Episode Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Denial Reason	Prescriber Decision Notes Our prior autnorization criteria for fremanezumab (AJOVY) nave not been met. From the records that we have received, Ajovy was denied for these re
						 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 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 botulin Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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
14529155 DAVID CABELL GRAY MD	INTERNAL MEDICINE	YVOLA	MIGRAINE PRODUCTS	G43.009 C	riteria Not Met	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
						 Prescribed for the prevention of migraine; AND Member has had four (4) or more migraine days per month for at least the previous three (3) months; AND A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (A) anticonvulsant (such valproate, etc.), OR (B) vasoactive agent (such as propranolol, metoprolol, etc.), OR (C) antidepressant (such as amitriptyline, venlafaxine, etc.); AND Ajovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the following at least three (3) months of individual therapy with Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy. AND (B) Member has failed at least three (3) months of individual therapy with a 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 i may be required and quantity limits may apply to covered drugs. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: Proctofoam HC. Please look at the formulary to see what drugs are covered. Prior a
						ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted
14530460 CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.9 - Unspecified hemorrhoids N	lot Covered	 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 P	lan 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 i 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
14548762 JOANA LYNN HICKS NP	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified P	lan Exclusion	treatments for vour 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 i 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
						treatments for your health issue. Our prior authorization criteria for risankizumad (אזאובו) nave not been met. From the records that we have received, אאיזובו was denied for these records that notes were not sent to us to show your response to this drug.
14561917 LINDA ELIZAB NELSON PA-C	PHYSICIAN ASSISTANT	SKYRIZI	TARGETED IMMUNOMODULATORS	L40.9 - Psoriasis, unspecified C	riteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 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 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 subm Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is may be required and quantity limits may each to general drugs.
14563391 DALIA ELIAS EL BEJJANI MD	INFECTIOUS DISEASES	CEFAZOLIN SODIUM	CEPHALOSPORINS	M00.849 P	lan 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 pro are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from
						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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may Our prior authorization criteria for apremilast (OIEZLA) have not been met. From the records that we have received, Otezla was denied for these reas 1) This drug was not prescribed for Behcet's disease, Plaque Psoriasis, OR Psoriatic Arthritis. (Please note: no diagnosis was provided) Additional criteria 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
14567605 SARAH NORANNE GEE MD	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	No dx given C	riteria 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 had 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 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 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-c The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
14570380 LORENA MOSER PNP	ADVANCED PRACTICE NURSE	NORDITROPIN FLEXPRO	ENDOCRINE AND METABOLIC AGENTS - MIS	e23.0 N	lot 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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
						4) Prescription drug samples were not used to establish treatment.

14530460 CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.

Episode Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied Denial Reason	Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these received and the formulation criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for these received and the formulation 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 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, 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 the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is and quantity limits may apply to covered drugs.
14529155 DAVID CABELL GRAY MD	INTERNAL MEDICINE	AJOVY	MIGRAINE PRODUCTS	G43.009 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the information we 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 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 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 for 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 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 may he required and quantity limits may apply to covered druce. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 co
14530460 CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.9 - Unspecified hemorrhoids 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
14531388 ERIN RENEE BURGE FNP	NURSE PRACTITIONER	IMCIVREE	ANTI-OBESITY/ANOREXIANTS	E66.09 Plan Exclusion	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 i 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 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 i 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 treatments for your health issue. Our prior authorization criteria for risankizumab (אזאובו) nave not been met. From the records that we have received, Skyrizi was denied for these received
14561917 LINDA ELIZAB NELSON PA-C	PHYSICIAN ASSISTANT	SKYRIZI	TARGETED IMMUNOMODULATORS	L40.9 - Psoriasis, unspecified Criteria Not Met	 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 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 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 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 subm Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 pro are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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 whe plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reas 1) This drug was not prescribed for Behcet's disease, Plaque Psoriasis, OR Psoriatic Arthritis. (Please note: no diagnosis was provided) Additional crite 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
14567605 SARAH NORANNE GEE MD	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	No dx given 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 had 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 list 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 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-coverage for the drug is not on our list of covered drugs, also known as a formulary.
14570380 LORENA MOSER PNP	ADVANCED PRACTICE NURSE	NORDITROPIN FLEXPRO	ENDOCRINE AND METABOLIC AGENTS - MIS	e23.0 Not Covered	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

Episode Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied Denial Reason	Prescriber Decision Notes Our prior authorization criteria for fremanezumab (AJOVY) nave not been met. From the records that we have received, Ajovy was denied for these re
					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 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 botulin Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 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
14529155 DAVID CABELL GRAY MD	INTERNAL MEDICINE	AJOVY	MIGRAINE PRODUCTS	G43.009 Criteria Not Met	 Prescribed for the prevention of migraine; AND Member has had four (4) or more migraine days per month for at least the previous three (3) months; AND A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (A) anticonvulsant (such valproate, etc.), OR (B) vasoactive agent (such as propranolol, metoprolol, etc.), OR (C) antidepressant (such as amitriptyline, venlafaxine, etc.); AND A jovy will NOT be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine; OR Ajovy will be used concomitantly with a botulinum toxin product (e.g., Botox, Dysport, Myobloc, Xeomin) for chronic migraine, and BOTH of the for 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 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 may be required and quantity limits may apply to covered druge. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: 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.
14530460 CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.9 - Unspecified hemorrhoids 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 i 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 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 i 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 treatments for your health issue. Our prior authorization criteria for risankizumap (SKYKIZI) nave not been met. From the records that we have received, Skyrizi was denied for these re
14561917 LINDA ELIZAB NELSON PA-C	PHYSICIAN ASSISTANT	SKYRIZI	TARGETED IMMUNOMODULATORS	L40.9 - Psoriasis, unspecified Criteria Not Met	 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 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 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 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 subm Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 pro are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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 whe plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may Our prior authorization criteria for apremilast (OIEZLA) have not been met. From the records that we have received, Otezla was denied for these reas 1) This drug was not prescribed for Behcet's disease, Plaque Psoriasis, OR Psoriatic Arthritis. (Please note: no diagnosis was provided) Additional crite 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
14567605 SARAH NORANNE GEE MD	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	No dx given 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 had 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 list 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 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
14570380 LORENA MOSER PNP	ADVANCED PRACTICE NURSE	NORDITROPIN FLEXPRO	ENDOCRINE AND METABOLIC AGENTS - MIS	e23.0 Not Covered	Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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 fremanezumab (AUOVY) have not been met. From the records that we have received, Ajovy was denied for these 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 botulinum toxin product (e.g., Botox, Dysport, Xeomin). If Ajovy will be 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 Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is and quantity limits may apply to covered drugs.
14529155 DAVID CABELL GRAY MD	INTERNAL MEDICINE	AJOVY	MIGRAINE PRODUCTS	G43.009 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the information we 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 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 (sucl 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 for 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 dotune This drug is not on our list of 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-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
14530460 CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.9 - Unspecified hemorrhoids 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
14531388 ERIN RENEE BURGE FNP	NURSE PRACTITIONER	IMCIVREE	ANTI-OBESITY/ANOREXIANTS	E66.09 Plan Exclusion	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 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 b 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 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 treatments for your health issue. Our prior authorization criteria for risankizumab (SKYKIZI) nave not been met. From the records that we have received, Skyrizi was denied for these r
14561917 LINDA ELIZAB NELSON PA-C	PHYSICIAN ASSISTANT	SKYRIZI	TARGETED IMMUNOMODULATORS	L40.9 - Psoriasis, unspecified Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained 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 subn Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 pro are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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 wh plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reas 1) This drug was not prescribed for Behcet's disease, Plaque Psoriasis, OR Psoriatic Arthritis. (Please note: no diagnosis was provided) Additional crite 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
14567605 SARAH NORANNE GEE MD	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	No dx given 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 had 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 list 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 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-or the graphic prior in this policy is used to decide if a not-or the graphic prior in this policy is used to decide if a not-or the graphic policy is used to decide if a not-or the
14570380 LORENA MOSER PNP	ADVANCED PRACTICE NURSE	NORDITROPIN FLEXPRO	ENDOCRINE AND METABOLIC AGENTS - MIS	e23.0 Not Covered	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pase of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

ese reasons:

will be used together with a otulinum toxin product alone. hat is covered. Prior authorization

Denials Overturned on internal appeal Denials overturned by an independet review organization

on we have received, the member riteria are listed here.

(such as topiramate, sodium ND

the following are met: (A) Member with a botulinum toxin product (e.g.,

vhat is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

tated in your benefit summary. nay be able to suggest other

ated in your benefit summary. ay be able to suggest other

ese reasons:

hat is covered.

n we have received, the member ned to the member above. The

submitted for an approval). what is covered. Prior authorization

re provider. Prescription drugs that I from coverage as indicated in your ee what is covered by your health may apply to covered drugs. e reasons:

criteria applies for each covered

hat is covered.

ve have received, the member does e listed here.

Yes

what is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

14571533 BRIAN DANIEL JAMES MD	EMERGENCY MEDICINE	DESCOVY	ANTIVIRALS	to human immunodefici

14578115 MICHELLE NICHOLE POZSONYI	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	to human immunodeficie

14587478 KRISHNA POKALA MD	NEUROLOGY	AIMOVIG	MIGRAINE PRODUCTS	
14587577 RAMESH M SINGA MD	ANESTHESIOLOGY	RELISTOR	GASTROINTESTINAL AGENTS - MISC.	K59.00 - Constipati

ficiency virus [HIV] (Criteria Not Met	Our prior autnorization criteria for emtricitabile/tenofovir alatenamide (DESCOVY) nave not been met. From the records we received, Descovy was 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 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 m 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 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 provide (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be (B) Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
ficiency virus [HIV] (Criteria Not Met	Since criteria have not heen met we are unable to approve coverage for this chrun at this time. Please refer to our formulan/ for information on we Our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the records we received, Descovy we 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 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 metere verse, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is required to be (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted Documentation is provided (chart notes including DATES OF THERAPY) of a severe adverse event or adverse effect that did not improve after at least treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not been met, we are unable to approve coverace for this drug at this time. Please refer to our formulary for information on we due prior authorization criteria have not been met, we are unable to approve coverace down the criteria brave networe, Almoving was denied on we due prior authorization criteria have not been met. We are unable to
Migraines	Criteria Not Met	 More information is needed to know if this drug 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 a 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 a does not been approved because our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the information widoes not meet number(s) 3 or 4 of our prior authorization criteria for erenumab (AIMOVIG) have not been met. From the information widoes 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 1) Prescribed for the prevention of migraine; AND Member has experienced a meaningful improvement in frequency and/or severity of migraine; AND Aimovig will NOT be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; OR Aimovig will be used concomitantly with botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; AND both or 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 (BOTOX, DYSPORT, MYOBLOC, XEOMIN) injections for chronic migraine; OR financing was initiated using manufacturer samples or any other mechanism, all of the following are met: (A) Member had four (4) or more mit three (3) months prior to starting treatment with erenumab (AIMOVIG); AND (B) Member has tried and failed, is intolerant to, or is contraindicater month trial from ONE of the following drug classes: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such
pation, unspecified I	Not Covered	 (c) antidoprocents (such as amittintuling used for inclust). This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

as aeniea for these reasons:

at is covered. Pre-approval may be

net. From the information we have er above. The criteria are listed

vided of a renal adverse event or be submitted for an approval); OR tted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered. Prior authorization was denied for these reasons:

at is covered. Pre-approval may be

net. From the information we have er above. The criteria are listed

vided of a renal adverse event or be submitted for an approval); OR tted for an approval); OR (C) least four (4) to eight (8) weeks of

what is covered. Prior authorization

Aimovig will be used together with alone AND a three (3) month trial

nat is covered.

we have received, the member eria are listed here.

of the following are met: (A) al therapy with botulinumtoxin

nigraine days per month for at least ted from trying a minimum three

as propranolol, metoprolol, etc.), or not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

						Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone get 1% 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:
14587753 JAMES SANCHO HAHN MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	e20	9.1 Criteria Not Met	This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the inform
						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
						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 formulan, for information on what is covered. Prive 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
14589819 ERIN RENEE BURGE FNP	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Body mass index (BMI) 34.0-34.9, ad	ult Plan Exclusion	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 sugge
						treatments for your health issue. This drug is not an our list of sourced drugs also known as a formulant. Our Coverage Determinations - Exceptions policy is used to deside if a pot sourced drug s
						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug c The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 equ
						azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua OTC equivalent), fluticas
						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.
14593163 ALEXANDER JAVIER ALVAREZ MD	ALLERGY & IMMUNOLOGY	AZELASTINE HYDROCHLO	RIDE NASAL AGENTS - SYSTEMIC AND TOPICAL	Allergic rhinitis due to poll	en 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 condition Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria
						denial is explained to the member above. The criteria from the policy are listed here.
						1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
						2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
						3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tr
						of trial and responses, and any other evidence to 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 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 block
						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
						and quantity limits may apply.
			ANTIHYPERLIPIDEMICS	67	3.4 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
14596443 MICHAEL FERNANDO LENIS MD	CARDIOLOGY, INTERVENTIONA	L REPATHA SURECLICK	ANTIFITERLIFIDEMICS	era	5.4 Chiena Not Met	This request has not been approved because our prior authorization criteria for evolocumab (REPATHA) have not been met. From the information we have received 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 grea
						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 provide the statin therapy or a combination provide the stating of the state o
						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. Price 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 qu
						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.
14599596 MARC EVAN WENZEL MD	ENDOCRINOLOGY, DIABETES &	NOZEMPIC	ANTIDIABETICS	R73.	03 Criteria Not Met	
						ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
						This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not me 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. Price
						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 benefi
14603170 JONATHAN ALAN LEE MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	Male erectile dysfunction, unspecifi	ed Plan Exclusion	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 sugge
						treatments for vour health issue. 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 qu
						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.
14605040 NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	Prediabet	tes Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
						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 me
						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. Price

estosterone gei 1% was denied for

net. From the information we have the member above. The criteria

what is covered. Prior authorization ated in your benefit summary. ay be able to suggest other

not-covered drug can be approved.

e 0.1% (Astelin equivalent) (TRIED), equivalent), fluticasone (Flonase

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

these reasons: . The LDL-C is a blood test that

nat is covered. Prior authorization

on we have received, the member

A) atorvastatin greater than or

or a combination product

what is covered. Prior authorization

be required and quantity limits may

ember does not meet number 1 of

what is covered. Prior authorization tated in your benefit summary. ay be able to suggest other

be required and quantity limits may

ember does not meet number 1 of

what is covered. Prior authorization

14607675 PRAVEEN KUMAR SAMPATH MD	GASTROENTEROLOGY	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.09 - Other co
14609004 MARCI ANNE ROY MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	

14609831 MARK LEROY ANDREWS MD	FAMILY PRACTICE	METFORMIN HYDROCHLORID	ANTIDIABETICS	s from other organs, syste
14619770 DANIEL NEIL SKOGLUND MD	PSYCHIATRY	VILAZODONE HYDROCHLORIE	OANTIDEPRESSANTS	
14625269 JENNIFER RENEE MULLICAN PA-C	PHYSICIAN ASSISTANT	EUCRISA	DERMATOLOGICALS	At

	Our prior authorization criteria for Motegrity have not been met. From the records that we have received, the following caused the denial of Mote 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 authorizat limits may apply to covered drugs.
r constipation Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Motegrity have not been met. From the information we have recein 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 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.
	S) Member's NOT currently using opiolds. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on wh This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
G43.909 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p of trial and responses, and any other evidence to 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 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.
ns and tissues 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
	 4) Prescription drug samples were not used to establish treatment. Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the deni 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 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, ven Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what
F33.2 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we 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 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); A 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 wh 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 approved. The conditions in our Eucrisa exception policy have not been met. From the records that we have received, the following caused the de 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
pic Dermatitis Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2,3,4 of the I 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; A 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 appropriately be used must be tried; AND

4) Member has tried and failed Opzelura.

tegrity.

zation may be required and quantity

ceived, the member does not meet

what is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

enial of vilazodone. am, escitalopram, fluoxetine, enlafaxine)

n we have received, the member does

a are listed here.

what is covered. Prior authorization a not-covered drug can be denial.

nat is covered.

nted if all conditions in our e Eucrisa exception policy criteria.

; AND ne highest potency steroid that can 14627168 THOMAS CRAIG BLEVINS MD

ENDOCRINOLOGY, DIABETES & N NOVOLOG FLEXPEN RELION ANTIDIABETICS

14629413 SCOTT DAVID BECKER MD	GASTROENTEROLOGY	REMICADE	TARGETED IMMUNOMODULATORS	
14630307 STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	
14634707 WILLIAM MONNING LOVING MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	
14636323 PATIENCE HARRIET READING MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	

14640144 SUSAN BALITE NUNEZ MD

ENDOCRINOLOGY, PEDIATRIC GENOTROPIN

ENDOCRINE AND METABOLIC AGENTS - MIS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
E10.65 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
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptic denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa
	of trial and responses, and any other evidence to 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 our formulary. REMICADE is a medication that must be given by a health care provider. administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co
K51.90 Plan Exclusion	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 w
	plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may 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 no
	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 inform
	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
	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
	problems with the generic drug. Please look at the formulary to see what drugs are covered.
F90.0 Not Covered	
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of t
	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
	 All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has
	with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fd
	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 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
	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.
	 All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extende 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
	problems with the generic drug.
	Please look at the formulary to see what drugs are covered.
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
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 of the ex 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 with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fd
	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 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
G43.719 Not Covered	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
	Please look at the list of covered drugs, also known as our formulary, to see what is covered. Our prior authorization criteria for somatropin Products have not been met. From the records that we have received, GENOTROPIN was denied for
	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 he
	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 in
	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.
E23.0 Criteria Not Met	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
	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 h
	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
	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 (IGE-1) and Insulin-like growth factor hinding protein-3 (IGE-BE
	(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-BF than 2 5th percentile) as determined by the laboratory reference range for age: OP

not-covered drug can be approved.

701, 66733077301).

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

der. Prescription drugs that are m coverage as indicated in your ee what is covered by your health may apply to covered drugs. a not-covered drug can be

formation is needed if this does not

ended release (ER),

t the FDA of efficacy and safety

nted if all conditions in our of the exception policy criteria. The

has been completed and submitted ta.fda.gov/scripts/medwatch/. ation on what is covered. Prior a not-covered drug can be

nded release (ER), methylphenidate

the FDA of efficacy and safety

nted if all conditions in our e exception policy criteria. The

has been completed and submitted a.fda.gov/scripts/medwatch/. ation on what is covered. Prior the plan. It is used to make sure a days is not covered by your plan.

for these reasons:

e how the brain or spinal cord

n infant.

ation may be required and quantity

we have received, the member does are listed here.

-BP3) levels below normal (less

14641083 DANA SPRUTE MD	FAMILY PRACTICE	ADAPALENE	DERMATOLOGICALS	
14641414 YVETTE MARIE GUTIERREZ-SCHIEFFER	MC OBSTETRICS & GYNECOLOGY	ESTRADIOL	ESTROGENS	lenopausal and female climacteric

14641542	FAITH ISIOMA OGALA	NP

ADVANCED PRACTICE NURSE VRAYLAR

ANTIPSYCHOTICS/ANTIMANIC AGENTS

14642573 DARSHAN NARENDRA SHAH MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	
14643029 ERICA ILENA STEVENS MD	DERMATOLOGY	HUMIRA PEN	TARGETED IMMUNOMODULATORS	
14644705 WILLIAM LOUIS HOLCOMB JR MD	PSYCHIATRY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	

lenied for these reas health issues of the
nulary, to see what is
rmation we have rec
criteria are listed he
information on what
information on wha ed to decide if a not
al tablets (TRIED), es
to covered drugs.
drug may be granted
ber 2 of the exception
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ry and lab results, pa
ed to decide if a not
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to covered drugs.
drug may be grante
ber 2 of the exception
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ry and lab results, pa
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drug allowed by the of 9 tablets per 16 o s Aimovig, Ajovy, an to see what drugs al
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vas denied for these litis, Psoriatic Arthrit or Uveitis. Additiona
mulary, to see what
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n the information we bove. The criteria are
Spondylitis (AS), Pso
information on wha ed to decide if a not
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ingla ER or Zohydro
to covered drugs.
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drug may be grante
ber 2 of the exception
d.
ry and lab results, pa

reasons: the skin. at is covered.

received, the member does not l here.

what is covered. Prior authorization not-covered drug can be approved.

), estradiol cream (Estrace

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

ipsychotic agents (risperidone,

anted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

the plan. It is used to make sure a 16 days is not covered by your plan. , and Emgality, must be used to s are covered on your pharmacy

ese reasons: hritis, Reactive Arthritis, Ankylosing onal criteria apply for each covered

nat is covered. Prior authorization

we have received, the member are listed here. Psoriatic Arthritis (PsA), Reactive

what is covered. Prior authorization not-covered drug can be approved.

ase (ER) (MS Contin equivalent), dro ER equivalent), tramadol ER

nted if all conditions in our eption policy criteria. The reason for

14645098 AMY ROMINGER MASON MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS
14649110 DHIREN B PATEL DO	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY

14659334 STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY

14659484 ERIN RENE	E BURGE FNP	NURSE PRACTITIONER	IMCIVREE	ANTI-OBESITY/ANOREXIANTS	Other obesity due to excess
14664326 SUSAN BAL	LITE NUNEZ MD	ENDOCRINOLOGY, PEDIATRIC	GENOTROPIN	ENDOCRINE AND METABOLIC AGENTS - MIS	

	Our prior authorization criteria for ruxolitinib (OPZELUKA) nave not been met. From the records that we have received, Opzelura was denied for to 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 viti 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 and quantity limits may apply to covered drugs.
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 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 cri 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 we may be required and quantity limits may apply to covered drugs. This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide it a 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 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿dexmethylphenidate extermethylphenidate 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 to
	problems with the generic drug. Please look at the formulary to see what drugs are covered.
F90.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of 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
	 All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, h with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata 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
	Authorization may be required. Quantity limits may apply to covered drugs. This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a 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 exten 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 to
	problems with the generic drug. Please look at the formulary to see what drugs are covered.
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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 3 of t 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
	 All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, h with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata
ess calories Plan Exclusion	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 informat This request cannot be approved because this drug is being used for weight loss without a documented covered genetic (inherited) health issue. the exception of Imcivree in cases of some specific genetic health issues (prior authorization required and quantity limits apply), are excluded from 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 suggest other treatments for your health issue.
	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 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 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 w not meet number 6 of our prior authorization criteria for Genotropin. The reason for denial is explained to the member above. The criteria are list
	 Member is 17 years of age or younger; AND Prescribed by, or in consultation with, a Pediatric Endocrinology Specialist; AND Member has a diagnosis of growth hormone deficiency (GHD); AND Member meets ONE (1) of the following:
E23.0 Criteria Not Met	 (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-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 grov
	microphallus, (vi) low IGF-1 AND IGF-BP3, (vii) multiple pituitary hormone deficiencies such as thyroid stimulation hormone and adrenocorticotro 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 malformati

(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)

r tnese reasons: 'itiligo, a health issue where patches

hat is covered. Prior authorization

n we have received, the member riteria are listed here.

what is covered. Prior authorization a not-covered drug can be

at this drug did not work for you. tended release (ER),

t the FDA of efficacy and safety

ranted if all conditions in our 3 of the exception policy criteria. The

has been completed and submitted ta.fda.gov/scripts/medwatch/. ation on what is covered. Prior

a not-covered drug can be

ended release (ER), methylphenidate

t the FDA of efficacy and safety

anted if all conditions in our f the exception policy criteria. The

has been completed and submitted ta.fda.gov/scripts/medwatch/. ation on what is covered. Prior e. Drugs used for weight loss, with om coverage as stated in your th care provider may be able to r mese reasons:

ation may be required and quantity

we have received, the member does sted here.

