such as sumatriptan, rizatriptan, or others) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. 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 for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials 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.	Yes

16590407	ANNA NICOLE WENDEL FNP-C	NURSE PRACTITIONER	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) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are trial of 1 of the following: buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
16599452	DAVID EDWARD O'CONNOR MD	PSYCHIATRY	QELBREE	ADHD/ANTI-NARCOLEPSY	f90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are atomoxetine and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or lisdexamfetamine (Vyvanse 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.
16619423	MARIAH ANN SIMMS	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	I70.8	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin 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. 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
16625596	SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	COSENTYX UNOREADY	TARGETED IMMUNOMODULATORS	l40.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are an adalimumab product (adalimumab-fkjp (Hulio equivalent), adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia, Otezla (TRIED), Skyrizi, and an ustekinumab product (Stelara) (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. 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.
16625653	EMILY LYNN RAMIREZ DO	PEDIATRICS	FYCOMPA	ANTICONVULSANTS	g40.a19	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topiramate and lacosamide (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.

							Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records did not show that at least TWO (2) of the following treatments did not work for you: topical steroids (such as betamethasone), topical calcineurin inhibitors (such as tacrolimus or pimecrolimus), light therapy, azathioprine, cyclosporine, methotrexate, and mycophenolate mofetil. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 months of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic moderate-to-severe atopic dermatitis (eczema) at baseline, and one of the following is met: (A) Greater than or equal to 10% body surface area (BSA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provided with the request (documentation is required to be submitted for an approval); AND 4) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (documentation is required to be submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL)), or (C) Narrow band Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed above are contraindicated; AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16634055	SABA ZABETIAN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczema	Criteria Not Met	
16643125	CHRISTY TAYLOR RISINGER MD	INTERNAL MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	coronary artery without angina pectoris	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.
16646197	CHRISTY TAYLOR RISINGER MD	INTERNAL MEDICINE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	coronary artery without angina pectoris	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.
16648430	ROSIE AUGUSTIN-WHEELER MD	FAMILY PRACTICE	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	IBS	Criteria Not Met	Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induced constipation (OIC). These are specific health issues that make it difficult to have a bowel movement. 2) Records did not show that taking one of the following over-the-counter (OTC) drugs for one month did not work for you: stimulants (e.g., bisacodyl, sennosides), or PEG 3350 (e.g., Miralax), or bulk-forming laxatives (e.g., Metamucil, Citrucel, Fibercon). 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 lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3, 4 of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon). 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
16663401	BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	LEVOCETIRIZINE DIHYDROCHL	ANTIHISTAMINES	Allergic Rhinitis	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 desloratadine (Clarinex 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.
16666475	KIMBERLY CARTER MD	OBSTETRICS & GYNECOLOGY	ESTRADIOL	ESTROGENS	N96.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿estradiol oral tablet, Premarin oral tablet, estradiol valerate injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16667594	EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	mass index (BMI) 45.0-49.9, adult (HCC)	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16669375	BRIAN TERRY MILLER DO	ALLERGY & IMMUNOLOGY	XOLAIR	ANTIASTHMATIC AND BRONCHODILATOR A	L50.1	Plan Limits Exceeded	The requested amount of Xolair 300mg/2mL injection 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 Xolair 300mg/2mL injection at 1 injection per 28 days for this use. The higher number of 2 injections per 28 days is not an approved dose for your health issue. For the higher quantity to be approved, medical support must be sent in to show this drug is required for your health issue. 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.

16669873	MIRANDA JO HARDEE MD	UROLOGY	GEMTESA	URINARY ANTISPASMODICS	N39.8	Not Covered
16678468	SABA ZABETIAN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	AD	Criteria Not Met
16682191	KIMBERLY ANNE GUAJARDO PA-C	PHYSICIAN ASSISTANT	DICLOFENAC SODIUM	DERMATOLOGICALS	M19.09	Criteria Not Met
16684376	RANI DAS MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	Migraines	Not Covered
16684543	SONIA SHARON DURAIRAJ MD	INTERNAL MEDICINE	IMVEXXY STARTER PACK	VAGINAL AND RELATED PRODUCTS	N95.8	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 (TRIED) AND 3 other drugs for your health issue, such as oxybutynin, trospium, tolterodine, darifenacin, solifenacin, and fesoterodine.
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.

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

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.

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy, and Zavzpret.
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.

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol vaginal tablets, estradiol cream (Estrace equivalent) (TRIED), Premarin vaginal cream, and Estring.
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.