-BP3) levels below normal (less

owth, (iv) midline defects, (v) ropic hormone deficiencies, or (viii)

14	1664378 HEATHER DARLENE DONAGHEY APN	ADVANCED PRACTICE NURSE	DRONABINOL	ANTIEMETICS	
14	1673518 TISA DONYELLE COLLINS-DOUGLAS	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	
14	1676573 STEPHANIE ANN SHAW MD	ENDOCRINOLOGY, DIABETES & N	TIROSINT-SOL	THYROID AGENTS	E03.9 Hypothyro
14	1678143 ANDREW PLUMMER MD	OPHTHALMOLOGY	TAFLUPROST	OPHTHALMIC AGENTS	

14684755 PAUL HIEN LE MD ANESTHESIOLOGY BUPRENORPHINE HCL

14685472 DAWN CAROLINE PEASE APN NURSE PRACTITIONER

PROLIA

ENDOCRINE AND METABOLIC AGENTS - MIS

ANALGESICS - OPIOID

		 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 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 whom the criteria have not been met, we are not able to approve.
R63.4	Criteria Not Met	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 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 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 a 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 we
		 Our pror authorization criteria for emtricitabline/tenorovir alatenamice (DESCOVY) nave not been met. From the records we received, Descovy we 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 needed and there may be limits on the amount of drug covered at a time.
Z20.6	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been m 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 here.
		 Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR Prescribed for pre-exposure prophylaxis of HIV infection; AND Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provide decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to b (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted tobe submitted to be submitted to be submitted to be submitted t
		Sur prior authorization criteria for levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the records that we have received, 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 wh
roidism, unspecified	Criteria Not Met	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 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. 1) Prescribed for ONE (1) of the following: (A) Hypothyroidism; OR (B) Pituitary thyrotropin (Thyroid-Stimulating Hormone, TSH) suppression; AN
		 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 we Our prior authorization criteria for Ophthalmic Prostaglandins have not been met. From the records that we have received, TAFLUPROST was der 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 is may apply to covered drugs.
H40.1132	Criteria Not Met	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 member does not meet number 1 of our prior authorization criteria for TAFLUPROST. The reason for denial is explained to the member above. T 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) 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 w 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 n 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.
G89.4	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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. F administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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

or these reasons.

ng the other drug you tried were

hat is covered.

n we have received, the member a are listed here.

antiemetic treatments. Please list

what is covered. Prior authorization vas denied for these reasons:

at is covered. Pre-approval may be

met. From the information we have er above. The criteria are listed

ided of a renal adverse event or be submitted for an approval); OR tted for an approval); OR (C) st four (4) to eight (8) weeks of

What is covered Prior authorization Throsint-Sol was denied for these

nat is covered.

met. From the information we have mber above. The criteria are listed

what is covered Prior authorization nied for these reasons:

zation may be required and quantity

ation we have received, the The criteria are listed here. latanoprost ophthalmic solution;

what is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

Prescription drugs that are m coverage as indicated in your ee 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 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.
14686308 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	DEXCOM G6 RECEIVER	MEDICAL DEVICES	dx type 2 DM 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.
14686540 LOUIS JOSEPH LUX MD	INTERNAL MEDICINE	HYSINGLA ER	ANALGESICS - OPIOID	C51.411 Plan Limits Exceeded	plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.
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.
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
14687089 MARC EVAN WENZEL MD	ENDOCRINOLOGY, DIABETE	ES & N NOVOLOG FLEXPEN	ANTIDIABETICS	E10.65 Not Covered	 ADDITIONAL INFORMATION FOR FOOR HEALTH CARE PROVIDES. This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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.
14693289 STEVEN ZACHARY POWELL MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 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 PROPIONAT	TE/S# 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	 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 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. 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 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-intensi

using insulin before the requested

drug allowed by the plan. It is used ets per day is not covered by your Yes

not-covered drug can be approved.

Cs: 00002773701, 66733077301) OR

						Our prior authorization criteria for Trintellix nave 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-perepinentrine reuptake inhibitor (SNRI) antidepressant such as duloyetine, or veniafavine, has been tried and failed.
						 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.
14698154 IVAN SRDANOVIC PMHNPBC	ADVANCED PRACTICE NURSE	TRINTELLIX	ANTIDEPRESSANTS	F3	2.9 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet
						number 2,3 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) Device the set of the heavy of the heavy of the set of the set of the heavy of CCD by AND
						 Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 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
						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.
14703278 IRIS SOFIA WINGROVE MD	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY	G47.419 - Narcolepsy without catapl	exy Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received, the member does not 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. 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.
14706125 AMANDA KAY WATERMAN	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	Z68	3.34 Plan Exclusion	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 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.
14709176 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES &	N OZEMPIC	ANTIDIABETICS	E2	28.2 Criteria Not Met	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
						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
14710086 ZHAN YANG NP	NURSE PRACTITIONER	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31	.70 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
						denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
						3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 formulant. Our Coverage Determinations – Excentions policy is used to deside if a net covered drug can be approved.
						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
14711758 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	lisorder, predominantly hyperactive t	vpe 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
				isoraci, predominantiy hyperactive t	ype not covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
						 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
						 Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Records have been received showing the requested to establish treatment.

					Our prior authorization criteria for Trintellix nave 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, tried and failed. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
14698154 IVAN SRDANOVIC PMHNPBC	ADVANCED PRACTICE NURSE	TRINTELLIX	ANTIDEPRESSANTS	F32.9 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, a 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 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 limits may apply to covered drugs.
14703278 IRIS SOFIA WINGROVE MD	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY	G47.419 - Narcolepsy without cataplexy Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received, th number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria are 1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (documentatio 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 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is 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 i 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 treatments for your health issue.
14709176 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES &	L N 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 rec 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 co 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 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
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (risp olanzapine, ziprasidone, quetiapine, and others). *Please note, if member is stable on medication, please provide length of use and we may be able to Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14710086 ZHAN YANG NP	NURSE PRACTITIONER	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.70 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
14711758 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	disorder, predominantly hyperactive type Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Trintellix nave 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 tried and failed. 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried
14698154 IVAN SRDANOVIC PMHNPBC	ADVANCED PRACTICE NURSE	TRINTELLIX	ANTIDEPRESSANTS	F32.9 Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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, 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 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 limits may apply to covered drugs.
14703278 IRIS SOFIA WINGROVE MD	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY	G47.419 - Narcolepsy without cataplexy Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received, the number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria are 1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (documentation 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 positiv Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 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 treatments for each be list is a stated.
					treatments for vour health issue. 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 re 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 c
14709176 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES &	& N OZEMPIC	ANTIDIABETICS	E28.2 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the memb 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (ris olanzapine, ziprasidone, quetiapine, and others). *Please note, if member is stable on medication, please provide length of use and we may be able to Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14710086 ZHAN YANG NP	NURSE PRACTITIONER	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.70 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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 information on what information approves coverage for this drug at this time.
14711758 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	disorder, 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-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
					 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Records have a camples were not used to establish treatment.

ellix.

n tried and failed. hat is covered.

14716678 DIANA NATHALIE ANDINO MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS

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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 N 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 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 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 cr 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 tw 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
14721069 JOSEPH CASIMIR SWIDER DO 14722147 PRIYA MATHEW PHILIP MD	PSYCHIATRY FAMILY PRACTICE	SPRAVATO 84MG DOSE OZEMPIC	ANTIDEPRESSANTS	urrent severe without psychotic features Plan Exclusion E66.9 - Obesity, unspecified 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. Pres administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from cov 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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may a 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 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
14723198 ELIZABETH HAVEY MILLER MD	DERMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	L20.9 Criteria Not Met	 treatments for your health issue. Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these references and the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is a 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 ledoes 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 liste 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 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, not tolerated, or contraindicated (documentatio for an approval); AND 6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentatio 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 supproval.
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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (TRIED), betamethasone, halobetasol), one topical vitamin D analog (such as calcipotriene, calcitriol), tazarotene, tacrolimus, pimecrolimus, and Zoryce Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

al of Wakix. zation may be required and quantity

have received, the member does

The criteria are listed here. and two (2) or more sleep onset

what is covered. Prior authorization r. Prescription drugs that are m coverage as indicated in your ee what is covered by your health may apply to covered drugs. ated in your benefit summary.

ay be able to suggest other ese reasons: nat is covered.

n we have received, the member e listed here.

than 10% BSA affected, but

cumentation required to be

ntation is required to be submitted

vhat is covered. Prior authorization not-covered drug can be approved.

steroid (such as triamcinolone Zoryve.

nted if all conditions in our eption policy criteria. The reason for

14723977 AMARA SAYED DO	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L20.9 Crite	eria 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 rea 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 p 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 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 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 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 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 treatm 5) Roflumilast will not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i may be required and quantity limits may apply to covered drugs.
14724465 SAIMA KANWAL JEHANGIR MD	OBSTETRICS & GYNECOLOGY	MYFEMBREE	ESTROGENS	abnormal uterine bleeding Crite	eria Not Met	Our prior authorization criteria for relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. From the records that we have received, Myfereasons: 1) The drug is not being used for heavy menstrual bleeding caused by uterine fibroids (noncancerous growths in the uterus), OR for pain associated to 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 Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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. 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 mer 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
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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 i
14726976 MAYA BADACHHAPE BLEDSOE MD	INTERNAL MEDICINE	SOMATULINE DEPOT	ENDOCRINE AND METABOLIC AGENTS - MIS	E22.0 Not	Covered	 Since cheria have not been find, we are drable to approve coverage for this drug at this time. Prease feter to the formularly for information of what is this drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. Our prior autonization function approved to establish treatment.
14728756 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TESTOSTERONE	ANDROGENS-ANABOLIC	R79.89 Crite	eria Not Met	 but plot dution dution dution dution dution and open structures indeced to be duties indeced by does not make received, it but 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 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. F 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 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 it is appropriate to continue treatment.

14726514 ELDA EVELIA VILLARREAL PA-C	PHYSICIAN ASSISTANT	INVOKANA	ANTIDIABETICS

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 read 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 p 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 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 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 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 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 treatr Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is Since criteria have not been met, we are unable to approve coverage for this drug at this time.
14724465 SAIMA KANWAL JEHANGIR MD	OBSTETRICS & GYNECOLOGY	MYFEMBREE	ESTROGENS	abnormal uterine bleeding Criteria Not Met	 may be required and quantity limits may apply to covered drugs. Our prior authorization criteria for relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. From the records that we have received, Myfereasons: 1) The drug is not being used for heavy menstrual bleeding caused by uterine fibroids (noncancerous growths in the uterus), OR for pain associated to 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 Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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. 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 merelisted 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 it is the criteria have not been met, we are unable to approve coverage for this drug at this time.
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-control conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 it is the please refer to the formulary for information on what it is the please refer to the formulary for information on what it is content in how not been met, we are unable to approve coverage for this drug at this time.
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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 autionization chema for Antrogens. Transdeman restosterone Products have not been met. From the records that we have received, restoches 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 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. F 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 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.

e reasons: dry patches and scales.

erapy (e.g. adalimumab, Enbrel) for

hat is covered. Prior authorization

we have received, the member does listed here.

treatment of plaque psoriasis. what is covered. Prior authorization

Myfembree was denied for these

ated with endometriosis (a health each covered diagnosis. hat is covered.

met. From the information we have e member above. The criteria are

what is covered. Prior authorization not-covered drug can be approved.

iance or Synjardy (XR).

anted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

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nat is covered.

met. From the information we have o the member above. The criteria

what is covared Driar authorization

						 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 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 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 F problems with the generic drug. Please look at the formulary to see what drugs are covered.
14729283 ISRAEL CALZADA MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.9 N	ot Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
						ADDITIONAL INFORMATION FOR YOOR HEALTH CARE PROVIDER. This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in 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 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
						 All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has b
						with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda. Since criteria have not been met. we are not able to approve coverage for this drug at this time. Please refer to the formularv for specific information Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 d
14729284 JENNY ROSE TOBAT	FAMILY PRACTICE	FREESTYLE LIBRE 14 DAY/SE	MEDICAL DEVICES	E11.9 C	riteria 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
						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 of 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
						authorization may be required and quantity limits may apply. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co
						The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 fo
						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:
14731400 DAVID CABELL GRAY MD	INTERNAL MEDICINE	DEXCOM G7 SENSOR	MEDICAL DEVICES betes	mellitus with hyperglycemia (HCC) N	ot Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
						 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
						3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Ophthalmic Prostaglandins have not been met. From the records that we have received, tafluprost was denied for t
						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 limits may apply to covered drugs.
14737560 GHADA HASBANI ABDALLAH OD	OPTOMETRIST	TAFLUPROST	OPHTHALMIC AGENTS	H40.013 C	riteria Not Met	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
						member does not meet number 1 of our prior authorization criteria for tafluprost. The reason for denial is explained to the member above. The criter 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latar 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 i 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 P	an 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 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 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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 n
						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.
				120.1 M	at Coverad	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
14739143 DONALD ROBERT BRODE MD	FAMILY PRACTICE	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.1 N	ot Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
						1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
						 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
						4) Prescription drug samples were not used to establish treatment

14729284 JENNY ROSE TOBAT	FAMILY PRACTICE	FREESTYLE LIBRE 14 DAY/SE	MEDICAL DEVICES

					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 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 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 F problems with the generic drug. Please look at the formulary to see what drugs are covered.
14729283 ISRAEL CALZADA MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.9 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 of the excert 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 b with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda 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 Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 d
14729284 JENNY ROSE TOBAT	FAMILY PRACTICE	FREESTYLE LIBRE 14 DAY/SE	MEDICAL DEVICES	E11.9 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 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 o 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 authorization may be required and quantity limits may apply.
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-control of the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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:
14731400 DAVID CABELL GRAY MD	INTERNAL MEDICINE	DEXCOM G7 SENSOR	MEDICAL DEVICES	betes mellitus with hyperglycemia (HCC) Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Ophthalmic Prostaglandins have not been met. From the records that we have received, tafluprost was denied for the of the received showing the requested drug is not covered drugs are likely to be ineffective or unsafe for the member.
					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 limits may apply to covered drugs.
14737560 GHADA HASBANI ABDALLAH OD	OPTOMETRIST	TAFLUPROST	OPHTHALMIC AGENTS	H40.013 Criteria Not Met	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 member does not meet number 1 of our prior authorization criteria for tafluprost. The reason for denial is explained to the member above. The criter 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latar 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 i 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 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 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-construction or not list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-construction of the policy have not been met. From the records that we have received, these reasons caused 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 not construct drugs are provided to the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

a not-covered drug can be

nded release (ER), methylphenidate

the FDA of efficacy and safety

nted if all conditions in our e exception policy criteria. The

has been completed and submitted a.fda.gov/scripts/medwatch/. ation on what is covered. Prior using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

not-covered drug can be approved.

DC for the sensors is 08627007701)

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

d for these reasons:

zation may be required and quantity

ation we have received, the criteria are listed here.

latanoprost ophthalmic solution;

what is covered. Prior authorization

ited in your benefit summary. ay be able to suggest other

not-covered drug can be approved.

lide nasal solution, trimcinolone

nted if all conditions in our eption policy criteria. The reason for

14742348 STEPHANIE ANN SHAW MD	ENDOCRINOLOGY, DIABETES & N TIROSINT-SOL	THYROID AGENTS

14743883 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY

14746883 CYNTHIA LYNN BENTON MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	
14747036 TERRY SCOTT PEERY DO	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY	

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-The conditions in this policy have not been met. From the records that we have received, these reasons caused 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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, par of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
E03.9 Criteria Not Met	 4) Prescription drug samples were not used to establish treatment. Our prior authorization criteria for levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the records that we have received, Tiror reasons: 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 in 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 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 here. 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.
F90.0 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 relea 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 ne 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 extende 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 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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2, 3 of the excereason 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 with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fd
G47.419 Criteria Not Met	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 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 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, number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria are 1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (documentat 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 posit Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what may be required and quantity limits may apply to covered drugs.

not-covered drug can be approved.

nted if all conditions in our

ption policy criteria. The reason for

, past treatments tried with dates

lirosint-Sol was denied for these

nat is covered.

Yes met. From the information we have mber above. The criteria are listed

١D what is covered. Prior authorization not-covered drug can be approved.

release (ER), methylphenidate ER,

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

a not-covered drug can be

nded release (ER), methylphenidate

t the FDA of efficacy and safety

nted if all conditions in our

exception policy criteria. The

has been completed and submitted a.fda.gov/scripts/medwatch/.

ation on what is covered. Prior

ation may be required and quantity

ed, the member does not meet a are listed here.

ntation is required to be submitted

ositive airway pressure therapy. what is covered. Prior authorization Yes

14749117 CARTER REID HANSON PA-C	PHYSICIAN ASSISTANT	DESCOVY	ANTIVIRALS
14752130 MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS

14752408 MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	EMGALITY	MIGRAINE PRODUCTS	

14754072 MAYA BADACHHAPE BLEDSOE MD INTERNAL MEDICINE

LANREOTIDE ACETATE

ENDOCRINE AND METABOLIC AGENTS - MIS

14754830 JOHN ANTHONY QUENG MD	FAMILY PRACTICE	TRETINOIN	DERMATOLOGICALS) - Disorder of pigmentation, u
14754996 KENNETH ALLEN PEREZ DO	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Abnormal w

Prep	Criteria Not Met	Our prior autinorization criteria for emtricitabine/tenofovir alatenamide (DESCOVY) nave not been met. From the records we received, Descovy we 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 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 meterieved, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member 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 provide dor an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitt Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitt Documentation is provided (chart notes including dates of therapy) of a severe adverse eert or adverse effect that did not improve after at least treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA). Since criteria have not heen met we are unable to approve coverage for this drug at this time. Please refer to our formulary for informa
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 net or 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
G43.119	Criteria Not Met	 4) Prescription drug samples were not used to establish treatment. Our prior authorization criteria for galcanezumab (EMGALLET 120mg) have not been met, from the records that we have received, Emgality 120m 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.), records must also show you have had at least a three (3) month trial of Emmonth trial of 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 Emmonth 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 wh 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 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. 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
		 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 folload at loast three (2) months of individual therapy with Emgality. AND (P) Momber has failed at loast three (2) months of individual therapy with This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a month conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
E22.0	Not Covered	 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
ation, 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 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 p
ormal weight gain	Plan Exclusion	other treatments for your health issue. This request cannot be approved because this drug/product is in a class of drugs/products called anti-obesity or weight loss drugs. Drugs/product 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
		health care provider may be able to suggest other treatments for your health issue.

was denied for these reasons:

at is covered. Pre-approval may be

met. From the information we have ber above. The criteria are listed

vided of a renal adverse event or be submitted for an approval); OR nitted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered. Prior authorization a not-covered drug can be approved.

anted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

mg was denied for these reasons:

If Emgality will be used together mgality alone AND a three (3)

nat is covered.

information we have received, the e. The criteria are listed here.

s (such as topiramate, sodium

ollowing are met: (A) Member has a not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

Yes

s, past treatments tried with dates

age as stated in your benefit provider may be able to suggest

lucts of this type are excluded from red by your plan. Your doctor or

14759367 RANI DAS MD	NEUROLOGY	SUNOSI	ADHD/ANTI-NARCOLEPSY

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 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, th number 3 of our prior authorization criteria for Sunosi (Initial Therapy) for Excessive Daytime Sleepiness with Narcolepsy. The reason for denial is exp 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 t 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 rea 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 p Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 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 her 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 treatm Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is may be required and quantity limits may apply to covered drugs.
14765207 ERIN JENNIFER MOHLKE	NURSE PRACTITIONER	TRAMADOL HYDROCHLORIE	DE ANALGESICS - OPIOID	G89.4	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 and 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/acetar hydrocodone/acetaminophen, hydromorphone, tramadol. Please note: We will only cover up to 7 days for the FIRST fill of an opioid pain reliever such 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 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 content of the request has not been approved because our Opioid Naive criteria for Step Therapy have not been met. From the information we have received, to 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.
14766421 WEIWEI CAO PHD	GASTROENTEROLOGY	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOIseas	se with esophagitis, without bleeding	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 it This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused 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). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-conditions in this policy have not been met. From the records that we have recei
14767286 NATHAN WALLACE ANDERSON MD	FAMILY PRACTICE	SEGLUROMET	ANTIDIABETICS	E11.65	Not Covered	 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

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 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 number 3 of our prior authorization criteria for Sunosi (Initial Therapy) for Excessive Daytime Sleepiness with Narcolepsy. The reason for denial is expl 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 the 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 reas 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 pa Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 ha 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 treatm Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is may be required and quantity limits may apply to covered drugs.
14765207 ERIN JENNIFER MOHLKE	NURSE PRACTITIONER	TRAMADOL HYDROCHLORIE	DE ANALGESICS - OPIOID	G89.4 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 and 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/acetann hydrocodone/acetaminophen, hydromorphone, tramadol. Please note: We will only cover up to 7 days for the FIRST fill of an opioid pain reliever such 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 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 complexed has not been approved because our Opioid Naive criteria for Step Therapy have not been met. From the information we have received, t 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.
14766421 WEIWEI CAO PHD	GASTROENTEROLOGY	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOIsease with esophagitis, without	t bleeding 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-core the conditions in this policy have not been met. From the records that we have received, these reasons caused 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). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-core the conditions in this policy have not been met. From the recor
14767286 NATHAN WALLACE ANDERSON MD	FAMILY PRACTICE	SEGLUROMET	ANTIDIABETICS	E11.65 Not Covered	Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

zation may be required and quantity

ved, the member does not meet s explained to the member above.

and two (2) or more sleep onset

e reasons:

dry patches and scales. nat is covered. Prior authorization

we have received, the member does d here.

treatment of plaque psoriasis. what is covered. Prior authorization

at another drug will need to be tried acetaminophen, er such as the drug requested. For

are in hospice care. Since step re covered.

ived, the member does not meet

what is covered. Prior authorization not-covered drug can be approved. e (tried), rabeprazole, lansoprazole,

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

14768759 CYNTHIA LYNN BENTON MD VYVANSE ADHD/ANTI-NARCOLEPSY PSYCHIATRY

14768769 PRIYA MATHEW PHILIP MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesi
14769136 KEN LIN FNP-C	NURSE PRACTITIONER	TRAMADOL HYDROCHLORIDE	ANALGESICS - OPIOID	

14773090 DAVID CABELL GRAY MD	INTERNAL MEDICINE	NOVOLOG FLEXPEN	ANTIDIABETICS	betes mellitus with hyperglyce

883 DANIEL ANTHONY CARRASCO ME

14775633 DAMIAN G LARA MD

FAMILY PRACTICE

UBRELVY

MIGRAINE PRODUCTS

	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 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 extend 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 problems with the generic drug. Please look at the formulary to see what drugs are covered.
F90.9 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 3 of 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, he with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata 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 informat This request cannot be approved because this drug/product is in a class of drugs/products called anti-obesity, or weight loss, drugs. Drugs/product
ty, 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/product 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 health care provider may be able to suggest other treatments for your health issue.
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 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 releat 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
lycemia (HCC) Not Covered	 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 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Huma Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 who Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the control of the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is the criteria have not been met, we are not able to approve.
I20.9 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 does not meet number(s) 1 of our prior authorization criteria for Dupixent (Continuing Therapy). The reason for denial is explained to the membe here. 1) Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval). 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 wh Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubreivy was denied for the 1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan, rizatriptan, or others) when taken WITH a nonsteroid (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
G43.809 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 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 he 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 annrove coverage for this drug at this time. Please refer to our formulan, for information on what is covered. Prior authorization

a not-covered drug can be

nded release (ER), methylphenidate

the FDA of efficacy and safety

nted if all conditions in our

the exception policy criteria. The

has been completed and submitted ta.fda.gov/scripts/medwatch/. ation on what is covered. Prior ducts of this type are excluded from ed by your plan. Your doctor or

not-covered drug can be approved.

lease (IR), oxycodone,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

nalog/Admelog equivalent).

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization denial of Dupixent.

nat is covered.

n we have received, the member er above. The criteria are listed

); AND

what is covered. Prior authorization nese reasons:

oidal anti-inflammatory drug

at is covered.

n we have received, the member ere.

147778	365 JAY LELAND VIERNES MD	DERMATOLOGY	TREMFYA	TARGETED IMMUNOMODULATORS	

14778042 CAROLINE ANNE KAUFMAN MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS	lenopausal and female climac

14778387	CELIA BETH SERVIN MD	FAMILY PRACTICE	FLUTICASONE PROPIONATE/S/	ANTIASTHMATIC AND BRONCHODILATOR A	09 - Unspecified asthma,

14781880 JOHNNY ZHAO MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	
14785045 MARCIAL ANDRES OQUENDO RINCON N	4 PEDIATRICS	VYVANSE	ADHD/ANTI-NARCOLEPSY	
14789645 MICHELLE LE MARKLEY MD	FAMILY PRACTICE	MOUNJARO	ANTIDIABETICS	id (severe) obesity due to exce

140.0	Criteria Not Met	 Con prior authorization criteria for guserkumab (TREINETA) have not been met. From the records that we have received, Treining 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 (TREINFYA) have not been met. From the information we have received 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 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 a Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered
acteric 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. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 condi Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy cri denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatment of trial and responses, and any other evidence to 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. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
ncomplicated	Not Covered	 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/salmeter 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 condicoverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy cridenial is explained to the member above. The criteria from the policy are listed here. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatmer of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
140.0	Criteria Not Met	 4) Prescription drug samples were not used to establish treatment. 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. I 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 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 place 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 may be required and quantity limits may apply to covered drugs.
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 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 exmethylphenidate 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 effip 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 condit 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 police 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 comp 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/scrip
xcess calories	Plan Exclusion	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 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 ber 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 su treatments for your health issue.

we have received, the member s explained to the member above.

submitted for an approval). what is covered. Prior authorization

not-covered drug can be approved.

oral tablet, one-time weekly

nted if all conditions in our

eption policy criteria. The reason for

past treatments tried with dates

not-covered drug can be approved.

asone/salmeterol breath-actuated

nted if all conditions in our otion policy criteria. The reason for

past treatments tried with dates

t is covered. Prior authorization

e have received, the member does

treatment of plaque psoriasis; AND

what is covered. Prior authorization

a not-covered drug can be

Iphenidate extended release (ER),

the FDA of efficacy and safety

nted if all conditions in our e exception policy criteria. The

has been completed and submitted a.fda.gov/scripts/medwatch/. ation on what is covered. Prior ated in your benefit summary. ay be able to suggest other

						Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubreivy was denied for these 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 (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 a
14790808 CRAIG HEWELL COUCH MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	g43.009	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we 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 he 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.
14791445 PRIYA MATHEW PHILIP MD	FAMILY PRACTICE	TRULICITY	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 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 treatments for your health issue.
						Our prior authorization criteria for roflumilast (ZORYVE) have not been met. From the records that we have received, Zoryve was denied for these real 1) Records show this drug will be used together with one of the following drugs: Vtama, Otezla, Sotyktu, or biologic therapy (e.g. adalimumab, Enbre Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is and quantity limits may apply.
14792005 JOHNNY ZHAO MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L40.0	Criteria Not Met	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 h 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 he 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 treat 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 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-or 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), venlafa Please look at the formulary to see what drugs are 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	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 4 of the 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
						tolerated. 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 re 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
14796185 KRISTIE SONTAG DAPP NP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	E28.2	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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
						Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide it a no 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 pro- 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, Tou 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 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.
14801099 BRYAN TODD IRVIN MD	FAMILY PRACTICE	LANTUS SOLOSTAR	ANTIDIABETICS	E11.9	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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 of the exc 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 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

						Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubreivy was denied for these 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 (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 a
14790808 CRAIG HEWELL COUCH MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	g43.009	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we 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 he 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.
14791445 PRIYA MATHEW PHILIP MD	FAMILY PRACTICE	TRULICITY	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 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 treatments for your health issue.
						Our prior authorization criteria for roflumilast (ZORYVE) have not been met. From the records that we have received, Zoryve was denied for these real 1) Records show this drug will be used together with one of the following drugs: Vtama, Otezla, Sotyktu, or biologic therapy (e.g. adalimumab, Enbre Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is and quantity limits may apply.
14792005 JOHNNY ZHAO MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L40.0	Criteria Not Met	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 h 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 he 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 treat 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 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-or 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), venlafa Please look at the formulary to see what drugs are 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	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 4 of the 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
						tolerated. 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 re 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
14796185 KRISTIE SONTAG DAPP NP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	E28.2	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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
						Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide it a no 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 pro- 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, Tou 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 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.
14801099 BRYAN TODD IRVIN MD	FAMILY PRACTICE	LANTUS SOLOSTAR	ANTIDIABETICS	E11.9	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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 of the exc 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 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

14801099 BRYAN TODD IRVIN MD	FAMILY PRACTICE	LANTUS SOLOSTAR	ANTIDIABETICS	

tnese reasons:

roidal anti-inflammatory drug

nat is covered.

on we have received, the member sted here.

what is covered. Prior authorization tated in your benefit summary. may be able to suggest other

se reasons: , Enbrel) for your health issue.

what is covered. Prior authorization

n we have received, the member does ted here.

treatment of plaque psoriasis; AND

what is covered. Prior authorization

not-covered drug can be approved.

enlafaxine, or others)

anted if all conditions in our of the Vraylar exception policy

cation was ineffective or not

o be required and quantity limits may

hat is covered.

nember does not meet number 1 of

what is covered. Prior authorization

al product that is approved by the

, Toujeo, Tresiba,Semglee. rt the FDA of efficacy and safety

nted if all conditions in our ne exception policy criteria. The

rug, has been completed and

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

					Our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the records that we have received, Oriahnn 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 co
					ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
14803121 CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	ORIAHNN	ESTROGENS	frequent menstruation with regular cycle Criteria Not Met	This request has not been approved because our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From 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 about the received of the member about the member abou
					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
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
					 All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Proctosol HC cream (ANUSOL HC 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:
14811609 APRIL WEST FOX MD	SURGERY, COLON & RECTAL	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	other hemorrhoids Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i
					Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
					1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
					 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 2) Reserve have been received chewing the requested drug is medically persented.
					3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these re
					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
					ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
14812016 JOHN JOSEPH ZIEBERT MD	GASTROENTEROLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	dx UC Criteria Not Met	This request has not been approved because our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the information we l 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 liste
					 Prescribed by a Gastroenterology Specialist; AND 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, contraindicate Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is
					may be required and quantity limits may apply to covered drugs Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason:
					1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be rec 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 co
14812141 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES &	& N OZEMPIC	ANTIDIABETICS	E28.2 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
					This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.
					 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 Our prior authorization criteria for Ophthalmic Prostagiandins have not been met. From the records that we have received, tatluprost ophthalmic solutions on the records that we have received.
					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 limits may apply to covered drugs.
14812958 ZARMEENA VENDAL MD	OPHTHALMOLOGY	TAFLUPROST	OPHTHALMIC AGENTS	H04.123 Criteria Not Met	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
					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
					1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latar 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 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-co
					The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
14813045 CASEY RENEE MCLEOD	PHYSICIAN ASSISTANT	VITAMIN D3	VITAMINS	E55.9 - Vitamin D deficiency, unspecified Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i
17010079 CASET NEINEE WICLEOD				255.5 Vitamin D dendency, unspecified Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
					1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
					2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
					3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

ahnn was denied for these reasons:

at is covered.

. From the information we have er above. The criteria are listed

what is covered. Prior authorization not-covered drug can be approved.

equivalent),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ese reasons:

nat is covered.

n we have received, the member e listed here.

dicated, or not tolerated. what is covered. Prior authorization

be required and quantity limits may at is covered.

ember does not meet number 1 of

what is covered. Prior authorization

zation may be required and quantity

ation we have received, the iteria are listed here.

latanoprost ophthalmic solution;

what is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

14813555 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TESTOSTERONE	ANDROGENS-ANABOLIC	
14814909 AMY HERRIN KOWALSKI APN	ADVANCED PRACTICE NURSE	ESTRADIOL	ESTROGENS	

14817189 ANDREW PAUL BARGER APN	ADVANCED PRACTICE NURSE	CLOMID	ENDOCRINE AND METABOLIC AGENTS - MIS	E29.1 - Testicular hyp
14821174 BENJAMIN PAUL FIEDLER MD	FAMILY PRACTICE	NOVOLOG FLEXPEN	ANTIDIABETICS	

14821862	MICHAEL JOSEPH REGAN IV MD	EMERGENCY MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3
14823935	JOHNNY ZHAO MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	

	Our phor authorization criteria for Androgens. Transdemai restosterone Products have not been met. From the records that we have received, restosterone GEL 1%(SOIVIG) 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.
R79.89 Criteria Not Met	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 hav 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. Places refer to our formulary for information on what is covered. Brier 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 approve
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
N95.1 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 approve
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
hypofunction Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
E11.21 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason fo
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 weightloss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary.
- Overweight Plan Exclusion	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 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.
PsO Criteria Not Met	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 do 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
	 Member is at least 6 years of age or older; AND Roflumilast will not be used in combination with tapinarof (Vtama), apremilast (Otezla), deucravacitinib (Sotyktu), or biologic therapy for the treatment of plaque psoriasis; AN 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.

IESIUSIEKUNE GEL 1%(JUNG)

hat is covered.

Yes net. From the information we have

not-covered drug can be approved.

oral tablet, one-time weekly

nted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

lerm patches, testosterone

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

ispro (Humalog/Admelog

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

ated in your benefit summary.

ay be able to suggest other

e reasons:

Enbrel) for your health issue. hat is covered. Prior authorization

we have received, the member does d here.

treatment of plaque psoriasis; AND

what is covered. Prior authorization

14825316 HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS
14834878 KARISA RAE STANCIL FNP-C	NURSE PRACTITIONER	VILAZODONE HYDROCHLO	RID ANTIDEPRESSANTS

14842226 SIMONA MARIANA SCUMPIA MD

14850623 EMILY WANTLAND HICKS FNP-C NURSE PRACTITIONER

14850835 PATIENCE HARRIET READING MD NEUROLOGY

14852902 MOHAMMAD BASHASHATI SAGHEZCHI NGASTROENTEROLOGY

GASTROINTESTINAL AGENTS - MISC.

GASTROINTESTINAL AGENTS - MISC.

MIGRAINE PRODUCTS

LINZESS

UBRELVY

LINZESS

ENDOCRINOLOGY, DIABETES & N ZEPBOUND

ANTI-OBESITY/ANOREXIANTS

CALS

Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records showing this drug is working well have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: nasal polyps Criteria Not Met 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: depression Criteria Not Met 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 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 obesity Plan Exclusion 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. 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 uprogepant (UBRELVY) have not been met. From the records that we have received, Upreivy 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. 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 formulan, for information on what is covered. Prior authorization Our prior authorization 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. 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 N GASTROENTEROLOGY LINZESS GASTROINTESTINAL AGENTS - MISC.

14853156 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	QELBREE	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, com
14853539 MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	
			DENINATOLOGICALS	,

14858282 LIEF ERICSSON FENNO MD	PSYCHIATRY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	opio

14860483 DAVID FRANCIS ESCAMILLA MD	FAMILY PRACTICE	HYDROQUINONE	DERMATOLOGICALS	
14862566 CYNTHIA CHAPARRO-KRUEGER DO	OBSTETRICS & GYNECOLOGY	ORIAHNN	ESTROGENS	

14868464 RABIN KHERADPOUR MD

INTERNAL MEDICINE

KERENDIA

ENDOCRINE AND METABOLIC AGENTS - MIS

	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these 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 and quantity limits may apply to covered drugs.
CIC 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 w 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 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 whether the syndrome with the syndrome withet wit
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a normation of the conditions in this policy have not been met. From the records that we have received, these reasons caused 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), gatomoxetine 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:
er, combined type Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
Aging Skin Plan Exclusion	4) Prescription drug samples were not used to establish treatment. 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 related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from cover covered drugs, also known as the formulary, to see what is covered by your plan. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a ne
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Su 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.
pioid dependence 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here.
	 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from cover covered drugs, also known as the formulary, to see what is covered by your plan.
	Our prior authorization criteria for elagolix/estradiol/norethindrone (ORIAHNN) have not been met. From the records that we have received, Oria 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
N92.0 Criteria Not Met	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. 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 here.
	 Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND Member has NO known osteoporosis; AND 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 we say provide the technology and technology and technology and the technology and t
	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 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 bloc not work for you.
E11.8 Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what 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 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 crit 1) Member has a diagnosis of BOTH Type 2 Diabetes AND Chronic Kidney Disease (CKD); AND
	 A trial of any angiotensin-converting enzyme (ACE) inhibitor or any angiotensin receptor blocker (ARB) was ineffective, not tolerated or contrai Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on whe may be required and quantity limits may apply to covered drugs.

e reasons:

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we have received, the member does re listed here.

what is covered. Prior authorization not-covered drug can be approved.

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anted if all conditions in our

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s, past treatments tried with dates

d Therapeutics (P&T) Committee,

erage. Please look at the list of

not-covered drug can be approved.

Suboxone Film) (TRIED) and

anted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

d Therapeutics (P&T) Committee, erage. Please look at the list of

ahnn was denied for these reasons:

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t. From the information we have er above. The criteria are listed

what is covered. Prior authorization

to filter blood and remove extra

ocker (ARB), such as valsartan, did

hat is covered.

n we have received, the member iteria are listed here.

aindicated. what is covered. Prior authorization

					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:
					 Records did not show the generic version of this drug, called lisdexamfetamine, did not work for you. 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.
14872963 ANNE CLAIRE ADAMS	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.9 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
					This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be 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
14876733 LORIE JUNE KMETZ	NURSE PRACTITIONER	AQUEOUS VITAMIN D INFA	ANT: VITAMINS	E55.9 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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approve
					The conditions in this policy have not been met. From the records that we have received, these reasons caused 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) (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.
					rease look at the formulary to see what drugs are covered. This authorization may be required and quantity innits may apply to covered drugs.
14877247 PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	METFORMIN HYDROCHLOR		nellitus with other specified complication Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
					Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
					denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
					2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
					3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
					4) Prescription drug samples were not used to establish treatment.
					Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization 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.
14877838 JACQUELINE MARIE KERR MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Z68.25 Body mass index Plan Exclusion	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.
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approve The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
14880594 YEN DANG NIEMAN	OPHTHALMOLOGY	TYRVAYA	OPHTHALMIC AGENTS	h04.123 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
					Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
					denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
					2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
					3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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.
14883597 LINDSEY ANN HANSEN FNP-BC	NURSE PRACTITIONER	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	DIC 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) 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
					 Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 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

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

ylphenidate extended release (ER),

has been completed and submitted a.fda.gov/scripts/medwatch/. ation on what is covered. Prior . Drugs/products of this type are e what is covered by your plan.

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

what is covered. Prior authorization ated in your benefit summary.

not-covered drug can be approved.

ion (RESTASIS equiv) (Restricted to

nted if all conditions in our ption policy criteria. The reason for

for these reasons: -induced constipation (OIC). These

14887408 LESLIE SLEDGE GUILLORY FNP	NURSE PRACTITIONER	QUETIAPINE FUMARATE	ANTIPSYCHOTICS/ANTIMANIC AGENTS	dx MDD Not Covere	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 Covere	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
14893067 ATHIRA UNNIKRISHNAN MD	HEMATOLOGY & ONCOLOGY	TAGRISSO	ANTINEOPLASTICS AND ADJUNCTIVE THERA	NSCLC Criteria No	Cur prior autnorization criteria for osimertinib (IAGRISSO) have not been met. From the records that we have received, Tagrisso was denied for these 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 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 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 liss 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 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is may be required and quantity limits may apply to coverad drugs.
14895991 PRIYA MATHEW PHILIP MD	FAMILY PRACTICE	RYBELSUS	ANTIDIABETICS	E66.9 - Obesity, unspecified Plan Exclus	This request cannot be approved because this drug is being used for obesity (weight loss). Drugs used for this purpose are excluded from coverage a
14897115 MARCO ANTONIO VEGA MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	ADHD Not Covere	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 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 dexmethylphe 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 F 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. d ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, & 3 of 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 b with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda
14904489 BRIANNA LAREE HURTADO NP	NURSE PRACTITIONER	TIROSINT	THYROID AGENTS	hypothyroidism Not Covere	d Since criteria have not been met. we are not able to approve coverade for this drug at this time. Please refer to the formulary for specific information This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

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-or. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 autnorization criteria for osimertinib (TAGRISSO) nave not been met. From the records that we nave received, Tagrisso was denied for these 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 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 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 lis 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 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 a 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 provide the summary.
14897115 MARCO ANTONIO VEGA MD	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	ADHD Not Covered	 other treatments for your health issue. This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a no approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: Records did not show the generic version of this drug, called lisdexamfetamine, did not work for you. 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 dexmethylph methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 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 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, & 3 of the reason for denial is explained to the member above. The criteria from the policy are listed here. The generic form of the drug has been tried and failed; AND All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has the with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda
14904489 BRIANNA LAREE HURTADO NP	NURSE PRACTITIONER	TIROSINT	THYROID AGENTS	hypothyroidism Not Covered	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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

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not-covered drug can be approved.

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tnese reasons:

nat is covered. on we have received, the member

are listed here.

ed for an approval). what is covered. Prior authorization age as stated in your benefit provider may be able to suggest

a not-covered drug can be ylphenidate extended release (ER),

the FDA of efficacy and safety

nted if all conditions in our of the exception policy criteria. The

has been completed and submitted ta.fda.gov/scripts/medwatch/. ation on what is covered. Prior not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

						 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-cov 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 ¿dexmethylphenid 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 or 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.
14904889 LISA ALANE DAMURA	ADVANCED PRACTICE NURSE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2,3 of the exception 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 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/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 we have an efficiency and safety problems with the specific information on we 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 we have not been met.
14909716 CHRISTOPHER CHANG MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ed abnormal findings of blood chemistry	r 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 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 verification 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 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 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 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 1 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 based on guidance from our Pharmacy and Therape
14911420 CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	BIMATOPROST	DERMATOLOGICALS	sis of unspecified eye, unspecified eyelic	Plan Exclusion	related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Plea covered drugs, also known as the formulary, to see what is covered by your plan. 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 cover
14912785 MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	Dx.L90.8	Criteria Not Met	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, 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 cover This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-cover The analities in this policy have not been met.
						The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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:
14916018 SAMMY LERMA III MD	FAMILY PRACTICE	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20	Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception polic denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past tree of trial and responses, and any other evidence to 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 Trintenix nave not been met. From the records that we have received, the following caused the demai of Trintenix. 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 particle and failed. 3) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried and Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered solutions.
14916745 ROGER EARL CAGLE MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	F32.A	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the 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).

						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 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 ¿dexmethylph 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 F 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.
14	4904889 LISA ALANE DAMURA	ADVANCED PRACTICE NURSE	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2,3 of the except 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 b with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda. 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
14	4909716 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 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 block 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 purry 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 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 inform 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 lis 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 i 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 The
14	4911420 CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	BIMATOPROST	DERMATOLOGICALS	sis of unspecified eye, unspecified eyelid Plan Exclusion	related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage covered drugs, also known as the formulary, to see what is covered by your plan. 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 sk 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 set of the sk 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 set of the sk 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 set of the sk set of the sk set of the sk set of the set
14	4912785 MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	Dx.L90.8 Criteria Not Met	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 receive 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 i This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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:
14	4916018 SAMMY LERMA III MD	FAMILY PRACTICE	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 autionization (FDA). 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 tried and failed. 3) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has been tried Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
14	4916745 ROGER EARL CAGLE MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	F32.A Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, 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).

3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).

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nted if all conditions in our exception policy criteria. The reason

has been completed and submitted ta.fda.gov/scripts/medwatch/. ation on what is covered. Prior aused the denial of SILDENAFIL

ne blood vessels that go from the

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zation may be required and quantity

nformation we have received, the are listed here.

what is covered. Prior authorization d Therapeutics (P&T) Committee, erage. Please look at the list of

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received, the member does not

what is covered. Prior authorization not-covered drug can be approved.

ngual film (SUBOXONE equivalent)

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

xetine, or paroxetine, have been

n tried and failed. hat is covered.

ived, the member does not meet here.

14917934 LAURA MARIE KENNEDY MD FAMILY PRACTICE INVOKANA ANTIDIABETICS

CARDIOLOGY PRALUENT 14921789 DEBORAH LYNN EKERY MD

LINZESS 14930470 SANDEEP BADYAL MD FAMILY PRACTICE

14938374 NATALIA MILLIKEN NP-C ADVANCED PRACTICE NURSE DESCOVY

14939293 DIANA NATHALIE ANDINO MD NEUROLOGY

QULIPTA

ANTIVIRALS

MIGRAINE PRODUCTS

GASTROINTESTINAL AGENTS - MISC.

ANTIHYPERLIPIDEMICS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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
DM2 Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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
e78.5 Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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:
k58.1 Criteria Not Met	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.
	 Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 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 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
HIV PrEP Criteria Not Met	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 of an estimated clearance between so and of the permittee (bocumentation is required to be submittee for an approval), OK (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
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
g43.009 Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

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ance or Synjardy (XR).

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s, past treatments tried with dates

what is covered. Prior authorization

not-covered drug can be approved.