16688182	ELISABETH ANNE CLAYTON MD	ALLERGY & IMMUNOLOGY	AZELASTINE HYDROCHLORIDE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.89	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 nasal antihistamines (azelastine 0.1% (Astelin equivalent), azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua equivalent), fluticasone (Flonase equivalent) (TRIED), triamcinolone (Nasacort equivalent), and flunisolide). 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.
16690237	ELIZABETH YIM MPH	DERMATOLOGY	JUBLIA	DERMATOLOGICALS	B35.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ciclopirox topical nail solution (Penlac equivalent) (TRIED), terbinafine tablet (TRIED), itraconazole capsule, and griseofulvin. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16690362	RANI DAS MD	NEUROLOGY	XYWAV	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	G47.419	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 modafinil (TRIED), armodafinil, Sodium Oxybate oral solution, Wakix (TRIED), Sunosi (TRIED), Lumryz. 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.
16695126	RICHARD DOUGLAS SAMBROOK	ADVANCED PRACTICE NURSE	BUPROPION HYDROCHLORIDE	ANTIDEPRESSANTS	F33.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are bupropion XL at a dose of 450 mg (150mg + 300mg OR three 150mg 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.
16695145	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	SANDOSTATIN LAR DEPOT	ENDOCRINE AND METABOLIC AGENTS - MIS	D35.2	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Sandostatin LAR Depot 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.
16695324	RANI DAS MD	NEUROLOGY	FIORICET	ANALGESICS - NONNARCOTIC	R51	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 non-specific headaches. 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 ibuprofen, naproxen, diclofenac tablets, rizatriptan, sumatriptan, naratriptan, Reyvow, Ubrelvy, Zavzpret and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16695333	JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F33.9	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 our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show aripiprazole (Abilify equivalent) did not work for you. 2) Records did not show that another drug called quetiapine OR olanzapine used with an antidepressant medication did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2, 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND 5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication.
16695383	DAWN CAROLINE PEASE APN	NURSE PRACTITIONER	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MIS	M81.0	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Prolia 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.
16703147	CHRISTOPHER JAMES O'CONNOR PA	PHYSICIAN ASSISTANT	BUPRENORPHINE HCL	ANALGESICS - OPIOID	Z79.891	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent) (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16705206	TESSA KIMBERLY NOVICK MD	INTERNAL MEDICINE	KERENDIA	ENDOCRINE AND METABOLIC AGENTS - MIS	T2DM	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 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) 1 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 any angiotensin-converting enzyme (ACE) inhibitor or any angiotensin receptor blocker (ARB) was ineffective, not tolerated or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16706231	SERENA HON MD	FAMILY PRACTICE	QELBREE	ADHD/ANTI-NARCOLEPSY	disorder, predominantly inattentive type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are atomoxetine and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER (TRIED) or lisdexamfetamine (Vyvanse equivalent) (TRIED)). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16710025	STEVEN KIRK FOSTER MD	GENERAL PRACTICE	TALTZ	TARGETED IMMUNOMODULATORS	L40.9	Criteria Not Met	Our prior authorization criteria for ixekizumab (TALTZ) have not been met. From the records that we have received, Taltz was denied for these reasons: 1) This drug was not prescribed by a doctor who specializes in your health issue. 2) Records did not show that 10 percent (or more) of your Body Surface Area (BSA) is affected by your health issue. 3) Records did not show that your health issue is causing significant functional disability for you. More information is needed to show how your health issue is impacting your day-to-day life. 4) Records did not show that you have palmoplantar psoriasis. This is a health issue where skin cells build up and form itchy, dry patches and scales on the palms of the hands and the soles of the feet. 5) At least one (1) of the following treatments has not been tried and failed: (A) 15 sessions of light therapy, OR (B) methotrexate 15 mg per week, OR (C) acitretin. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 ixekizumab (TALTZ) have not been met. From the information we have received, the member does not meet number(s) 1, 2 and 3 of our prior authorization criteria for Taltz. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
16710372	HYMAN DEMARCUS THOMPSON MD	FAMILY PRACTICE	BUPRENORPHINE HCL	ANALGESICS - OPIOID	11.21 - Opioid dependence, in remission	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 buprenorphine/naloxone film (Suboxone Film), buprenorphine/naloxone tablet (Suboxone tablet) and Zubsolv sublingual 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.
16711404	RANI DAS MD	NEUROLOGY	XYREM	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	G47.419	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 modafinil (TRIED), armodafinil, Sodium Oxybate oral solution, Wakix (TRIED), Sunosi (TRIED), and Lumryz. 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.
16711438	JOHN KAI-LING TSAI MD	GASTROENTEROLOGY	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.00	Criteria Not Met	Our prior authorization criteria for prucalopride (MOTEGRITY) have not been met. From the records that we have received, Motegrity was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation. This is a health issue with ongoing constipation that has no known cause. 2) Records did not show that another drug called Trulance did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for prucalopride (MOTEGRITY) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Motegrity. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC); AND 2) A trial of plecanatide (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.
16712410	GRACE WHITNEY KIMMEL MD	DERMATOLOGY	TRETINOIN	DERMATOLOGICALS	L73.8	Plan Exclusion	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/products used for a cosmetic 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.
16713548	MARIAH ANN SIMMS	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	L70.8	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin cream was denied for these reasons: 1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. These are health issues of the skin. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Acne Agents have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for tretinoin cream. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of acne vulgaris, acne rosacea, or actinic keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