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nted if all conditions in our eption policy criteria. The reason for

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e reasons:

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ve have received, the member does d here.

what is covered. Prior authorization as denied for these reasons:

met. From the information we have er above. The criteria are listed

vided of a renal adverse event or be submitted for an approval); OR ted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our ption policy criteria. The reason for

14940437 FRANK JOSEPH SUPPA DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	HIV PrEP Criteria Not Met	Our prior autnorization criteria for emtricitabine/tenofovir alatenamide (DESCOVY) nave not been met. From the records we received, Descovy was de 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 conserved 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 reason for denial is explained to the member able to the member able to approve. The reason for denial is explained to the member able to the member able to approve. The reason for denial is explained to the member able to the member able.
					 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 decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be sul (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted f Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least fou 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 if 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 The
14941485 JAMES FINAS HOLLEMAN III MD	INTERNAL MEDICINE	FINASTERIDE	DERMATOLOGICALS	plasia with lower urinary tract symptoms Plan Exclusion	related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage covered drugs, also known as the formulary, to see what is covered by your plan. Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 d
14943691 MATTHEW SCOTT HILL DO	FAMILY PRACTICE	DEXCOM G7 SENSOR	MEDICAL DEVICES	r73.03 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 methave received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The of 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 wha authorization may be required and quantity limits may apply. Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for t 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-indu 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., bisacody (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 and quantity limits may apply.
14946771 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	obesity 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 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 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 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, set (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon). Since criteria have not been met. we are unable to approve coverace for this drug at this time. Please refer to our formulary for information on what i This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 ca 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.
14947161 BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	E78.2 - Mixed hyperlipidemia 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial or prior authorization criteria for vilazodone (Viibryd) have not been met.
					 Two (2) drugs in a class of drugs called selective serotonin reuptake inhibitors (SSRIs) have not been tried and failed. (e.g., sertraline, citalopram, esparoxetine) One (1) drug in a class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRIs) has not been tried and failed. (e.g., duloxetine, venlafa Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
14949047 KARISA RAE STANCIL FNP-C	NURSE PRACTITIONER	VILAZODONE HYDROCHLORII	D 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 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 1 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); ANE 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 it is the series of the series of
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 i 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 treatments for your health issue.

vas denied for these reasons:

at is covered. Pre-approval may be

net. From the information we have er above. The criteria are listed

vided of a renal adverse event or be submitted for an approval); OR tted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered. Prior authorization d Therapeutics (P&T) Committee, erage. Please look at the list of

using insulin before the requested

hat drugs are covered.

en met. From the information we . The criteria are listed here.

n what is covered. Prior

d for these reasons: d-induced constipation (OIC). These

acodyl, sennosides), or PEG 3350

hat is covered. Prior authorization

n we have received, the member . The criteria are listed here.

osage escalation; AND

dyl, sennosides), or (B) PEG 3350

what is covered. Prior authorization not-covered drug can be approved.

ster caps (Lovaza equivalent), one

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

enial of vilazodone. am, escitalopram, fluoxetine,

enlafaxine) hat is covered.

ve have received, the member does are listed here.

AND

what is covered. Prior authorization rated in your benefit summary. nay be able to suggest other

14954730 ALYSON DANELLE GARCIA MD	OBSTETRICS & GYNECOLOGY	BONJESTA	ANTIEMETICS	
14959171 ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	

ZORYVE DERMATOLOGICALS 14960482 TRICIA LYNN WINTERS PA PHYSICIAN ASSISTANT

14961306 MOHAMMAD BASHASHATI SAGHEZCHI NGASTROENTEROLOGY TRULANCE GASTROINTESTINAL AGENTS - MISC.

14964314 KERI LEE PINNOCK MD

GASTROENTEROLOGY

LINZESS

GASTROINTESTINAL AGENTS - MISC.

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
	Thease look at the formulary to see what drugs are covered. Their authorization may be required and quantity innits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
O21.9 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
	of trial and responses, and any other evidence to 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 autnorization criteria for Androgens: Transdermal Testosterone Products nave not been met. From the records that we have received, testosterone gei 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:
e34.9 Criteria Not Met	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 annrove coverage for this drug at this time. Please refer to our formularly for information on what is covered. Prior authorization
	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
PsO Criteria Not Met	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).
	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
	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.
	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 autnorization criteria for Truiance nave not been met. From the records that we have received, the following caused the denial of Truiance.
	 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 autnorization criteria for Truiance nave not been met. From the records that we have received, the following caused the denial of Truiance. 1) The drug is not prescribed to treat Chronic Idiopathic Constipation (CIC) OR Trritable Bowel Syndrome with Constipation (IBS-C).
	 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 autnorization criteria for Truiance nave not been met. From the records that we have received, the following caused the denial of Truiance. 1) The drug is not prescribed to treat Chronic Idiopathic Constipation (CIC) OR Trritable 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
	 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 autnorization criteria for Trulance nave 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 Trritable 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).
	 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 autnorization criteria for Truiance nave not been met. From the records that we have received, the following caused the denial of Truiance. 1) The drug is not prescribed to treat Chronic Idiopathic Constipation (CIC) OR Trritable 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
	 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 autnorization criteria for iruiance nave not been met. From the records that we have received, the following caused the denial or iruiance. 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.
chronic constipation Criteria Not Met	 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 autnorization criteria for irulance nave not been met. From the records that we have received, the following caused the denial of irulance. 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.
chronic constipation Criteria Not Met	 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 autnorization criteria for i ruiance nave not been met. From the records that we nave received, the following caused the denial of i ruiance. 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.
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	 5) A trial of topical corticosteroids was ineffective, not tolerated, or contraindicated (Documentation is required for approva). Since criteria have not been met, we are unable to approve coverage for this drug at this time. 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 irrulance have not been met, rom the recorves that we have received, the rollowing Caused the denial of irrulance. 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 (biascody), 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 fulance. 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 (ICO 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 (biascodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Cincar criteria have not beam met, we are unable to approve. Expression of the sereasons: Records did not show that another drug calle
	 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. Uur prior autnorzation criteria tor i ruiance nave not been met. from the records that we have received, the following Caused the denial of i ruiance. 1) The drug is not prescribed to treat Chronic lidiopathic Constipation (CIC) OR. Irritable Bowel Syndrome with Constipation (BS-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 (bisacody), sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR buik-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trulance. 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 (bisacody), sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR buik-forming laxatives (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 criteria for linaclotide (ILVIZESS) have not been met. From the information we have received, the member does not meet rou
	 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 irrulance have not been met, rom the records that we have received, the rollowing Caused the denial of irrulance. 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 (biascodyl, sennosides); PEG 3350 (IRRALAX, 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 fulance. 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 (ICC) 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 (biascodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Cincar criteria have not been met, we are unable to approve. Expression of the se reasons: Records did not show that another drug call
	 S) 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. Uur pror autnorization criteria for i ruiance nave not been met, rrom the records that we have received, the tollowing caused the denial or i ruiance. 1) The drug is not prescribed to treat Chronic Idiopathic Constipation (IC) 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 have not been met. From the information we have received, the member does not meet number 1 & 2 of our prior authorization criteria for final christicated, or not tolerated: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxities (METAMUCIL, CITRUCEL, FIBERCON). Circure criteria have not hear met we are unable to approve. Becords did not show that another drug called ubjerostone (Arnitiza) did not work for you. 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) R

Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

ANALGESICS - OPIOID 14966317 ADAM WESLEY SPJUTE MD ANESTHESIOLOGY OXYCONTIN chronic p

F11.20-Opioid 14973947 MELVIN LEON COOPER JR NP NURSE PRACTITIONER **BUPRENORPHINE HCL** ANALGESICS - OPIOID E66.9 - Obesi 14975890 LINDSEY DIEGUEZ NP NURSE PRACTITIONER ZEPBOUND ANTI-OBESITY/ANOREXIANTS

14985685 MICHAEL ANDREW MUSGROVE MD PSYCHIATRY DULOXETINE HYDROCHLORIDI ANTIDEPRESSANTS essive disorder, single episor

PHYSICIAN ASSISTANT ZORYVE DERMATOLOGICALS 14985729 MONICA RENEE SCHEPP

14991167 VICTORIA KATHLEEN GACA MD

INTERNAL MEDICINE

VYVANSE

ADHD/ANTI-NARCOLEPSY

t hyperactivity disorder, un

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro I 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.
c pain syndrome Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa of trial and responses, and any other evidence to 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- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
ioid Dependence Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa of trial and responses, and any other evidence to 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
esity, unspecified Plan Exclusion	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 b 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- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 equ 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:
oisode, moderate Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa of trial and responses, and any other evidence to 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 roflumilast (ZORYVE) have not been met. From the records that we have received, Zoryve was denied for these re 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 p Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
L40.0-psoriasis Criteria Not Met	This request has not been approved because our prior authorization criteria for roflumilast (ZORYVE) have not been met. From the information we have 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 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 treat 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 may be required and quantity limits may apply to covered drugs.
	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not 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, 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 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.
unspecified type Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 3 of 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 with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fd 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

not-covered drug can be approved.

ase (ER) (MS Contin equivalent), dro ER equivalent), tramadol ER

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

ted if all conditions in our ption policy criteria. The reason for

past treatments tried with dates

ted in your benefit summary. y be able to suggest other

not-covered drug can be approved.

equivalent), in 20mg, 30mg, and

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

reasons:

dry patches and scales. at is covered. Prior authorization

e have received, the member does ted here.

reatment of plaque psoriasis; AND

what is covered. Prior authorization

a not-covered drug can be

/Iphenidate extended release (ER),

t the FDA of efficacy and safety

nted if all conditions in our the exception policy criteria. The

has been completed and submitted a.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 FNI	P. 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 i 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 t 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)
14992262 MELANI INOKA DAYAL APN	ADVANCED PRACTICE NURSE	LEVOCETIRIZINE DIHYDROCH	IL ANTIHISTAMINES	j30.2-Other seasonal allergic rhinitis	Not Covered	other drugs include loratadine, fexofenadine, cetirizine, levocetirizine. All available over-the-counter (OTC). Please note these other drugs are not cov benefit. Please refer to the formulary for specific information on what is covered.
14992403 DARSHAN NARENDRA SHAH MD	NEUROLOGY	вотох	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. Prescr administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co 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 whet plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may
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 a 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 provi 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 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
15001942 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	r79.89	Formulary Alternatives Available	 treatments for vour health issue. 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 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 tablec 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, Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.
15001942 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGEINTS - MISC.	179.89	Formulary Alternatives Available	
15005492 CARTER REID HANSON PA-C	PHYSICIAN ASSISTANT	DESCOVY	ANTIVIRALS	Z72.52 - High risk homosexual behavior	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have rece 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. Sinr prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 4) Records were not sent to us to show your 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. 5) 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 a needed and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy. The reason for denial is explained to the member at here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is required to be submitted Documentation is provided (chart notes including dates of therapy) of a severe adverse event o
15007512 JONATHAN NICHOLAS POSEY MD	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	e28.2	Criteria Not Met	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formulant for information on what 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 reapply. 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 of 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 membro 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 here met we are unable to approve coverage for this drug at this time. Please refer to our formulation on what is the formulation on 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 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 o
15007727 GRAHAM MILLER BLOCK MD	INTERNAL MEDICINE	VICTOZA	ANTIDIABETICS	I10 - Essential (primary) hypertension	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the memb 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
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 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 treatments for vour health issue.

14991879 LAUREN DAVENPORT EASTERWOOD FN	IP NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 40.0-44.9, adul	t 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 i 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 t 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) other drugs include loratadine, fexofenadine, cetirizine, levocetirizine. All available over-the-counter (OTC). Please note these other drugs are not cover the drugs include loratadine, fexofenadine, cetirizine, levocetirizine. All available over-the-counter (OTC).
14992262 MELANI INOKA DAYAL APN	ADVANCED PRACTICE NURSE	LEVOCETIRIZINE DIHYDROCH	AL ANTIHISTAMINES	j30.2-Other seasonal allergic rhiniti	s Not Covered	benefit. Please refer to the formulary for specific information on what is covered.
14992403 DARSHAN NARENDRA SHAH MD	NEUROLOGY	вотох	NEUROMUSCULAR AGENTS	g81.1 ⁻	1 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. Prescr administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co 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 wh plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may
14992782 MICHAEL RIE MD	FAMILY PRACTICE	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.) - Male erectile dysfunction, unspecified	d 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 a 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 provi other treatments for your health issue.
14999122 LINDSEY DIEGUEZ NP	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	d 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 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
						treatments for your health issue. 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 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 table capsule, or tamsulosin capsule.
15001942 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	r79.80	9 Formulary Alternatives Available	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, Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.
15001942 UNILE TORRES-ZUNICA NE-C	NONSEPRACIMONER		CARDIOVASCOLAR AGLIVIS - MISC.	175.0.	Tornulary Alternatives Available	
						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 rece
						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 our formation of the second s
						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.
						 Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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 on needed and there may be limits on the amount of drug covered at a time.
						ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
15005492 CARTER REID HANSON PA-C	PHYSICIAN ASSISTANT	DESCOVY	ANTIVIRALS	Z72.52 - High risk homosexual behavior Criteria Not Met		This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. 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 ab
						here.
						1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR
						 Prescribed for pre-exposure prophylaxis of HIV infection; AND Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided
						decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be su
						(B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted
						Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least for 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 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 re
						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 o
15007512 JONATHAN NICHOLAS POSEY MD	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	e28.2	2 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
						This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member
						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 Our Diagnosis Restricted criteria have not been met. From the records that we have received, VICTOZA was denied for this reason:
						 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 a supervised of the supervised of
15007727 GRAHAM MILLER BLOCK MD	INTERNAL MEDICINE	VICTOZA	ANTIDIABETICS	110 - Essential (primary) hypertension Criteria Not Met		ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
						This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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
15009135 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	QSYMIA	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	d 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 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
19009199 LEIZADETTI ETININ FOLLOCK MID		QUINIA		Loo.9 - Obesity, unspecified		treatments for your health issue.

14991879 LAUREN DAVENPORT EASTERWOOD FNF	P. 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 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 t
14992262 MELANI INOKA DAYAL APN	ADVANCED PRACTICE NURSE	LEVOCETIRIZINE DIHYDROCH	L ANTIHISTAMINES	j30.2-Other seasonal allergic rhinitis Not Covered	vour 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 (UTC) of other drugs include loratadine, fexofenadine, cetirizine, levocetirizine. All available over-the-counter (OTC). Please note these other drugs are not coverefit. Please refer to the formulary for specific information on what is covered.
14992403 DARSHAN NARENDRA SHAH MD	NEUROLOGY	вотох	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. Prescri administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co 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 wh plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may
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 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 provide 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 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
	Nonsernacimonen			Loo. 9 Obesity, dispectice Field Exclusion	treatments for your health issue. 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 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
					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, v
15001942 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	r79.89 Formulary Alternatives Available	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 rece 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 Our prior authorization criteria for emtricitable/tenofovir alatenamiae (DESCOVY) have not been met. From the records we received, Descovy was a
					 Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 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.
					 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 of the criteria has not been met, we are not able to approve.
					needed and there may be limits on the amount of drug covered at a time.
					ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
15005492 CARTER REID HANSON PA-C	PHYSICIAN ASSISTANT	DESCOVY	ANTIVIRALS	Z72.52 - High risk homosexual behavior Criteria Not Met	This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. 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 ab
					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 decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be su
					(B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted f
					Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least fou 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 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 re-
					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 o
15007512 JONATHAN NICHOLAS POSEY MD	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	e28.2 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
					This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the memb 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 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 o
15007727 GRAHAM MILLER BLOCK MD	INTERNAL MEDICINE	VICTOZA	ANTIDIABETICS	110 - Essential (primary) hypertension Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
					This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member above. The criteria are listed here
					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 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 the state of the s
15009135 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	QSYMIA	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified Plan Exclusion	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
					treatments for your health issue.

tated in your benefit summary. Please able to suggest other treatments for

(OTC) without a prescription. These ot covered by your prescription drug

Prescription drugs that are

om coverage as indicated in your see what is covered by your health s may apply to covered drugs. age as stated in your benefit provider may be able to suggest

tated in your benefit summary. may be able to suggest other

From the records that we have

tablet, alfuzosin tablet, silodosin

n met, we are not able to approve.

e received, the member does not

what is covered. Prior authorization was denied for these reasons:

hat is covered. Pre-approval may be

met. From the information we have

ber above. The criteria are listed

vided of a renal adverse event or o be submitted for an approval); OR itted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered Prior authorization

be required and quantity limits may

at is covered.

nember does not meet number 1 of

what is covered. Prior authorization

hat is covered.

member does not meet number 1 of

what is covered. Prior authorization stated in your benefit summary. may be able to suggest other

			Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these rea 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 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 and quantity limits may apply to covered drugs.
15010643 EMILY WANTLAND HICKS FNP-C NUR	SE PRACTITIONER LINZESS GAS	TROINTESTINAL AGENTS - MISC. k59.09 Criter	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 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 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
			Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for to 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-indu 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 and quantity limits may apply.
15019782 ELIZABETH LYNN POLLOCK MD	LY PRACTICE LUBIPROSTONE GAS	TROINTESTINAL AGENTS - MISC. Z68.41 Criter	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 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 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 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, se (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
			Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reas 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
15025822 SHWOL-HUO DANNY KIANG DO DERM	MATOLOGY OTEZLA TAR	GETED IMMUNOMODULATORS L40.0 Psoriasis vulgaris Criter	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: a Not Met This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) have not been met. From the information we had 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 explain 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 subm 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent). Please note: capsules may be opened and sp
15050303 SHERI MICHELLE RAVENSCROFT MD DEVE	LOPMENTAL-BEHAVIORAL I QUILLIVANT XR ADH	D/ANTI-NARCOLEPSY r46.3 Not C	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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Except
15060193 ALYSSA RODANICHE PA PHYS	ICIAN ASSISTANT PROAIR RESPICLICK ANT	IASTHMATIC AND BRONCHODILATOR A Mild intermittent asthma, uncomplicated Not C	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, PROV 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptior denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas
15050303 SHERI MICHELLE RAVENSCROFT MD DEVE	LOPMENTAL-BEHAVIORAL I QUILLIVANT XR ADH	D/ANTI-NARCOLEPSY r46.3 Not C	 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 know ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) have not been not meet number(s) 2, 3, and 4 of our prior authorization criteria for Otzela for Plaque Psoriasis (Continuing Therap 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 limprovement within the past year submitted with this request (docu 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 is not orun list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions The conditions in this policy have not beem met. From the records that we have received, these reasons caused the 1) All covered drugs used of your health issue have not been tride and failed. Other drugs that can be used are de amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), Please note 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 appetamine/js being used for a condition approved by the United State Food and Drug Administration (FDA). Ald DirtiONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not in formulary. An exception to allow coverage of a nor Coverage Determinations - Exceptions policy are met. From t

s, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

e reasons:

ritable bowel syndrome with

hat is covered. Prior authorization

we have received, the member does a are listed here.

what is covered. Prior authorization for these reasons: -induced constipation (OIC). These

hat is covered. Prior authorization

n we have received, the member The criteria are listed here.

sage escalation; AND yl, sennosides), or (B) PEG 3350

what is covered. Prior authorization e reasons:

hat is covered.

we have received, the member does plained to the member above. The

submitted for an approval); AND

what is covered. Prior authorization not-covered drug can be approved.

release (ER), methylphenidate ER, and sprinkled on applesauce or

anted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

, PROVENTIL equivalent), and

nted if all conditions in our eption policy criteria. The reason for

15060503	ERIC TODD MEEHAN	PSYCHIATRY, CHILD & ADOLESCE	E MOUNJARO	ANTIDIABETICS	R73.03

15065593 KOHLBE THOMAS PA-C	PHYSICIAN ASSISTANT	NURTEC	MIGRAINE PRODUCTS	(

|--|

15060503 ERIC TODD MEEHAN	PSYCHIATRY, CHILD & ADOLESCI	E MOUNJARO	ANTIDIABETICS	R73.03 - Prediabetes Criteria	ria 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 Co	Covered	 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons 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	ria 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 methorexate at a dose of at least 200m/week for at least 8 weeks. If you are not able to take methorexate at this dose, records should be sent to us to show that you have had side effects to lower doses of methotrexate QR 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 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 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 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 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
15071439 AZIM GHAFARI SHEKARCHI MD	INTERNAL MEDICINE	SOLOSEC	AMEBICIDES	N76.0 - Acute vaginitis Criteria	ria 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 or 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
15072425 LIZANN BAKER ROGERS	NURSE PRACTITIONER	HUMALOG	ANTIDIABETICS	DM2 Not Co	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.

15072425 LIZANN BAKER ROGERS	NURSE PRACTITIONER	HUMALOG	ANTIDIABETICS	

at is covered.

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 de 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 conserved 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. Freeeved, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member able here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for the treatment of human immunodeficiency virus (HIV) and to ONE (1) of the following: (A) Documentation is provided of the provide of the pro
					decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be sub (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least fou treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
15075313 JOHN MICHAEL MCINTYRE FNP-C	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	E13.69 Criteria Not Met	Since criteria have not heap met we are unable to approve coverane for this drug at this time. Please refer to our formulary for information on what i 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 re- 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 c 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 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).
15075347 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	Atopic dermatitis Criteria Not Met	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i Our prior authorization criteria for dupilumab (DUPIXEN1) have not been met. From the records that we have received, the following caused the deni 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 cove 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 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 list 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); AN 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 i
15078322 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	ed abnormal findings of blood chemistry Formulary Alternatives	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 recein 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.
15081058 EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ED Plan Exclusion	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i This request cannot be approved because this drug is being used for Erectile Dysfunction. Drugs used for this purpose are excluded from coverage as 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 provid other treatments for vour health issue. Our prior authorization criteria for evolocumab (REPATHA) have not been met. From the records that we have received, Repatha was denied for these 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 I 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 and quantity limits may apply.
15083413 JESSICA LONG DARNUTZER NP-C	NURSE PRACTITIONER	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.5 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for evolocumab (REPATHA) have not been met. From the information we 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 list 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) ato 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 c 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 i

15074159 FRANK JOSEPH SUPPA DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	Prep Criteria Not Met	Our prior autnorization criteria for emtricitabine/tenorovir alatenamide (UESCOVY) nave not been met. From the records we received, Descovy was de 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 conserved 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. Free ereceived, the member does not meet number(s) 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member able 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 decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be sub (B) 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 treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
15075313 JOHN MICHAEL MCINTYRE FNP-C	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	E13.69 Criteria Not Met	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formulany for information on what is 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 recapply. 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 concerned apply. 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 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).
15075347 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	Atopic dermatitis Criteria Not Met	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i Our prior authorization criteria for dupilumab (DUPIXEN1) have not been met. From the records that we have received, the following caused the denied 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 cove 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 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 lis 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); AN 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 i
15078322 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	ed abnormal findings of blood chemistry Formulary Alternatives Availab	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 recei 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.
15081058 EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ED Plan Exclusion	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is This request cannot be approved because this drug is being used for Erectile Dysfunction. Drugs used for this purpose are excluded from coverage as 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 provid other treatments for your health issue. Our prior authorization criteria for evolocumab (REPATHA) have not been met. From the records that we have received, Repatha was denied for these 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 l 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 and quantity limits may apply.
15083413 JESSICA LONG DARNUTZER NP-C	NURSE PRACTITIONER	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.5 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for evolocumab (REPATHA) have not been met. From the information we 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 list 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) ato 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 c 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 i

					Our prior authorization criteria for emtricitable/tenorovir alatenamide (DESCOVY) have not been met. From the records we received, Descovy was de 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 coneeded and there may be limits on the amount of drug covered at a time. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
15074159 FRANK JOSEPH SUPPA DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	Prep Criteria Not Met	This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. F 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 ab- 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 decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be sul (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least fou 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 i
15075313 JOHN MICHAEL MCINTYRE FNP-C	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	E13.69 Criteria Not Met	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formular, for information on what i 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 records that we have received, or 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 to the criteria has not been approved because our Restricted Diagnosis criteria have not been met. From 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 and the reason of the treatment of Type 2 Diabetes Mellitus (E11 diagnosis code).
15075347 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	Atopic dermatitis Criteria Not Met	 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. 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 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 list 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); AN 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 i
15078322 URIEL TORRES-ZUNIGA NP-C	NURSE PRACTITIONER	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	ed abnormal findings of blood chemistry Formulary Alternatives Available	 Bay he required and quantity limits may apply to covered drunc. 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 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, 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 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 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.
15081058 EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ED Plan Exclusion	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is This request cannot be approved because this drug is being used for Erectile Dysfunction. Drugs used for this purpose are excluded from coverage as 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 provide other treatments for vour health issue. Our prior authorization criteria for evolocumab (REPATHA) have not been met. From the records that we have received, Repatha was denied for these 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 li- 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 and quantity limits may apply.
15083413 JESSICA LONG DARNUTZER NP-C	NURSE PRACTITIONER	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.5 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for evolocumab (REPATHA) have not been met. From the information we 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 list 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) ato 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 c 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 i

15083413 JESSICA LONG DARNUTZER NP-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

as denied for these reasons:

at is covered. Pre-approval may be

met. From the information we have er above. The criteria are listed

vided of a renal adverse event or be submitted for an approval); OR tted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered Prior authorization

be required and quantity limits may

at is covered.

nember does not meet number 1 of

what is covered. Prior authorization e denial of Dupixent.

o covered drugs.

n we have received, the member are listed here.

I); AND

what is covered. Prior authorization

rom the records that we have

tablet, alfuzosin tablet, silodosin

met, we are not able to approve.

e received, the member does not

what is covered. Prior authorization rage as stated in your benefit

provider may be able to suggest

these reasons: The LDL-C is a blood test that

hat is covered. Prior authorization

on we have received, the member re listed here.

A) atorvastatin greater than or

or a combination product

15085111 REY XIMENES MD	ANESTHESIOLOGY	MORPHINE SULFATE ER	ANALGESICS - OPIOID	G89.4-Chronic
15085365 AARON ALAN LAVIANA MD	UROLOGY	LINEZOLID	ANTI-INFECTIVE AGENTS - MISC.	

15090092 TRICIA LYNN WINTERS	PA	PHYSICIAN ASSISTANT

15092699 DIANE LOISE BRINKMAN MD OBSTETRICS & GYNECOLOGY ESTRADIOL VAGINAL AND RELATED PRODUCTS 195.2-Postmenopausal atr 15092728 NATALIE ADRIANNE WILLIAMS MD FAMILY PRACTICE OZEMPIC ANTIDIABETICS OZEMPIC Z68.38-Bod 15094491 JONATHAN EDWARD MACCLEMENTS MD FAMILY PRACTICE ANTIDIABETICS 15096543 CATHERINE CELESTELEWIS NP NURSE PRACTITIONER MOUNJARO ANTIDIABETICS ncounter for issue of repe

CLINDAMYCIN PHOSPHATE/TR DERMATOLOGICALS

15096543 CATHERINE CELE	ESTE LEVVIS INP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	incounter for issue of repeat

15102443 YVETTE MARIE GUTIERREZ-SCHIEFFER MC OBSTETRICS & GYNECOLOGY	INTRAROSA	VAGINAL AND RELATED PRODUCTS	95.2 - Postmenopausal atr

15105258 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	
15109466 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & N	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obes

nic 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 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/ace hydrocodone/acetaminophen, hydromorphone, tramadol. Please note: We will only cover up to 7 days for the FIRST fill of an opioid pain reliever 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 a 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 at 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 receiv 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.
N30.80	Criteria Not Met	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on w Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, linezolid was denied for this r 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 wh 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 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.
L70.8-acne	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 w This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 en (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline(TRIED), minocycline, sulfamethoxaz Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 w
l 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 d 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
E66.01-obesity		is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered. This request cannot be approved because this drug is being used for weightloss. Drugs used for this purpose are excluded from coverage as state 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 ab your health issue.
B-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 station 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 at your health issue.
epeat 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 sta 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 ma treatments for your health issue.
l 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 n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, estradice 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Uur pror autnorzation criteria or oupliumap (DUPTAENT) nave not been met. From the records that we nave received, the following caused the
AD	Criteria Not Met	Cur prior authorization criteria for dupliumab (DUPIXENT) have not been met. From the records that we have received, the following caused the 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 wh 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 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 a 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 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 w
besity, unspecified	Plan Exclusion	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 ma treatments for your health issue.

at another drug will need to be tried

acetaminophen, er such as the drug requested. For

r are in hospice care. Since step are covered. Yes

eived, the member does not meet

vhat is covered. Prior authorization reason:

nat is covered.

e have received, the member does

what is covered. Prior authorization not-covered drug can be approved. erythromycin, tretinoin, adapalene

azole/trimethoprim, cephalexin). s.

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization drug allowed by the plan. It is used The higher amount of 40 per 93 days ated in your benefit summary. Please

able to suggest other treatments for ated in your benefit summary. Please able to suggest other treatments for

nay be able to suggest other

not-covered drug can be approved. diol cream (Estrace

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

denial of Dupixent.

nat is covered. Prior authorization

n we have received, the member are listed here. I); AND

what is covered. Prior authorization tated in your benefit summary.

ay be able to suggest other

					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 rec 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 co
15116311 CHRISTA DRURY JONES NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	R73.03 - Prediabetes	s Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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.
15117130 DEVIKA MARANGATTU MADHAVAN ENDOCRINOLOGY, DIABETES &	& N 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 our formulary for information on what is This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in 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
15121135 FARHEEN YOUSUF MD ENDOCRINOLOGY, DIABETES &	& N WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	l Plan Exclusion	 treatments for vour 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 i 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 treatments for vour health issue. 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 since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
15122110 SHAWN ROBERT AGENBROAD-ELANDER NURSE PRACTITIONER	TRINTELLIX	ANTIDEPRESSANTS	F32.9	9 Criteria Not Met	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, 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 in Our prior authorization criteria for emtricitabine/tenorovir alatenamice (JESCOVY) nave not been met. From the records we received, Jescovy was defined.
					 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 conneeded and there may be limits on the amount of drug covered at a time.
15123054 JAMES JOHN TEET DO FAMILY PRACTICE	DESCOVY	DESCOVY ANTIVIRALS	Z20.6 Criteria Not Met		ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. F 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 abo 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 decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be sub (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for 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 treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
15127672 KRISHNA POKALA MD NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.709	Not Covered	Since criteria have not heen met we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 1 FAMILY PRACTICE	LYRICA	ANTICONVULSANTS	M54.9 - Dorsalgia, unspecified	l 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 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 list of covered drugs. also known as our formulary, to see what is covered. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-complete the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Twist Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15133775 JONATHAN NICHOLAS POSEY MD INTERNAL MEDICINE	PULMICORT FLEXHALER	ANTIASTHMATIC AND BRONCHODILATOR	Avild intermittent asthma, uncomplicated	l 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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 re 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 c
15116311 CHRISTA DRURY JONES	NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	R73.03 - Prediabetes	s Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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 i
15117130 DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES	& N WEGOVY	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories	s Plan Exclusion	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i 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 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
15121135 FARHEEN YOUSUF MD	ENDOCRINOLOGY, DIABETES	& N WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	d Plan Exclusion	treatments for vour 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 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 treatments for vour health issue. 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 Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
15122110 SHAWN ROBERT AGENBROAD-ELANDER	NURSE PRACTITIONER	TRINTELLIX	ANTIDEPRESSANTS	F32.9	9 Criteria Not Met	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, 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 i UUr prior authorization criteria for we 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. 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. 5) 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 c needed and there may be limits on the amount of drug covered at a time.
15123054 JAMES JOHN TEET DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	Z20.6	5 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. F 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 ab- 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 decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be sub (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least fou treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
15127672 KRISHNA POKALA MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	G43.709	9 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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, unspecifiec	d 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 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 list of covered drugs, also known as our formulary, to see what is covered. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-complete the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Twis Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15133775 JONATHAN NICHOLAS POSEY MD	INTERNAL MEDICINE	PULMICORT FLEXHALER	ANTIASTHMATIC AND BRONCHODILATOR	A Vild intermittent asthma, uncomplicated	d Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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

be required and quantity limits may

at is covered.

ember does not meet number 1 of

what is covered. Prior authorization ated in your benefit summary. ay be able to suggest other

ated in your benefit summary. ay be able to suggest other

ellix. work for you. nat is covered.

ived, the member does not meet

what is covered. Prior authorization vas denied for these reasons:

at is covered. Pre-approval may be

net. From the information we have er above. The criteria are listed

ided of a renal adverse event or be submitted for an approval); OR ted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered Prior authorization not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

by the plan. It is used to make sure ed by your plan. Please look at the

not-covered drug can be approved.

Twisthaler, fluticasone inhaler.

nted if all conditions in our eption policy criteria. The reason for

15137953 AMY HERRIN KOWALSKI APN ADVANCED PRACTICE NURSE DIVIGEL ESTROGENS	
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15140347 MARSAL SANCHES MD	PSYCHIATRY	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS

151429	01 MOHAMMAD BASHASHATI SAGHEZCHI N	v GASTROENTEROLOGY	KRISTALOSE	LAXATIVES	- Irritable bowel syndrome with
151430	57 SARA JANE PAVITT MD	NEUROLOGY	ALMOTRIPTAN MALATE	MIGRAINE PRODUCTS	

15143732 JORDAN DAVID HARTMAN MD FAMILY PRACTICE IVERMECTIN DERMATOLOGICALS 15147981 GERMAN ECHEVERRY MD ANESTHESIOLOGY ZEPBOUND ANTI-OBESITY/ANOREXIANTS

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 nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 ora 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 grant
		 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
f31.81	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 the conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
ith diarrhea	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), e 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.
G43.709	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 nor 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.
Other acne	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
e669	Plan Exclusion	4) Prescription drug samples were not used to establish treatment. 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 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 ab

vour health issue.

not-covered drug can be approved.

ral tablet, one-time weekly

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

s (risperidone, aripiprazole,

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

eletriptan, naratriptan,

nted if all conditions in our ption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

in your benefit summary. Please

able to suggest other treatments for

15151574	LISA ALA	NE DAM	URA

15151574 LISA ALANE DAMURA	ADVANCED PRACTICE NURSE	VILAZODONE HYDROCHLORI	DANTIDEPRESSANTS	f33.2 Criteria Not Met	Our prior autionization criteria for vilazodone (viloryu) have not been met. From the records that we have received, the following caused the demar 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, fl 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 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. Primary he required and quantity limits may apply to coverage drugs.
					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.
15154496 MICHAEL WILLIAM LATTANZI MD	HEMATOLOGY & ONCOLOGY	NUBEQA	ANTINEOPLASTICS AND ADJUNCTIVE THERA C61 - Malignant neoplasm of	prostate Criteria Not Met	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 receive 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. Pri
					may be required and quantity limits may apply to covered drugs Our Diagnosis Restricted criteria have not been met. From the records that we have received, 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 quapply.
					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.
15156994 FAUSTIN MURHUBUBA BAHIZI	PHYSICIAN ASSISTANT	MOUNJARO	ANTIDIABETICS	R73.03 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not mour 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. Pri Our prior authorization criteria for viazodone (vibryd) have not been met. From the records that we have received, the following caused the denial of viazodone. 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, fl 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.
15157490 MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	VILAZODONE HYDROCHLORI	DANTIDEPRESSANTS	F33.9 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, th 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
					 Weinber has a diagnosis of high depressive disorder, AND Member is 18 years of age or older; AND Member must try and fail at least 2 selective serotonin reuptake inhibitors (SSRIs) (sertraline, citalopram, escitalopram, fluoxetine, paroxetine); AND 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. Pri
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug of the second drug of
					The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Conti Xtampza ER (TRIED), oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equ 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:
15157622 ERIN JENNIFER MOHLKE	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all condition Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
					 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments to of trial and responses, and any other evidence to 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 dys	function 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 you 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 ab
					other treatments for your health issue. Our prior authorization criteria for ubrogepant (UBRELVY) nave not been met. From the records that we have received, Ubreivy 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-inflamm (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.
15167771 JOE HIDROGO III DO	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.909 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 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. Pri-

ена от мадоцоне. am, escitalopram, fluoxetine,

Yes

ve have received, the member does listed here.

what is covered. Prior authorization

these reasons:

on we have received, the member

what is covered. Prior authorization

be required and quantity limits may

ember does not meet number 1 of

what is covered. Prior authorization am, escitalopram, fluoxetine (TRIED),

hat is covered.

e have received, the member does listed here.

what is covered. Prior authorization not-covered drug can be approved.

ase (ER) (MS Contin equivalent), or Zohydro ER equivalent),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ge as stated in your benefit provider may be able to suggest

nese reasons: oidal anti-inflammatory drug

n we have received, the member ed here.

what is covered Prior authorization

15172310 MELANIE MARIE PICKETT MD

15173061 HOLLIE ANN HALL ARNP-C

DERMATOLOGY

SODIUM SULFACETAMIDE/SUL DERMATOLOGICALS

L70.0 - /

15172885 MOLLY THOMPSON CAMPA

DERMATOLOGY

NURSE PRACTITIONER

STELARA

TARGETED IMMUNOMODULATORS

PSYCHOTHERAPEUTIC AND NEUROLOGICAL -52.0 - Hypoactive sexual de

VICTOZA NURSE PRACTITIONER ANTIDIABETICS 15179154 CHRISTA DRURY JONES ANESTHESIOLOGY ZEPBOUND ANTI-OBESITY/ANOREXIANTS 15179694 GERMAN ECHEVERRY MD

ADDYI

TARGETED IMMUNOMODULATORS 15184926 SONIA YOUSUF III MD RHEUMATOLOGY HUMIRA

15188741 STEVEN ZACHARY POWELL MD

FAMILY PRACTICE

VYVANSE

ADHD/ANTI-NARCOLEPSY

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 erythromyc (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trime Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
Acne vulgaris 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 wh Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for the
	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, Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what
	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 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
L40.0 Criteria Not Met	are listed here.
	 Prescribed by a Dermatologist; AND Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to seven
	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 1 (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified 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.
	This request cannot be approved because your plan has chosen this drug/product to be excluded from coverage. Other drugs/products for your h
desire disorder Plan Exclusion	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 heal suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this d
	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 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
r73.03 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the me
	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 whe This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as state
E66.9 Plan Exclusion	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 treatments for your health issue.
	Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Humira was denied for thes 1) Records did not show that you have tried a conventional disease-modifying antirheumatic drug (DMARD), such as methotrexate, sulfasalazine, 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
	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 v 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 criteri 1) Prescribed by a Rheumatology Specialist; AND
	2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND
M05.79 Criteria Not Met	 Member has tried one (1) or more conventional disease-modifying antirheumatic drugs (DMARDs) (e.g., methotrexate, sulfasalazine, hydroxych 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) weel 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
	are specified; OR (C) Member has a contraindication to methotrexate, AND contraindication is specified (Note: a contraindication to methotrexate
	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 methotrexa
	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 Inde
	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 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.
	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 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
	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:
F90 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 3 of the exce
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 3 of the exce 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
	 All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has a second second
	with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.
	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

not-covered drug can be approved.

ycin, tretinoin(tried), adapalene

methoprim, cephalexin).

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

what is covered. Prior authorization hese reasons: k, OR (C) acitretin. nat is covered.

n we have received, the member to the member above. The criteria

vere plaque psoriasis (PP) (greater

15 sessions of phototherapy; OR ed. NOTE: A contraindication or

health issue may be covered by ealth care provider may be able to drug from coverage.

be required and quantity limits may

t is covered.

ember does not meet number 1 of

what is covered. Prior authorization ated in your benefit summary. ay be able to suggest other

ese reasons: e, hydroxychloroquine, and/or

nat is covered.

we have received, the member ria are listed here.

chloroquine, leflunomide,

eks, AND the dates of utilization of te, AND dose-limiting side effects te does NOT cancel the

xate at a dose of greater than or dex (SDAI) or Clinical Disease 0-3.3, CDAI score of 0.0-2.8) or low

a not-covered drug can be

t the FDA of efficacy and safety

nted if all conditions in our ception policy criteria. The reason

has been completed and submitted a.fda.gov/scripts/medwatch/. ation on what is covered. Prior

15195089 HANA AUBRECHTOVA MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	
15198256 JENNA GRAY	PHYSICIAN ASSISTANT	TRI-LUMA	DERMATOLOGICALS) - Disorder of pigmenta
15203174 MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	
15203617 BRAD ERIC VENGHAUS MD	INTERNAL MEDICINE	VYVANSE	ADHD/ANTI-NARCOLEPSY	
15203635 LUCY MARIBEL AMIEVA NP	NURSE PRACTITIONER	LUMRYZ	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	
15206287 CHELLYANNE COLLEEN HINDS PA	PHYSICIAN ASSISTANT	MAVYRET	ANTIVIRALS	

		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
G43.719	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
tation, unspecified	Plan Exclusion	4) Prescription drug samples were not used to establish treatment. This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/propurpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to s 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 northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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 re 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.
F90.0	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
F90.0	Criteria Not Met	 4) Prescription drug samples were not used to establish treatment. 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 approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: Records did not show the generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), did not work for you. 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 dexmethyl methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert t 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 of the reason for denial is explained to the member above. The criteria from the policy are listed here. The generic form of the drug has been tried and failed; AND All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND All formulary alternatives 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 with the request. The
G47.419	Criteria Not Met	Our prior authorization criteria for Lumyz have not been met. From the records that we have received, Lumyz 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 wha 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 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) I eight (8) minutes, AND (B) Two (2) or more sleep onset rapid eye movement (REM) sleep periods (documentation is required to be submitted for 4) A trial of ONE (1) of the following 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 wh
B18.2	Criteria Not Met	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formularly for information on wire our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the records that we have received, Mavyret was of 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 a data and the prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the the member does not meet number(s) 3 and 5 of our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the 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 ab 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 approva 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 genot 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 wh may be required and quantity limits may apply to covered drugs.

not-covered drug can be approved.

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eption policy criteria. The reason for

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eption policy criteria. The reason for

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15207397 RUMI AHMED KHAN MD	INTERNAL MEDICINE	YUPELRI	ANTIASTHMATIC AND BRONCHODILATOR A	
15208810 CHELLYANNE COLLEEN HINDS PA	PHYSICIAN ASSISTANT	MAVYRET	ANTIVIRALS	

15210497 SAGAR SHAILESH PARIKH MD PAIN MEDICINE NURTEC MIGRAINE PRODUCTS

15212589 ALLISON LEIGH ANDERSON MD OBSTETRICS & GYNECOLOGY ESTROGEL ESTROGENS tenopausal and female climacter

15213778 BRET MICHAEL BELLARD MD FAMILY PRACTICE VYVANSE ADHD/ANTI-NARCOLEPSY

		 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n 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.
J45.50	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the reason for denial is explained to the member above. The criteria from 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, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
		 4) Prescription drug samples were not used to establish treatment. Our prior autnorization criteria for giecaprevir/pibrentasvir (MAVYKEI) nave not been met. From the records that we have received, Mavyret was 1) The drug is not prescribed by, or together with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist. These are docto issue
		 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 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 who
		ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
hep c	Criteria Not Met	This request has not been approved because our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the 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
		 Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND Member has a diagnosis of Hepatitis C Virus (HCV); AND 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
		 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 genot 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 w
		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, 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:
G43.119	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptions
		denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
		of trial and responses, and any other evidence to 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 n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 o 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.
eric states	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
		denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a
		 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 dexmethy 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 a state of the sta
		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.
F90.0	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
		This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 3 of t 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
		 All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, h with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata
		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 informa-

not-covered drug can be approved.

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e information we have received, er above. The criteria are listed here.