16737765	JOHN COOPER HALL MD	INTERNAL MEDICINE	STEGLATRO	ANTIDIABETICS	diabetes mellitus without complications	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Farxiga or Xigduo XR, and Jardiance or Synjardy (XR). 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
16742209	QUAN TRAN DANG MD	INTERNAL MEDICINE	OXYCONTIN	ANALGESICS - OPIOID	oplasm of overlapping sites of pancreas	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER equivalent), tramadol ER tablet (Ultram ER equivalent), and buprenorphine patch (Butrans equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. 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.
16745378	ANDREW CHRISTIAN PELPHREY MD	NEPHROLOGY/RENAL MEDICINE	DAPAGLIFLOZIN PROPANEDIO	ANTIDIABETICS	CKD IV	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 and Jardiance (Brand name only). 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.
16750047	YUE DENG MD	INTERNAL MEDICINE	JUBLIA	DERMATOLOGICALS	B35.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ciclopirox topical nail solution (Penlac equivalent), terbinafine tablet, itraconazole capsule, griseofulvin. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16752799	EMMANUEL CHUKWUKELO EDOKA MD	GERIATRIC MEDICINE	LEVOCETIRIZINE DIHYDROCHL	ANTIHISTAMINES	T78.40XA	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 loratadine, fexofenadine, cetirizine, levocetirizine, and others. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.
16753780	LISA M BOURBEAU DO	OBSTETRICS & GYNECOLOGY	ANNOVERA	CONTRACEPTIVES	Z30.018	Plan Limits Exceeded	The requested amount of Annovera 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 Annovera at 1 ring per year for this use. The higher amount of 1 ring per 84 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.
16753836	ALBERTO GLENDALYZ MD	GERIATRIC MEDICINE	OZEMPIC	ANTIDIABETICS	E66.01	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16753886	JOE HIDROGO III DO	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	migraine	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy and Zavzpret. 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.

16753900	JEFFREY NORMAN HIGGINBOTHAM MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20	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 trial of 1: buprenorphine/naloxone tablet, buprenorphine/naloxone film, or Zubsolv. 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.
16756081	LEIGHA ANA SHARP MD	DERMATOLOGY	COSENTYX UNOREADY	TARGETED IMMUNOMODULATORS	I73.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are an adalimumab product (adalimumab-adaz (Hyrimoz equivalent), adalimumab-fkjp (Hulio equivalent), adalimumab-aaty (Yuflyma equivalent), Hadlima, Simlandi, Humira). 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.
16761004	BRAD ERIC VENGHAUS MD	INTERNAL MEDICINE	NURTEC	MIGRAINE PRODUCTS	G43.909	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Reyvow, Ubrelvy and Zavzpret. 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.
16763369	EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	DEXCOM G7 SENSOR	MEDICAL DEVICES	e 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G7 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
16766841	KATHARINE HOPE JONES ARNP	NURSE PRACTITIONER	AIRSUPRA	ANTIASTHMATIC AND BRONCHODILATOR A	J45.20	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 albuterol HFA inhaler (Proair, Proventil equivalent) or Ventolin HFA inhaler. 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.
16766931	SYLVIA GARCIA-BEACH MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	Z68.41	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 vour health issue.

16772233	BRIAN TERRY MILLER DO	ALLERGY & IMMUNOLOGY	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	j30.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide (Rhinocort Aqua equivalent), fluticasone (Flonase equivalent), triamcinolone (Nasacort equivalent), flunisolide. 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.
16775467	SCOTT ADAM BORUCHOW MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	t 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, Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16781891	KATHARINE HOPE JONES ARNP	NURSE PRACTITIONER	AIRSUPRA	ANTIASTHMATIC AND BRONCHODILATOR A	Mild intermittent asthma, uncomplicated	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: albuterol HFA inhaler (Proair, Proventil equivalent) or Ventolin HFA inhaler. 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.