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otype 3, and (B) Member has no

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oral tablet, one-time weekly

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has been completed and submitted

ta.fda.gov/scripts/medwatch/. ation 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-control to conditions in this policy have not been met. From the records that we have received, these reasons caused 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 of Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Description drug areales uncerta and the optime and the part of the exception of the advecta and the reduced to a tothic a transference.
					 4) Prescription drug samples were not used to establish treatment. Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 d
15222031 DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEXCOM G6 SENSOR	MEDICAL DEVICES	Type II diabetes 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 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 1) Member is currently using insulin.
15224933 NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	ere) obesity due to excess calories (HCC) Plan Exclusion	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 wha authorization may be required and quantity limits may apply. 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 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 treatments for vour health issue. Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reas 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 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
15226161 ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	ENBREL SURECLICK	TARGETED IMMUNOMODULATORS	m05.79 Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 had 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. 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, hydroxy 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 da 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 da methotrexate is indicated (Note: a contraindication to methotrexate does NOT cancel the requirement of a 3-6 month trial of conventional DMARI 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 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 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 11.0, CDAI score of 2.9-10.0); AND
15226945 ALBERTO GLENDALYZ MD	GERIATRIC MEDICINE	UBRELVY	MIGRAINE PRODUCTS	g43.109 Criteria Not Met	 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 i may be required and quantity limits may apply to covered drugs. Our prior autionization criteria for ubrogepant (UBKELVY) nave not been met. From the records that we nave received, Ubreivy was denied for these 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 (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. 3) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 3) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 4) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 3) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 4) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 5) Two triptan the anot been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is c 4) 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 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 hee 1) Member has a diag
15227201 MARC EVAN WENZEL MD	ENDOCRINOLOGY, DIABETES &	LNNOVOLOG 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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas

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-control conditions in this policy have not been met. From the records that we have received, these reasons caused 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 created please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 device drugs.
15222031 DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEXCOM G6 SENSOR	MEDICAL DEVICES	Type II diabetes 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 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 1) Member is currently using insulin.
15224933 NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	ere) obesity due to excess calories (HCC) Plan Exclusion	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 wha authorization may be required and quantity limits may apply. 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 i 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 treatments for vour health issue. Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reas 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 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
15226161 ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	ENBREL SURECLICK	TARGETED IMMUNOMODULATORS	m05.79 Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 had 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. 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, hydroxy 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 da 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 da methotrexate is indicated (Note: a contraindication to methotrexate does NOT cancel the requirement of a 3-6 month trial of conventional DMAR 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 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 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 11.0, CDAI score of 2.9-10.0); AND
15226945 ALBERTO GLENDALYZ MD	GERIATRIC MEDICINE	UBRELVY	MIGRAINE PRODUCTS	g43.109 Criteria Not Met	 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 may be required and quantity limits may apply to covered drugs. Our prior autonization criteria for ubrogepant (UBKELVY) nave not been met. From the records that we nave received, Ubreivy was denied for these 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 (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. 3) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 4) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 5) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 6) This request 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 or does not meet number(s) 2 and 3 of our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we 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 he 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.
15227201 MARC EVAN WENZEL MD	ENDOCRINOLOGY, DIABETES &	& N NOVOLOG FLEXPEN	ANTIDIABETICS	E11.65 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 in This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-our The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptior denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas

1	5226161 ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	ENBREL SURECLICK	TARGETED IMMUNOMODULATC

15226945 ALBERTO GLENDALYZ MD	GERIATRIC MEDICINE	UBRELVY	MIGRAINE PRODUCTS

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

eam or suppository.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

ated in your benefit summary. nay be able to suggest other

e reasons: take methotrexate at this dose, drug and cannot take it.

hat is covered.

we have received, the member does oove. The criteria are listed here.

droxychloroquine, leflunomide,

he dates of utilization of ubmitted; OR (C) A contraindication MARDs); AND greater than or equal to 20 isease Activity Index (CDAI) score;

isease activity (SDAI score of 3.4-

what is covered. Prior authorization nese reasons:

oidal anti-inflammatory drug

at is covered.

n we have received, the member ed here.

what is covered Prior authorization not-covered drug can be approved.

nalog equivalent).

nted if all conditions in our eption policy criteria. The reason for

15227553 TINA CHADHA BUNCH MD	RHEUMATOLOGY	HYDROCODONE BITARTRATE/	# ANALGESICS - OPIOID	Arthropathic psoriasis, unspec
15229415 RUMI AHMED KHAN MD	INTERNAL MEDICINE	DUPIXENT	DERMATOLOGICALS	
15230938 ERIN JENNIFER MOHLKE	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	

15231530 REDDIAH BABU MUMMANENI MD NEUROLOGY SUNOSI ADHD/ANTI-NARCOLEPSY

15233623 DANIEL ANTHONY CARRASCO MD DERMATOLOGY IVERMECTIN DERMATOLOGICALS Jnspecified blepharitis right

ecified (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 fo an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have 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 dispe- 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 appro- 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.
	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for the 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 beneed 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 may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
J45.5 Criteria Not Met	This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information 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 ar 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 blood eosinophil concentration is provided, OR (B) oral corticosteroid dependent asthma requiring daily doses of greater than or equal to 5 mg p 5) Member has a history of greater than or equal to 2 asthma exacerbations requiring treatment with systemic corticosteroids or emergency depa treatment of asthma within the past year despite adherent utilization of either an inhaled corticosteroid (ICS) with one additional asthma controlled 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
	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 wh This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a no
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Xtampza ER (tried), oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or 2 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.
f11.20 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 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 is may apply to covered drugs.
g47.411 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Sunosi have not been met. From the information we have received number 1 of our prior authorization criteria for Sunosi (Continuing Therapy). The reason for denial is explained to the member above. The criteria 1) Documentation of a reduction in symptoms of excessive daytime sleepiness or idiopathic hypersomnia is provided with the request (document 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 pos Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on wh
	 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 the conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: This drug is being used for blepharitis right lower eyelid. This is not an approved use. 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.
t lower eyelid 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the reason for denial is explained to the member above. The criteria from 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, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment. ugs are likely to

for members who are new to using e dispensing limits. We will only pensed if our records show recent roved if records are sent in

these reasons: body fight infections) OR that you

nat is covered. Prior authorization

n we have received, the member are listed here.

er microliter, and the baseline prednisone (or equivalent); AND partment visit or hospitalization for ller medication or maximally

ith another targeted

what is covered. Prior authorization not-covered drug can be approved.

ase (ER) (MS Contin equivalent), or Zohydro ER equivalent), tramadol

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

ation may be required and quantity

ed, the member does not meet a are listed here. ntation is required to be submitted

ositive airway pressure therapy. what is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our the exception policy criteria. The

, past treatments tried with dates

Yes

15233908 ITAMAR BIRNBAUM MD	CARDIOLOGY	PRALUENT	ANTIHYPERLIPIDEMICS
15235612 MAYA BADACHHAPE BLEDSOE MD	INTERNAL MEDICINE	MYCAPSSA	ENDOCRINE AND METABOLIC AGENTS - MIS

15240420 TRICIA LYNN WINTERS PA	PHYSICIAN ASSISTANT	CLINDAMYCIN PHOSPHATE/TF	RDERMATOLOGICALS	
15244832 VENKATESH BABU SEGU MD	ENDOCRINOLOGY, DIABETES &	N OMNIPOD 5 DEXCOM G7G6 P	MEDICAL DEVICES	
15249172 AJAY ZACHARIAH MD	FAMILY PRACTICE	MOUNJARO	ANTIDIABETICS	
15251720 MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	BIMZELX	TARGETED IMMUNOMODULATORS	

15251990 DANIEL ANTHONY CARRASCO MD

DERMATOLOGY

IVERMECTIN

DERMATOLOGICALS

Unspecified blepharitis right lo

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
i25.10 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 grante Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p
	of trial and responses, and any other evidence to 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 no
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
Acromogaly 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 grante
Acromegaly Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, post tried and responses, and any other originance to show the several drugs are likely to be ineffective or unsets for the member.
	of trial and responses, and any other evidence to 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 nor
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 eryth (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (tried) (doxycycline, minocycline, sulfamethoxazole Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
170.8 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 grante Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p
	of trial and responses, and any other evidence to 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
DM2 Plan Limits Exceeded	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 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 be list of covered drugs, also known as our formulary, to see what is covered. This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as state
obesity Plan Exclusion	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 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 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (ADALIMI 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.
PP Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grante
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p of trial and responses, and any other evidence to 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 nor 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.
lower eyelid 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 grante Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of th reason for denial is explained to the member above. The criteria from the policy are listed here.
	reason for denial is explained to the member above. The criteria from 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, or

 Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
 Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

nted if all conditions in our ption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved. in equivalent) and Somavert

nted if all conditions in our eption policy criteria. The reason for

past treatments tried with dates

not-covered drug can be approved. /thromycin, tretinoin, adapalene ole/trimethoprim, cephalexin).

nted if all conditions in our ption policy criteria. The reason for

, past treatments tried with dates what is covered. Prior authorization he plan. It is used to make sure a

d by your plan. Please look at the ated in your benefit summary. ay be able to suggest other

iot-covered drug can be approved. MUMAB-ADAZ, ADALIMUMAB-

nted if all conditions in our ption policy criteria. The reason for

past treatments tried with dates

iot-covered drug can be approved.

nted if all conditions in our the exception policy criteria. The

past treatments tried with dates

15253820 KENNETH ALLEN PEREZ DO	FAMILY PRACTICE	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHO	
15253970 ASHLEY HEATHER WHATLEY NP	NURSE PRACTITIONER	JATENZO	ANDROGENS-ANABOLIC	

15254890 LORENA CARBAJAL CARBALLO MD	INTERNAL MEDICINE	INVOKANA	ANTIDIABETICS	athy wout macular edema, bilatera
15255615 GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unsp
15257617 DANIEL ANTHONY CARRASCO MD	DERMATOLOGY	SEYSARA	TETRACYCLINES	

15260425 SHWOL-HUO DANNY KIANG DO

DERMATOLOGY

OTEZLA

TARGETED IMMUNOMODULATORS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
K21.9 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
	of trial and responses, and any other evidence to 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 ¿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:
F64.9 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
F64.9 Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
	of trial and responses, and any other evidence to 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 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:
hilatanal(IIIIC) Nat Causad	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
bilateral(HHS) Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 in a class of drugs called Weight Loss medications. Drugs of this type are excluded from coverage as stated in your benefit
y, unspecified Plan Exclusion	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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
L70.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
	of trial and responses, and any other evidence to 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.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
L40.0 Criteria Not Met	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
	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

not-covered drug can be approved.

meprazole, lansoprazole, and

15262853 ROBERT JAMES DOUGHERTY JR MD FAMILY PRACTICE

15266340 KETA PANDIT

15271102 WILLIAM MONNING LOVING MD

15278638 CRAIG HEWELL COUCH MD

15279422 GREG MICHAEL THAERA MD

NEUROLOGY

PSYCHIATRY

NEUROLOGY

GILENYA

NURTEC

MULTIPLE SCLEROSIS AGENTS

ADHD/ANTI-NARCOLEPSY

MIGRAINE PRODUCTS

ENDOCRINOLOGY, DIABETES & N REPATHA SURECLICK ANTIHYPERLIPIDEMICS

VYVANSE

ANDROGENS-ANABOLIC

TESTOSTERONE

	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:
N95.1 Criteria Not Met	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. 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.
E78.2 Criteria Not Met	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 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.
F90.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
G43.109 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
	of trial and responses, and any other evidence to 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 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.
G35 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 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.
	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

testosterone gel was denied for

estosterone.

ata.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

15282122 MANUEL JOSEPH MARTIN MD	FAMILY PRACTICE	ACCRUFER	HEMATOPOIETIC AGENTS

15283990 KATIE	e jo dixon fnp-c	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	09 - Other obesity due to excess ca
15284944 EMM	IY JO GALVAN FNP-C	NURSE PRACTITIONER	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	
15285216 STEV	'EN CURTIS CROW MD	FAMILY PRACTICE	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	
15287812 REUB	3en jeremiah elovitz Md	INTERNAL MEDICINE	UBRELVY	MIGRAINE PRODUCTS	G4
15299304 MAR	TIN CHRISTOPHER MOLINA MD	FAMILY PRACTICE	VYVANSE	ADHD/ANTI-NARCOLEPSY	

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be appro 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.
	 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.
G43.909 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - 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 dat of trial and responses, and any other evidence to 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 appro-
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
D50.9 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason denial is explained to the member above. The criteria from the policy are listed here.
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat
	of trial and responses, and any other evidence to 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 in a class of drugs called Weight Loss medications. Drugs of this type are excluded from coverage as stated in your benef
ss calories Plan Exclusion	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. 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
N52.9 Plan Exclusion	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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be appro
	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.
G43 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 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).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat
	of trial and responses, and any other evidence to 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) nave not been met. From the records that we have received, Ubreivy 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.
G43.009 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because our prior authorization criteria for ubrogepant (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 authorizat 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 methylphenidate ER_amphetaming (devtroamphetaming ER_(Adderall XR_aquivalent))
	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.
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.
	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 submi
	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

not-covered drug can be approved.

en, or both.

Aimovig, Ajovy, and Emgality.

nted if all conditions in our ne exception policy criteria. The

, past treatments tried with dates

not-covered drug can be approved. tablet, Multigen Folic tablet,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

overage as stated in your benefit provider may be able to suggest ge as stated in your benefit

provider may be able to suggest not-covered drug can be approved.

tablet, rizatriptan, sumatriptan,

nted if all conditions in our ne exception policy criteria. The

past treatments tried with dates ese reasons: oidal anti-inflammatory drug

t is covered.

n we have received, the member here.

what is covered. Prior authorization a not-covered drug can be

ylphenidate extended release (ER),

t the FDA of efficacy and safety

nted if all conditions in our of the exception policy criteria. The

has been completed and submitted a.fda.gov/scripts/medwatch/.

15299326 BRIANNA LAREE HURTADO NP	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	

15304808 DARUSH RAHMANI DO RHEUMATOLOGY BENLYSTA MISCELLANEOUS THERAPEUTIC CLASSES 2.9-SYSTEMIC LUPUS ERYTH CLINDAMYCIN PHOSPHATE/TR DERMATOLOGICALS 15306048 TRICIA LYNN WINTERS PA PHYSICIAN ASSISTANT

15306268 CLAYTON WARREN ADAMS MD G89.4-Chronic pa ANESTHESIOLOGY ANALGESICS - OPIOID BUPRENORPHINE

15308003 ATHIRA UNNIKRISHNAN MD HEMATOLOGY & ONCOLOGY NUBEQA ANTINEOPLASTICS AND ADJUNCTIVE THERAnone-Sensitive Prostate Can

	Our prior autnorization criteria for emtricitable/tenofovir alatenamide (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:
PrEP Not Covered	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 formulan, for information on what is covered. Prior authorization 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.
THEMATOSUS Criteria Not Met	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
	 Prescribed by, or in consultation with, a Rheumatologist or Dermatologist; AND 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
Acne Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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.
ain syndrome Formulary Alternatives Available	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
	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.
ncer (mHSPC) Criteria Not Met	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.

as denied for these reasons:

what is covered. Prior authorization sta SC was denied for these

what is covered. Prior authorization t another drug will need to be tried

						Our prior authorization criteria for lenvatinib (LENVIMA) have not been met. From the records that we have received, the following caused the denial
						 Control authorization criteria for renvalue (LERVINIA) have not been met. From the records that we have received, the following caused the denial 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 limits may apply to covered drugs.
15309538	15309538 MARIAN YVETTE WILLIAMS-BROWN ME	O OBSTETRICS & GYNECOLOGY	NECOLOGY LENVIMA 20 MG DAILY DOSE ANTINEOPLASTICS AND ADJUNCTIVE THERA		C54.1 Criteria Not Met	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 h 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 li 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
	15311003 NAWALAGE RAVI NAYANADUL COORAY	' NFAMILY 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 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 device what device the 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 device the 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 device the 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 device the 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 device the therapy has not been met, we are not able to approve.
						This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met 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 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 wha authorization may be required and quantity limits may apply.
						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
153142	15314262 CHRISTOPHER JAMES O'CONNOR PA	PHYSICIAN ASSISTANT	TANT BUPRENORPHINE HCL	ANALGESICS - OPIOID	dx f11.20 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-or. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 received, 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.
	15318739 JACQUELYN MARIE RODRIGUEZ NP	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20-Opioid dependence 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-co
						The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 relea 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.
	15319669 DANIEL NEIL SKOGLUND MD	PSYCHIATRY	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	F90.0-ADHD Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas

15309538 MARIAN YVETTE WILLIAMS-BROWN MD OBSTETRICS & GYNECOLOGY	LENVIMA 20 MG DAILY DOSE ANTINEO	PLASTICS 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 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 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 h 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 li 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).
15311003 NAWALAGE RAVI NAYANADUL COORAY I FAMILY PRACTICE	DEXCOM G6 SENSOR MEDICAL	DEVICES	dx E13.69	Criteria Not Met	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formularv for information on what Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 device 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 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 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 authorization may be required and quantity limits may apply.
15314262 CHRISTOPHER JAMES O'CONNOR PA PHYSICIAN ASSISTANT E	BUPRENORPHINE HCL ANALGES	ics - 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-our the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-our the conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be use
15318739 JACQUELYN MARIE RODRIGUEZ NP NURSE PRACTITIONER E	BUPRENORPHINE HCL ANALGES	ics - opioid	F11.20-Opioid dependence	Not Covered	 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptior denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 relear 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.
15319669 DANIEL NEIL SKOGLUND MD PSYCHIATRY A	ADZENYS XR-ODT ADHD/AN	ITI-NARCOLEPSY	F90.0-ADHD	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas

15318739 JACQUELYN MARIE RODRIGUEZ NP	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20-

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. story a 4) Prescription drug samples were not used to establish treatment.

denial of Lenvima.

zation may be required and quantity

we have received, the member are listed here. Yes

what is covered. Prior authorization

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

not-covered drug can be approved.

/films.

anted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

ne required (Suboxone film/Zubsolv

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

d release (ER), methylphenidate ER,

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

15325792 ELIZABETH LYNN POLLOCK ME	D FAMILY PRACTICE	LIDOCAINE 5%	ANORECTAL AND RELATED PRODUCTS	B02.9 - Zoster withou
15330529 HETU YOGESHKUMAR PAREKH	MD ALLERGY & IMMUNOLOGY	XOLAIR	ANTIASTHMATIC AND BRONCHODILATOR A	

SYMBICORT

15330548 DONALD DAVIS COLE III MD FAMILY PRACTICE

15331849 LUCY MARIBEL AMIEVA NP

NURSE PRACTITIONER

LUMRYZ

PSYCHOTHERAPEUTIC AND NEUROLOGICAL

ADHD/ANTI-NARCOLEPSY

15334821 MICHAEL ANDREW MUSGROVE MD PSYCHIATRY

QELBREE

ANTIASTHMATIC AND BRONCHODILATOR Aderate persistent asthma, un

out

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 pate 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:
complications Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, portional and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug camples were not used to establish treatment.
	 Prescription drug samples were not used to establish treatment. This drug is not on our list of covered drugs, also known as our formulary. Xolair 150 mg Subcutaneous Solution (Reconstituted) is a medication to
Other urticaria Plan Exclusion	care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Plea 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 auth
	Originative limits may apply to covered drugs. This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a
	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 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 th 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.
ncomplicated 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 grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, 3 of 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, ha with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.
	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 informati Our prior authorization criteria for sodium oxybate ER suspension (LUMRYZ) have not been met. From the records that we have received, LUMRYZ
	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 wha and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
G47.419 Criteria Not Met	This request has not been approved because our prior authorization criteria for sodium oxybate ER suspension (LUMRYZ) have not been met. From 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 here.
G47.415 Chicha Hot Met	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) N eight (8) minutes, AND (B) Two (2) or more sleep onset rapid eye movement (REM) sleep periods (documentation is required to be submitted for a
	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 wh
	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
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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
	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.
	neuse look at the formalary to see what alogs are covered. The authorization may be required and quantity innits may apply to covered drugs.
FOO 2 Net Coursed	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
F90.2 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

atch, gabapentin, amitriptyline,

nted if all conditions in our

eption policy criteria. The reason for

past treatments tried with dates

that must be given by a health or in urgent care settings are lease review your medical benefit thorization may be required.

a not-covered drug can be

ota(TRIED), Advair HFA(TRIED) or

the FDA of efficacy and safety

nted if all conditions in our ne exception policy criteria. The

has been completed and submitted a.fda.gov/scripts/medwatch/. ation on what is covered. Prior YZ was denied for these reasons:

at is covered. Prior authorization

om the information we have

r above. The criteria are listed

Mean onset to sleep of less than r an approval); AND

what is covered. Prior authorization

not-covered drug can be approved.

ng-acting stimulant drug (e.g.,

nted if all conditions in our eption policy criteria. The reason for

15339167 DANIEL NEIL SKOGLUND MD PSYCHIATRY ADZENYS XR-ODT ADHD/ANTI-NARCOLEPSY	
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OZEMPIC

15346498 FAUSTIN MURHUBUBA BAHIZI	PHYSICIAN ASSISTANT

15351295 AMANDA BOUY BALCH WHNP

15354649 ISELA ARRIETA WERCHAN MD PSYCHIATRY

NURSE PRACTITIONER

LUCEMYRA

TESTOSTERONE

PSYCHOTHERAPEUTIC AND NEUROLOGICAL

ANTIDIABETICS

ANDROGENS-ANABOLIC

15356026 KELLY HETHERINGTON SIMPSON	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	

		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-core The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
F90.0-ADHD.	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if
		Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception p denial is explained to the member above. The criteria from the policy are listed here.
		 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Description drug complex were not used to establish treatment.
		 4) Prescription drug samples were not used to establish treatment. 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 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 co
r73.03	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member
		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 Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Testost
		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 testoste Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is c and quantity limits may apply to covered drugs.
		ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
R68.82	Criteria Not Met	This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. Fro 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 n 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; AND4) 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 testoster with the request. Our prior autnorization criteria for Lucemyra nave not been met. From the records that we have received, the following caused the denial of Lucemyra.
		 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 r limits may apply to covered drugs.
F11.23	Criteria Not Met	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, 3 of our prior authorization criteria for Lucemyra. The reason for denial is explained to the member above. The criteria are listed here.
		 Member has diagnosis of mitigation of opioid withdrawal symptoms, AND Prescribed by, or in consultation with, a physician specializing in pain management or addiction treatment, AND Ticken block in a 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. From the records that we have received, Dupixent was denied for these 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 c 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 h 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 list
	Critoria Nat Mat	 Member is 6 months of age or older; AND Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND
AD	Criteria Not Met	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 e 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 provide (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 (docu submitted for an approval): (A) medium to yony high potency tonical steroid, or (R) tonical calcingurin inhibitor (e.g., tascrolimus cintment (PROTORIC), pimeerolimus cream (ELIDEL
		(A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEL Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed 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

not-covered drug can be approved.

release (ER), methylphenidate ER,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

be required and quantity limits may

at is covered.

nember does not meet number 1 of

what is covered. Prior authorization Testosterone gel 1% was denied for

estosterone. what is covered. Prior authorization

met. From the information we have o the member above. The criteria

estosterone must be documented

cemyra.

zation may be required and quantity

ceived, the member does not meet

eatment. what is covered. Prior authorization r these reasons:

not received. hat is covered. Prior authorization

n we have received, the member are listed here.

han or equal to 10% body surface provided with the request

t (documentation is required to be

(ELIDEL)), or (C) Narrow band s listed above are contraindicated;

what is covered Prior authorization

					Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these re 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
15362018 MARY ANN MARTINEZ MD	DERMATOLOGY	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	psoriasis Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the information we does not meet number(s) 3 of our prior authorization criteria for Skyrizi for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained t 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 subm
					Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i may be required and quantity limits may apply to covered druge. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 releas amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. Please note: Extended 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.
15364636 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	QUILLICHEW ER	ADHD/ANTI-NARCOLEPSY	f90.9 Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15366416 JESSLYN JIAEN LU MD	ENDOCRINOLOGY, DIABETE	ES & N WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified Plan Exclusion	 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what i 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 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 health care provider may be able to suggest other treatments for your health issue. Our prior authorization criteria for pitolisant (WAKIX) have not been met. From the records that we have received, the following caused the denial of 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
15374025 NEERAJ MANCHANDA MD	NEUROLOGY	WAKIX	ADHD/ANTI-NARCOLEPSY	EDS Criteria Not Met	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 not meet number 1 of our prior authorization criteria for Wakix (Continuing Therapy). The reason for denial is explained to the member above. The cr 1) Documentation of a reduction in symptoms of excessive daytime sleepiness is provided with the request (documentation is required to be submitt Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i may be required and quantity limits may apply to covered drugs. Our prior authorization criteria for QUITAENT) have not been met. From the records that we have received, Duptxent was denied for these 1) Records did not show that at least TWO (2) of the following treatments did not work for you: topical steroids (triamcinolone (tried)), topical calcine 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 and quantity limits may apply to covered drugs.
15375183 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	DUPIXENT	DERMATOLOGICALS	L20.84 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 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 lis 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 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 provi (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 (doc submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDE Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies liste AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.
15382283 PREETHI ILANGOVAN MD	ENDOCRINOLOGY, DIABETE	S & N OMNIPOD 5 DEXCOM G	7G6 P(MEDICAL DEVICES	E10.69 Plan Limits Exceeded	Since criteria have not been met we are upable to approve coverage for this drug at this time. Please refer to our formulant for information on what is 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 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 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. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed me 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 faile 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 p 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 ap issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer review 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 other treatments cannot be used. Please leak at the list of generated drugs, also known as the formulant to see what is generate by user plan.
					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.

15382283 PREETHI ILANGOVAN MD	ENDOCRINOLOGY, DIABETES & N	OMNIPOD 5 DEXCOM G7G6 PC	MEDICAL DEVICES	
15384959 JOHN ROBERTSON JEFFERSON MD	NEUROLOGY	PREGABALIN	ANTICONVULSANTS	
15385339 ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	ACTEMRA ACTPEN	TARGETED IMMUNOMODULATORS	

ese reasons:

nat is covered.

n we have received, the member ned to the member above. The

submitted for an approval). what is covered. Prior authorization

not-covered drug can be approved.

release (ER), methylphenidate ER, tended release capsules can be

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization ducts of this type are excluded from ed by your plan. Your doctor or

al of Wakix.

zation may be required and quantity

have received, the member does he criteria are listed here. bmitted for an approval).

what is covered. Prior authorization

these reasons. lcineurin inhibitors (such as

nat is covered. Prior authorization

n we have received, the member are listed here.

an or equal to 10% body surface provided with the request

t (documentation is required to be

ELIDEL)), or (C) Narrow band listed above are contraindicated;

what is covored. Prior authorization ot covered by your plan. Please

by the plan. It is used to make sure oproved dose for your health issue. ed medical journals, treatment n failed, and reasons why other

the plan. It is used to make sure a an approved dose for your health eviewed medical journals, t have been failed, and reasons why

15398109 JAMES JOHN TEET DO	FAMILY PRACTICE	DESCOVY	ANTIVIRALS	

FAMILY PRACTICE 15399148 AFREEN KHAN MD HYDROCORTISONE ACETATE ANORECTAL AND RELATED PRODUCTS

15401480 KAREN SPURGEON WELCH MD	FAMILY PRACTICE	STELARA	TARGETED IMMUNOMODULATORS	
15401741 ANDREW ALAN COLLINS MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	

15403387 KATIE JO DIXON FNP-C

NURSE PRACTITIONER

OZEMPIC

ANTIDIABETICS

Z20.6 Criteria Not Met	 Our prior autnorization criteria for emtricitabine/tenorovir alatenamide (DESCOVY) nave not been met. From the records we received, Descovy was 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 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 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 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 provid decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least 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 whom the provided of the provided of a provided on the provided of the provide
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a normal transmission of the second transmission of transmission of transmission of the second transmission of the second transmission of tran
K64.9 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, j of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 the 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 wha 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 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 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 su 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 wh
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 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pof trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 stat 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

treatments for your health issue.

as denied for these reasons:

at is covered. Pre-approval may be

met. From the information we have er above. The criteria are listed

ided of a renal adverse event or be submitted for an approval); OR tted for an approval); OR (C) st four (4) to eight (8) weeks of

what is covered. Prior authorization not-covered drug can be approved.

n (Anamantle equivalent),

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

hese reasons:

nat is covered.

on we have received, the member al is explained to the member

submitted for an approval); AND

vhat is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ated in your benefit summary. ay be able to suggest other

15405225 KELLY HETHERINGTON SIMPSON	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	
15405777 STEPHANIE BROOKE KNIGHT NP	NURSE PRACTITIONER	AIMOVIG	MIGRAINE PRODUCTS	
15406865 SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	OTEZLA	TARGETED IMMUNOMODULATORS	
15407194 YUE DENG MD	INTERNAL MEDICINE	DEXCOM G6 RECEIVER	MEDICAL DEVICES	

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 the 1) Records show you may not be able to use topical steroids (such as betamethasone-TRIED), topical calcineurin inhibitors (such as tacrolimus or pi azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil, but more information is needed to know why each of these treatments are 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 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 w 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 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 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 proc (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 (d submitted for an approval); and (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELII Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies lis AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.
	 Records did not show that you have had fewer or less severe migraine headaches since starting this drug. More information is needed to know if this drug will be used together with botulinum toxin product (such as Botox, Dysport, Xeomin, etc.). If Aim 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 alo
	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 follow anticomputants (such as topicaments, sodium values at a), vacanetic (such as propriate least 3 months) other drugs from at least ONE of the follow
G43.909 Criteria Not Met	anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as a Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what 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 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 criter 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
	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezia was denied for these real 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 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 wee 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 and quantity limits may apply to covered drugs.
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 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 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 (Persignificant 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 (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. 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 Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be usin 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
e11.9 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 m 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 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 wh
	authorization may be required and quantity limits may apply.

r these reasons: or pimecrolimus), light therapy, e not right for you. rhat is covered. Prior authorization

n we have received, the member are listed here.

han or equal to 10% body surface s provided with the request

t (documentation is required to be

ELIDEL)), or (C) Narrow band s listed above are contraindicated;

what is covered. Prior authorization nese reasons:

Aimovig will be used together with alone AND a three (3) month trial

llowing drug classes: as amitriptyline, venlafaxine, etc.).

nat is covered.

we have received, the member riteria are listed here.

e reasons: r health issue is impacting your day-

week, OR acitretin.

hat is covered. Prior authorization

we have received, the member does a are listed here.

s (PsO) AND Member has

of 15 sessions of phototherapy; OR ied. NOTE: A contraindication or

what is covered. Prior authorization using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

					Our prior authorization criteria for levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the records that we have received, Tiros 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
15408827 JULIE ANN REARDON MD	FAMILY PRACTICE	TIROSINT-SOL	THYROID AGENTS	E03.9 Criteria Not Met	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. I 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
					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 i 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 re- 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 c
15411312 CHRISTA DRURY JONES	NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	R73.03 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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 i 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
15414906 STARLING CORBETT REID MD	INTERNAL MEDICINE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories Plan Exclusion	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 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-control of the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
15415781 KATHRYN MARIE LANDHERR MD	OBSTETRICS & GYNECOLOGY	ESTROGEL	ESTROGENS	lenopausal and female climacteric states Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i
					Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
					1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
					 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past
					of trial and responses, and any other evidence to 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-control of the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15416160 BHAVIM ARUNN DESAI MD	FAMILY PRACTICE	XYWAV	PSYCHOTHERAPEUTIC AND NEUROLOGIC	CAL Narcolepsy with Cataplexy 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
15416160 BHAVINI ARUNIN DESAL MD	FAMILY PRACTICE	XTWAV	PSTCHOTHERAPEOTIC AND NEOROLOGIC	AL Narcolepsy with Cataplexy Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
					1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
					 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past
					of trial and responses, and any other evidence to 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-co
					The conditions in this policy have not been met. From the records that we have received, these reasons caused 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
					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:
15426261 MORGAN JANELLE MCCARTY DO	DERMATOLOGY	SOTYKTU	DERMATOLOGICALS	I40.0 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
					denial is explained to the member above. The criteria from the policy are listed here.
					 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
					3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. From the records that we have received, Myfe
					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
					ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
15427821 JENNIFER LYNNE TRAVIESO MD	OBSTETRICS & GYNECOLOGY	MYFEMBREE	ESTROGENS	D25.9 Criteria Not Met	This request has not been approved because our prior authorization criteria for relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. I 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 here.
					 Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND Member has NO known osteoporosis; AND Member is premenopousal; AND
					4) Member is premenopausal; AND5) A trial of a hormonal contraceptive was ineffective, contraindicated, or not tolerated.

15408827 JULIE ANN REARDON MD	FAMILY PRACTICE	TIROSINT-SOL	THYROID AGENTS	E03.9 Cr	riteria Not Met	Our prior authorization criteria for levothyroxine sodium oral solution (Tirosint-Sol) have not been met. From the records that we have received, Tiros 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 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. I 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 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 i
15411312 CHRISTA DRURY JONES	NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	R73.03 Cr	riteria 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 re- 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 c 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 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 i
15414906 STARLING CORBETT REID MD	INTERNAL MEDICINE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calories Pla	lan 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 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
15415781 KATHRYN MARIE LANDHERR MD	OBSTETRICS & GYNECOLOGY	ESTROGEL	ESTROGENS	lenopausal and female climacteric states No	lot Covered	treatments for vour 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-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 ta 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 NEUROLOGICA	L Narcolepsy with Cataplexy No	lot Covered	 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-control to the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-control of the drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-control of the drug is not on our list of covered drugs, also known as
15426261 MORGAN JANELLE MCCARTY DO	DERMATOLOGY	SOTYKTU	DERMATOLOGICALS	140.0 No	ot Covered	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Cr	riteria Not Met	 Application of the provided of establish relation. Our prior authorization criteria for relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. From the records that we have received, Myfereasons: 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 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. I 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 here. Prescribed by, or in consultation with, an Obstetrician-Gynecologist (OB/GYN) or other women's health reproductive specialist; AND Member has a diagnosis of heavy menstrual bleeding associated with uterine fibroids; AND Member is premenopausal; AND A trial of a hormonal contraceptive was ineffective, contraindicated, or not tolerated.

						() us prior authorization criteria for levelsh revine codum eral colution (lisecist Sel) have not been met brom the records that we have received lise
15408827 JULIE ANN REARDON MD	FAMILY PRACTICE	TIROSINT-SOL	THYROID AGENTS	E03.9	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, Tiros 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 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. 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 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.
15411312 CHRISTA DRURY JONES	NURSE PRACTITIONER	VICTOZA	ANTIDIABETICS	R73.03	3 Criteria Not Met	Since criteria have not been met we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what 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 re 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 constructed because our Restricted Diagnosis criteria have not been met. From the received, the memb 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 the request has not been met, we are unable to approve approve the member above. The criteria are listed here.
15414906 STARLING CORBETT REID MD	INTERNAL MEDICINE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	id (severe) obesity due to excess calorie	s 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 i 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
15415781 KATHRYN MARIE LANDHERR MD	OBSTETRICS & GYNECOLOGY	ESTROGEL	ESTROGENS	lenopausal and female climacteric state	s Not Covered	 treatments for vour 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-or. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ¿estradiol oral tablet, Premarin oral t 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptior denial is explained to the member above. The criteria from the policy are listed here. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-coverage Determinations - Exceptions policy is used to decide if a not-coverage Determina
15416160 BHAVIM ARUNN DESAI MD	FAMILY PRACTICE	XYWAV	PSYCHOTHERAPEUTIC AND NEUROLOGICA	AL Narcolepsy with Cataplex	y Not Covered	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Wakis Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptior denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-coverage Determinations - Exceptions policy and has results, pas
15426261 MORGAN JANELLE MCCARTY DO	DERMATOLOGY	SOTYKTU	DERMATOLOGICALS	140.4	0 Not Covered	 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Cimzi 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptior denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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	9 Criteria Not Met	 Applied and painples where not used to extabilish recention. Our prior authorization criteria for relugolix/estradiol/norethindrone (MYFEMBREE) have not been met. From the records that we have received, Myfereasons: 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 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. 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 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.

lirosint-Sol was denied for these

nat is covered.

met. From the information we have mber above. The criteria are listed

what is covered Prior authorization

be required and quantity limits may

at is covered.

nember does not meet number 1 of

what is covered. Prior authorization ated in your benefit summary. ay be able to suggest other

not-covered drug can be approved.

oral tablet, one-time weekly

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

Wakix, Lumryz, Sunosi.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

Cimzia, Otezla (tried), Skyrizi,

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

Myfembree was denied for these

nat is covered.

met. From the information we have mber above. The criteria are listed

15428274 JONATHAN EDWARD MACCLEMENTS MD FAMILY PRACTICE OZEMPIC ANTIDIABETICS GOUT AGENTS M10.9 - Gout 15429515 ELIZABETH LYNN POLLOCK MD FAMILY PRACTICE ALLOPURINOL

15430460 VANESSA AILEEN FRASSATI APN ADVANCED PRACTICE NURSE QELBREE ADHD/ANTI-NARCOLEPSY cit hyperactivity disorder, co

VYZULTA 15430683 MELODI EYVANAKI ESMAILI OD OPTOMETRIST OPHTHALMIC AGENTS

15431529 AJAY ZACHARIAH MD FAMILY PRACTICE MOUNJARO ANTIDIABETICS 15432292 PETER JEFFREY GEMBOL FNP NURSE PRACTITIONER MOUNJARO ANTIDIABETICS

15433610 LAURELIN NICOLE MULLINS NP NURSE PRACTITIONER VENLAFAXINE HYDROCHLORIE ANTIDEPRESSANTS

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 stat 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 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 new The conditions in this policy have not been met. From the records that we have received, these reasons caused 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
	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.
	Thease look at the formulary to see what drugs are covered. Thoi authorization may be required and quantity innits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
t, unspecified Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 2) Pacards have been received showing the requested drug is medically pacassany. These should include relevant medical history and lab results.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 ne The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 lor
	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:
ombined type Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 ne
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Tr
	(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:
H40.1131 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	 Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	4) Prescription drug samples were not used to establish treatment.
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 stat 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 ma
	treatments for your health issue.
	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 b
	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
E10.9 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the me
	our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.
	 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 w
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a new
	The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
	 All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are venlafaxine extended release (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 gran
depression Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	 All formularly alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

ulugs are likely to 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

ated in your benefit summary.

ay be able to suggest other

not-covered drug can be approved.

t). Please note: the 200mg tablets

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

ong-acting stimulant drug (e.g.,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

Travatan Z equivalent), tafluprost

nted if all conditions in our

ption policy criteria. The reason for

Yes

, past treatments tried with dates

ated in your benefit summary.

ay be able to suggest other

be required and quantity limits may

at is covered.

ember does not meet number 1 of

what is covered. Prior authorization not-covered drug can be approved.

R) capsules (Effexor XR equivalent).

nted if all conditions in our

ption policy criteria. The reason for

, past treatments tried with dates

15438185 MARJAN ABEDI LINNELL MD PEDIATRICS JORNAY PM ADHD/ANTI-NARCOLEPSY a	cit hyperactivity disorder,
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15440//1 HANA AUBRECHTOVA MD NEUROLOGY UBRELVY MIGRAINE PRODUCTS				
	5440771 HANA AUBRECHTOVA MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS

15444403 CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	

					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 valsartan, olmesartan, telmisartan, candesartan) along with chlorthalidone or hydrochlorothiazide (HCTZ). Additionally, other combination medic 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:
15434060 STANLEY SUCHY WANG MD	CARDIOLOGY	EDARBYCLOR	ANTIHYPERTENSIVES	i10 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 re 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.
15438185 MARJAN ABEDI LINNELL MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, combined type Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 th 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 wh and quantity limits may apply to covered drugs.
15440771 HANA AUBRECHTOVA MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	migraine Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information 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 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 w
					may be required and quantity limits may apply to covered drugs Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, TRETINOIN was denied for these rea 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 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
15444403 CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	D23.30 Criteria Not Met	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 r meet number 1 of our prior authorization criteria for TRETINOIN. The reason for denial is explained to the member above. The criteria are listed h 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 w
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n 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 m 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.
15448263 KYLE MATTHEW SUIRE DO	FAMILY PRACTICE	BUTALBITAL/ACETAMINOI	PHEN ANALGESICS - NONNARCOTIC	ाt intractable, without status migrainosus 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of 1 reason for denial is explained to the member above. The criteria from 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, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
15452713 CARSON PAUL HIGGS MD	FAMILY PRACTICE	UREA	DERMATOLOGICALS	L30.9 - Dermatitis, unspecified Not Covered	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 w 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 (O other drugs include Ureacin, Rea-Lo, Gordon's Urea 40 and others. Please note these other drugs are not covered by your prescription drug bene for specific information on what is covered.

a not-covered drug can be approved.

rs (ARBs) (irbesartan, losartan,

dications are available on formulary

ranted if all conditions in our ception policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

release (ER), methylphenidate ER,

anted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

hese reasons:

what is covered. Prior authorization

on we have received, the member are listed here.

what is covered. Prior authorization

easons: the skin. nat is covered.

received, the member does not d here.

n what is covered. Prior authorization a not-covered drug can be approved.

muscle contraction headaches.

anted if all conditions in our of the exception policy criteria. The

s, past treatments tried with dates

n what is covered. Prior authorization (OTC) without a prescription. These

enefit. Please refer to the formulary

15453482 KEN LIN FNP-C	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	
15455509 SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	
15459829 NEERAJ MANCHANDA MD	NEUROLOGY	AIMOVIG	MIGRAINE PRODUCTS	
15460360 JAY JOHNSON BAILEY	NURSE PRACTITIONER	FROVATRIPTAN SUCCINATE	MIGRAINE PRODUCTS	

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not
	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:
f11.20 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grante
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the
	reason for denial is explained to the member above. The criteria from 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, particular and the results of the results
	of trial and responses, and any other evidence to 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 subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta
	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
	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 t
	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 you
	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
M22.0 Critoria Not Mat	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
M32.9 Criteria Not Met	This request has not been approved because our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From 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 second sec
	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-do
	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)
	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.
	Our prior authorization criteria for erenumab (AliviOviG) have not been met. From the records that we have received, Almovig was denied for these
	1) Dependendiel met ekseveren keventeige dage feiled (often weiner fan et laget 2 menster) et en druge fram et laget ONE of the following druge dependente
	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: ar topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as 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
	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 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 l
migraine Criteria Not Met	does not meet humber(s) s of our phor authorization chtena for Almovig. The reason for demans explained to the member above. The chtena are i
	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 class
	topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlat
	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 t
	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 t (BOTOX, DYSPORT, MYOBLOC, XEOMIN).
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
	the second and quality in the second and get are control addiction may be required and quality innits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grante
G43.909 Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results in the requested drug is medically necessary.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, part of trial and responses, and any other evidence to 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

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

not-covered drug can be approved.

anted if all conditions in our f the exception policy criteria. The

, past treatments tried with dates

sta SC was denied for these

test for anti-smith antibodies. These wn tissues and organs, causing

your brain and spinal cord.

hat is covered.

rom the information we have to the member above. The criteria

-double stranded DNA (anti-

, (D) mycophenolate mofetil, or (E)

ese reasons:

s: anticonvulsants (such as ine, etc.).

nat is covered.

we have received, the member are listed here.

lasses: (a) anticonvulsants (such as nlafaxine, etc.); AND

of the following are met: (A) ual therapy with botulinumtoxin

not-covered drug can be approved.

tan, naratriptan, zolmitriptan.

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

15468371 SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	

15470191 SONIA YOUSUF III MD	RHEUMATOLOGY	TERIPARATIDE	ENDOCRINE AND METABOLIC AGENTS - MIS

15476433 ATHIRA UNNIKRISHNAN MD	HEMATOLOGY & ONCOLOGY	GILOTRIF	ANTINEOPLASTICS AND ADJUNCTIVE THERA	
15478286 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	AZSTARYS	ADHD/ANTI-NARCOLEPSY	

15482708 ATHIRA UNNIKRISHNAN MD

HEMATOLOGY & ONCOLOGY GILOTRIF

ANTINEOPLASTICS AND ADJUNCTIVE THERA

15483920 GERMAN ECHEVERRY MD

ANESTHESIOLOGY

WEGOVY

ANTI-OBESITY/ANOREXIANTS

id (severe) obesity due to excess

	 Our prior authorization criteria for subcutaneous beilmumab (BENETSTA SC) have not been met. From the records that we have received, Benijsta 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. T 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 net been met, we are not able to approve Please look at our list of covered drugs, also known as the formulant to see what is covered.
m32.9 Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for 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 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.
	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 formulan, for information on what is covered. Prior authorized This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be appro-
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
M81.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug camples were not used to establish treatment.
	4) Prescription drug samples were not used to establish treatment. Our prior authorization criteria for atatinib (GLOTRIF) nave not been met. From the records that we have received, Gliotrif 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.
C43.11 Criteria Not Met	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 do 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 authorizat
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be appro The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
F90.2 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat of trial and responses, and any other evidence to 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 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.
	 A) 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.
c34.11 Criteria Not Met	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 do 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 authorizat 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.
s calories Plan Exclusion	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.

ta SC was defiled for these

test for anti-smith antibodies. These

your brain and spinal cord.

hat is covered.

om the information we have member above. The criteria are

i-double stranded DNA (anti-

(D) mycophenolate mofetil, or (E)

what is covored Brier authorization

not-covered drug can be approved. cg/2.48 mL.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

reasons:

nat is covered. Prior authorization

have received, the member does

what is covered. Prior authorization not-covered drug can be approved.

l release (ER), methylphenidate ER,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

reasons:

nat is covered. Prior authorization

have received, the member does re listed here.

what is covered. Prior authorization ated in your benefit summary. ay be able to suggest other

					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
15486504 DUSTIN ALLEN FONTENOT PA-C	PHYSICIAN ASSISTANT	CLOMID	ENDOCRINE AND METABOLIC AGENTS - M	IS E29.1 - Testicular hypofunction Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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 - M	IS2.0 - 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 provi administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co 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 wh plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may
					 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: This drug is being used for migraines. This is not an approved use. All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ibuprofen, naproxen, diclofenac table 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.
15487456 CLAYTON WARREN ADAMS MD	ANESTHESIOLOGY	BUTALBITAL/ACETAMINOPHE	N ANALGESICS - NONNARCOTIC	G43.909 Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, e 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.
15487470 CRYSTAL MELANIE BOWDEN-MCKAY M	ID GASTROENTEROLOGY	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICH	OI K20.0 - Eosinophilic esophagitis 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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 linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these real 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 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 plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. 3) Since the crite
15491794 SARAH ALI MD	FAMILY PRACTICE	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.00 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we had 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 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).
					Our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the records that we have received, diclofenac 3% gel was der 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 ski 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 c
15491926 ANNE CLAIRE ADAMS	FAMILY PRACTICE	DICLOFENAC SODIUM	DERMATOLOGICALS	M79.644 Criteria Not Met	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 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 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 may be required and quantity limits may apply to covered drugs. 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
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 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 vour health issue.

not-covered drug can be approved.

erone enanthate, testosterone gel nt)

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

provider. Prescription drugs that are m coverage as indicated in your ee what is covered by your health s may apply to covered drugs. not-covered drug can be approved.

tablet, rizatriptan, sumatriptan,

anted if all conditions in our ne exception policy criteria. The

, past treatments tried with dates

not-covered drug can be approved.

azole, esomeprazole (TRIED),

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

e reasons: ritable bowel syndrome with

what is covered. Prior authorization

we have received, the member does a are listed here.

what is covered. Prior authorization s denied for these reasons: e skin.

at is covered.

nation we have received, the ove. The criteria are listed here.

what is covered. Prior authorization

ated in your benefit summary. Please able to suggest other treatments for

15493221 RUMI AHMED KHAN MD	INTERNAL MEDICINE	AIRSUPRA	ANTIASTHMATIC AND BRONCHODILATOR A 09 - Unspecified asthn	na, un
15500242 CHARLOTTE ELISE WRIGHT	NURSE PRACTITIONER	FERRETTS	HEMATOPOIETIC AGENTS	Iro

15503432 CLAYTON WARREN ADAMS MD ANESTHESIOLOGY BUPRENORPHINE HCL

 15506605
 ANDREA GEORGE MD
 ENDOCRINOLOGY, DIABETES & NOZEMPIC
 ANTIDIABETICS
 R73.0

 15507743
 TAMIKA DANIELLE LATTA MD
 FAMILY PRACTICE
 NOVOLIN N
 ANTIDIABETICS
 E11.0

ANALGESICS - OPIOID

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a no
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Pro-
	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:
uncomplicated Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
uncomplicated Not covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 tablet
	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:
Iron deficiency Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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/
	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:
Z51.81 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 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
	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
03-prediabetes Criteria Not Met	
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the me
	our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.
	 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 whether the second second
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 grant
.65-type 2 DM Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

roventil equivalent) or Ventolin HFA

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

lets, Multigen Folic tab, Multigen

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

n/tablet (SUBOXONE equivalent,

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

be required and quantity limits may

at is covered.

ember does not meet number 1 of

vhat is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

		15508268	ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	QUILLICHEW ER	ADHD/ANTI-NARCOLEPSY	
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15509948 ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	DICLOFENAC EPOLAMINE	DERMATOLOGICALS	0-Bilateral primary osteoar

15510605 DUSTIN ALLEN ZIMMERMAN PHYSICIAN ASSISTANT DEXCOM G6 SENSOR MEDICAL DEVICES

15510791 DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEXCOM G7 SENSOR	MEDICAL DEVICES	
15512168 GREG MICHAEL THAERA MD	NEUROLOGY	OCREVUS	MULTIPLE SCLEROSIS AGENTS	G35 - Mu

15512855 JONATHAN ANDREW FIGG MD	INTERNAL MEDICINE	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY

15514262 JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	INVEGA SUSTENNA

ANESTHESIOLOGY

ANTIPSYCHOTICS/ANTIMANIC AGENTS

ANTI-OBESITY/ANOREXIANTS

15515947 GERMAN ECHEVERRY MD

ZEPBOUND

	Net Coursed	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 re amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dextroamphetamine ER. Please note: Exter 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:
ADHD	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 whether and the sponse of the states for the sponse of the sp
		 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n 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 equi and 4 oral nonsteroidal anti-inflammatory drugs (NSAIDs) (eg. ibuprofen(TRIED), diclofenac, meloxicam, etodolac, naproxen, celecoxib, nabumeto Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
eoarthritis of knee	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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2 of the exc for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be u 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 wh
T2D	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 have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. T 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 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 u 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 wh
T2D	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 have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. T 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 authorization may be required and quantity limits may apply.
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. F administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits of This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 re 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.
F90.2	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 p are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded to 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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits r
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 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 hea suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this of the suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this optimized options.

not-covered drug can be approved.

release (ER), methylphenidate ER,

tended release capsules can be

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

uivalent), diclofenac 1.5% solution,

one).

nted if all conditions in our ception policy criteria. The reason

, past treatments tried with dates

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

n what is covered. Prior

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

Prescription drugs that are m coverage as indicated in your ee what is covered by your health may apply to covered drugs. not-covered drug can be approved.

release (ER), methylphenidate ER,

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

provider. Prescription drugs that I from coverage as indicated in your ee what is covered by your health s may apply to covered drugs.

health issue may be covered by ealth care provider may be able to s drug from coverage.

15518036 LAURELIN NICOLE MULLINS NP

NURSE PRACTITIONER

VENLAFAXINE HYDROCHLORIE ANTIDEPRESSANTS

1552	0102 JONATHAN ANDREW FIGG MD	INTERNAL MEDICINE	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY	
1552	1938 AJAY ZACHARIAH MD	FAMILY PRACTICE	MOUNJARO	ANTIDIABETICS	
1552	2650 RICARDO GARCIA JR MD	FAMILY PRACTICE	SALICYLIC ACID	DERMATOLOGICALS	B07.0
1552	3415 LORIE JUNE KMETZ	NURSE PRACTITIONER	SUBLOCADE	ANALGESICS - OPIOID	
1552	4445 WILLIAM LOUIS HOLCOMB JR MD	PSYCHIATRY	TRINTELLIX	ANTIDEPRESSANTS	
1552	7294 JENNA GRAY	PHYSICIAN ASSISTANT	TRUE METRIX BLOOD GLUCOS	DIAGNOSTIC PRODUCTS	e 2 diabetes mellitus with
1552	8607 PHOMMALONE MONE NGUYEN NP	NURSE PRACTITIONER	DEXCOM G6 SENSOR	MEDICAL DEVICES	

The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 sive disorder, single episode, unspecified Not Covered Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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: F90.2 Not Covered This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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. E66.9 Plan Exclusion 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 07.0 - Plantar wart Not Covered 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. 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 F11.21 Plan Exclusion 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 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: F33 Criteria Not Met This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 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 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 This product is not on our list of covered products, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide it 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. ith hyperglycemia 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) 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 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. 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. 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.

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.

15528857 PHOMMALONE MONE NGUYEN NP	NURSE PRACTITIONER	DEXCOM G6 SENSOR	MEDICAL DEVICES	
15534596 SETH MICHAEL HOLLANDER MD	ALLERGY & IMMUNOLOGY	SPIRIVA RESPIMAT	ANTIASTHMATIC AND BRONCHODILATOR ASevere persistent	t asthma, u
15536062 RAMESH M SINGA MD	ANESTHESIOLOGY	ZTLIDO	DERMATOLOGICALS ostherpetic nerv	'ous syster
15536139 JEFFREY NORMAN HIGGINBOTHAM MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	

15537692 ALLISON ANNE URRUTIA MD OBSTETRICS & GYNECOLOGY ORILISSA ENDOCRINE AND METABOLIC AGENTS - MIS

	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be u 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
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 have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. T
	 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 v authorization may be required and quantity limits may apply. 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. Fro received, Spiriva was denied for these reasons: 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 Please look at our list of several drugs, also known as the formulary to see what drugs are several.
na, uncomplicated Criteria Not Met	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 r 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 wh This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, a 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.
rstem involvement 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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/naloxor 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.
f11.20 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 autionization criteria for Omissa nave not been met, from the records that we nave received, Omissa was denied for mese 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 int 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
r10.2 Criteria Not Met	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 receive 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 E hormonal contraceptive.
K59.03 Not Covered	Circa citoria have been peet use are usable to energies covereds for this data at this time. Places refer to our formulaev for information and ut This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

rom the records that we have

met, we are not able to approve.

received, the member does not

what is covered. Prior authorization not-covered drug can be approved.

, amitriptyline, nortriptyline,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

one tablet, buprenorphine/naloxone

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

nto other areas of the body such as

at is covered.

ved, the member does not meet

/ Drugs (NSAIDs), AND (B) a

not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

15541578 AJAY ZACHARIAH MD	FAMILY PRACTICE	VILAZODONE HYDROCHLORID ANTIDEPRESSANTS

						Our prior authorization criteria for vilazodone (Viibryd) have not been met. From the records that we have received, the following caused the denial o 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, es 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, venlafa Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
155	541578 AJAY ZACHARIAH MD	FAMILY PRACTICE	VILAZODONE HYDROCHLOR	ID ANTIDEPRESSANTS	F32.a 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 hav 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 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 i This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 of Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
155	544466 JEFFREY WILLIAM CHAMP MD	FAMILY PRACTICE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	with other specified complication (HCC) 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 is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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 recapply. 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 contract.
155	544674 ANDREA GEORGE MD	ENDOCRINOLOGY, DIABETES &	N OZEMPIC	ANTIDIABETICS	R73.03 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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 formularv for information on what i Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Kinvoq was denied for these re 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
155	548913 ELIZABETH HAVEY MILLER MD	DERMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	L20.9 Criteria Not Met	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 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 a 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 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 (docume submitted for an approval); AND 6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentation for an approval); AND 7) Rinvog will NOT be used in combination with another targeted immunomodulator product for atopic dermatitis.
155	549551 GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight Plan Exclusion	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what in 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 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
						treatments for your health issue. Our prior authorization criteria for etanercept (ENBREL) nave not been met. From the records that we have received, Enbrei was denied for these reas 1) This drug was not prescribed for Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Peripheral Ankylosing Spondylitis, Psoriatic Arthriti 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
155	550595 CHRISTOPHER TR PARKER DO	RHEUMATOLOGY	ENBREL	TARGETED IMMUNOMODULATORS	NA Criteria Not Met	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 had 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 1) Member has a diagnosis of Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Peripheral Ankylosing Spondylitis (AS), Psoria 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 i
						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 o 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, esp 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, venlafa Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
15541578 AJAY ZACHARIAH MD	FAMILY PRACTICE	VILAZODONE HYDROCHLOR	ID ANTIDEPRESSANTS	F32.a Ci	riteria 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 hav 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 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).
15544466 JEFFREY WILLIAM CHAMP MD	FAMILY PRACTICE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	with other specified complication (HCC) N	ot 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 of Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
						 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason:
						 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 red 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 content of the criteria has not been met, we are not able to approve.
15544674 ANDREA GEORGE MD	ENDOCRINOLOGY, DIABETES &	2 N OZEMPIC	ANTIDIABETICS	R73.03 C	riteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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 Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Kinvoq was denied for these ref 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
15548913 ELIZABETH HAVEY MILLER MD	DERMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	L20.9 C	riteria Not Met	 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 l 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 at 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 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 submitted for an approval); AND 6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentation
						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 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
15549551 GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight Pl	an Exclusion	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 treatments for your health issue. Our prior authorization criteria for etanercept (ENBKEL) nave not been met. From the records that we have received, Enbrei was denied for these rease 1) This drug was not prescribed for Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Peripheral Ankylosing Spondylitis, Psoriatic Arthriti 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
15550595 CHRISTOPHER TR PARKER DO	RHEUMATOLOGY	ENBREL	TARGETED IMMUNOMODULATORS	NA C	riteria Not Met	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 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 lister 1) Member has a diagnosis of Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Peripheral Ankylosing Spondylitis (AS), Psoria 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
						may be required and quantity limits may apply to covered drugs

15541578 AJAY ZACHARIAH MD	FAMILY PRACTICE	VILAZODONE HYDROCHLOR	ID 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 o 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, es 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, venlafa Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been met, been met and been we been tried and been met from the information we have
						This request has not been approved because our prior authorization criteria for vilazodone (Viibryd) have not been met. From the information we have 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 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 i
						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 of Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15544466 JEFFREY WILLIAM CHAMP MD	FAMILY PRACTICE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	with other specified complication (HCC	C) 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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 rec 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 co
15544674 ANDREA GEORGE MD	ENDOCRINOLOGY, DIABETES a	& N OZEMPIC	ANTIDIABETICS	R73.0	3 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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 i Our prior authorization criteria for upadacitinib (KINVOQ) have not been met. From the records that we have received, Kinvoq was denied for these re 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
15548913 ELIZABETH HAVEY MILLER MD	DERMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	L20.1	9 Criteria Not Met	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 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 a 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 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 (docume submitted for an approval); AND
						 6) Documentation that a trial of a systemic immunosuppressant, including a biologic, was ineffective, not tolerated, or contraindicated (documentation 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 in 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 Coverage as stated in the state.
15549551 GERMAN ECHEVERRY MD	ANESTHESIOLOGY	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweigh		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 treatments for your health issue. Our prior autnorization criteria for etanercept (LINBKEL) nave not been met. From the records that we have received, Enbrei was denied for these reas 1) This drug was not prescribed for Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Peripheral Ankylosing Spondylitis, Psoriatic Arthriti 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
15550595 CHRISTOPHER TR PARKER DO	RHEUMATOLOGY	ENBREL	TARGETED IMMUNOMODULATORS	N	A Criteria Not Met	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 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 1) Member has a diagnosis of Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Peripheral Ankylosing Spondylitis (AS), Psoria 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 may be required and quantity limits may apply to covered drugs.

nial of vilazodone. am, escitalopram, fluoxetine,

enlafaxine) nat is covered.

e have received, the member does ia are listed here.

; AND

what is covered. Prior authorization not-covered drug can be approved.

alog equivalent) OR Humalog.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

hat is covered. Prior authorization

be required and quantity limits may

at is covered.

ember does not meet number 1 of

what is covered. Prior authorization nese reasons:

nat is covered.

n we have received, the member eria are listed here.

than 10% BSA affected, but

cumentation required to be

ntation is required to be submitted

what is covered. Prior authorization ated in your benefit summary. ay be able to suggest other

e reasons: rthritis, Reactive Arthritis,

nat is covered.

ve have received, the member does e listed here.

Psoriatic Arthritis (PsA), Reactive

what is covered. Prior authorization

15555034 KELLY CHAMBLISS WITTE

ADVANCED PRACTICE NURSE DOXEPIN HYDROCHLORIDE HYPNOTICS/SEDATIVES/SLEEP DISORDER AG

	15556134 DAMIAN G LARA MD	FAMILY PRACTICE	UBRELVY	MIGRAINE PRODUCTS	
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15557498 CHRISHANTHI MARY SUSAN PERERA MD INTERNAL MEDICINE

OBSTETRICS & GYNECOLOGY LUPRON DEPOT (1-MONTH) ANTINEOPLASTICS AND ADJUNCTIVE THERA 15557822 BETH LEE THAI MD

PHYSICIAN ASSISTANT INVOKANA 15561008 BRIA MILAN HARRIS PA

ANTIDIABETICS

LEVALBUTEROL TARTRATE HFA ANTIASTHMATIC AND BRONCHODILATOR A

ive diabetic retinopathy withou

15569294 DAVID CABELL GRAY MD INTERNAL MEDICINE DEXLANSOPRAZOLE ULCER DRUGS/ANTISPASMODICS/ANTICHOI WEGOVY 15569513 STEVEN ALEXANDER MD CARDIOLOGY ANTI-OBESITY/ANOREXIANTS id (severe) obesity due to exces

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be ap The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, zolpider 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.
f51.05 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The rea denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with of trial and responses, and any other evidence to 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 zolmitritpan(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 quantity limits may apply to covered drugs.
g43.809 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 mer 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 author
	 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 appr Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.
J30.2 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does 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 author 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
n80.9 Plan Exclusion	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 y 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 h 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 ap The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
out macular Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The rea denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with of trial and responses, and any other evidence to 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 author
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be ap The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
r10.12 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The rea denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
ess calories Plan Exclusion	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 summar 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

n Exclusior

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.

not-covered drug can be approved.

ivalent), ramelteon, zolpidem,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates nese reasons:

nat is covered. Prior authorization

n we have received, the member e listed here.

what is covered. Prior authorization rom the records that we have

met, we are not able to approve.

received, the member does not vhat is covered. Prior authorization

m coverage as indicated in your ee what is covered by your health may apply to covered drugs. not-covered drug can be approved.

iance or Synjardy (XR).

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

), rabeprazole, lansoprazole,

nted if all conditions in our ption policy criteria. The reason for

, past treatments tried with dates

ited in your benefit summary.

15571256 NEERAJ MANCHANDA MD

NEUROLOGY

AIMOVIG

MIGRAINE PRODUCTS

15572972 NATHAN HENRY PEKAR MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	
15572974 SAMMY LERMA III MD	FAMILY PRACTICE	BUPRENORPHINE HCL	ANALGESICS - OPIOID	
15573209 HEATHER CAROLYN LENZ PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	

15576835 BRIA MILAN HARRIS PA

PHYSICIAN ASSISTANT

INVOKANA

ANTIDIABETICS

15578133 KUSUMA KANAPARTHI MD

INTERNAL MEDICINE

WEGOVY

ANTI-OBESITY/ANOREXIANTS

	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.
g43.009 Criteria Not Met	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 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 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 or 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.
F32.9 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not mee 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 authorizat This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approv The conditions in this policy have not been met. From the records that we have received, these reasons caused 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/nalox 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.
z79.899 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
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 place 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 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:
E11.69 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
ess 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 authorizat 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.

id (severe) obesity due to excess calories Plan Exclusion

treatments for your health issue.

ese reasons:

lasses: (a) anticonvulsants (such as nlafaxine, etc.); AND

what is covered. Prior authorization tellix.

work for you. nat is covered.

ived, the member does not meet

what is covered. Prior authorization not-covered drug can be approved.

one tablet, buprenorphine/naloxone

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

roducts used for a cosmetic see what is covered by your plan. not-covered drug can be approved.

iance or Synjardy (XR).

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization ated in your benefit summary.

15580	067 ANITA SHARAN JESUDASS NP	NURSE PRACTITIONER	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG	G47.00 - Insomr
15583	834 EMILY DIANE HELMS NP	NURSE PRACTITIONER	BELBUCA	ANALGESICS - OPIOID	
15591	432 GERMAN ECHEVERRY MD	ANESTHESIOLOGY	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	

15595607 KAYELEIGH ELIZABETH HIGGERSON HEMATOLOGY & ONCOLOGY, PE MIDAZOLAM HCL HYPNOTICS/SEDATIVES/SLEEP DISORDER AC F41.9 - Anxiety disorder

15598765 BRAD ERIC VENGHAUS MD INTERNAL MEDICINE EVEKEO ADHD/ANTI-NARCOLEPSY

ANTI-OBESITY/ANOREXIANTS E66.9 - Obesi 15601169 GERMAN ECHEVERRY MD ANESTHESIOLOGY WEGOVY ENDOCRINOLOGY, DIABETES & N OZEMPIC 15605330 ANDREA GEORGE MD ANTIDIABETICS 15605583 MANUEL JOSEPH MARTIN MD FAMILY PRACTICE ZEPBOUND ANTI-OBESITY/ANOREXIANTS id (severe) obesity due to 15618752 SHELBY ELIZABETH THOMAS PA-C PHYSICIAN ASSISTANT DICLOFENAC SODIUM DERMATOLOGICALS

		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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), zale 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.
nia, unspecified	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Eventions and an entermost from the information we have received the member does not member 2 of the success
		Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
		of trial and responses, and any other evidence to 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 ne
		The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Xtampza EP, ovvcodono EP, fontanyl patch (Duragesic equivalent). Nucynta EP (tapentadol EP), bydrocodono bitartrate EP (Hysingla EP, or Zobyd
		Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohyd 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.
a ⁹⁰ 4	Not Covorad	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
g89.4	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
		Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 stat
e66.9	Plan Exclusion	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 ma
		treatments for vour 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 northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
ler, unspecified	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
		denial is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
		of trial and responses, and any other evidence to 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 ne
		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/dextroamphetami (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.
F90 0	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
150.0	Not covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the
		reason for denial is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
		of trial and responses, and any other evidence to 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 stat
ity, unspecified	Plan Exclusion	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
		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 stat
R73.03	Plan Exclusion	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
		treatments for vour 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 stat
excess calories	Plan Exclusion	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 treatments for your health issue.
		Our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the records that we have received, diclofenac 3% gel was
		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 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
		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
M13.0	Criteria Not Met	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 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
		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 we may be required and quantity limits may apply to covered drugs.

not-covered drug can be approved.

leplon (TRIED), trazodone (TRIED),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

ase (ER) (MS Contin equivalent), dro ER equivalent), tramadol ER

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

ated in your benefit summary. nay be able to suggest other

not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

Yes

, past treatments tried with dates

not-covered drug can be approved.

ine tablet (Adderall equivalent)

nted if all conditions in our

ne exception policy criteria. The

, past treatments tried with dates

ated in your benefit summary. ay be able to suggest other

ated in your benefit summary. hay be able to suggest other

ated in your benefit summary. ay be able to suggest other

s denied for these reasons: e skin.

at is covered.

ation we have received, the ve. The criteria are listed here.

what is covered. Prior authorization

						Our Diagnosis Restricted criteria have not been met. From the records that we have received, Mounjaro was denied for this reason:
						 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 reapply. 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 a since the criteria has not been met, we are not able to approve.
15621448 VAMSI KRISHNA MD	CARDIOLOGY, INTERVENTIONA	L MOUNJARO	ANTIDIABETICS	R73.03	3 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the membrour 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 Our prior authorization criteria for prucaiopride (NOTEGRITY) have not been met. From the records that we have received, Motegrity was denied for 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 and quantity limits may apply to covered drugs.
15631567 ENRIQUE SPINDEL MD	GASTROENTEROLOGY	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.04 - Chronic idiopathic constipation	n Criteria Not Met	 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 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 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
						 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-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (150 mg 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.
15634407 KEERTHI VEMULAPALLI MD	PSYCHIATRY	BUPROPION HYDROCHLORIDE	ANTIDEPRESSANTS	F33.1	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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-our the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (resolanzapine, 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pase of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
15638839 PRATIMA VIJAY KUMAR MD	ENDOCRINOLOGY, DIABETES &	N OZEMPIC	ANTIDIABETICS	e 1 diabetes mellitus with hyperglycemia	a Criteria Not Met	 4) Prescription drug samples were not used to establish treatment. 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 reapply. 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 a 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 membrour 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.
15649869 NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	no dx from prescriber	r Incomplete/More Information Needed	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what A member-initiated request for OZEMPIC was submitted. We did not receive records from your doctor showing what health issue this drug is being 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 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 docu
15651689 CHRISHANTHI MARY SUSAN PERERA MD	INTERNAL MEDICINE	LEVALBUTEROL TARTRATE HFA	ANTIASTHMATIC AND BRONCHODILATOR A	R06.2 - Wheezing	g Formulary Alternatives Available	 provide the clinical information from your doctor. The criteria are listed below. 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 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, 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 recerced 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 formularv for information on what

15621448 VAMSI KRISHNA MD	CARDIOLOGY, INTERVENTIONA	l Mounjaro	ANTIDIABETICS	R73.03	3 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 reapply. 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 of 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 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 UUP prior autnomization criteria for pruce (MUTEGRITY) have not been met. From the records that we have received, whotegrify was denied to
15631567 ENRIQUE SPINDEL MD	GASTROENTEROLOGY	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.04 - Chronic idiopathic constipatior	n Criteria Not Met	Our prior authorization criteria for prucaiopride (MOTEGRITY) have not been met. From the records that we have received, Motegrity was denied for 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 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 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 crit 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 may be required and quantity limits may apply to covered drugs
15634407 KEERTHI VEMULAPALLI MD	PSYCHIATRY	BUPROPION HYDROCHLORIE	DE ANTIDEPRESSANTS	F33.1	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-of The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pase of trial and responses, and any other evidence to 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	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-of The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (rist 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pase of trial and responses, and any other evidence to 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 &	N OZEMPIC	ANTIDIABETICS	e 1 diabetes mellitus with hyperglycemia	a 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 reapply. 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 of 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 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 A member-initiated request for OZEMPIC was submitted. We did not receive records from your doctor showing what health issue this drug is being in the set of the
15649869 NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS		r Incomplete/More Information Needed	 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 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 docu provide the clinical information from your doctor. The criteria are listed below. 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 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, 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. 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.

o be required and quantity limits may

at is covered.

nember does not meet number 1 of

what is covered. Prior authorization

hat is covered. Prior authorization

ation we have received, the

he criteria are listed here.

what is covered. Prior authorization

a not-covered drug can be approved.

) mg (150mg + 300mg OR three

anted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

ts (risperidone, aripiprazole,

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

be required and quantity limits may

at is covered.

ember does not meet number 1 of

what is covered. Prior authorization eing used for. We tried to reach edical history, any appropriate lab

documentation submitted did not

rom the records that we have met, we are not able to approve.

received, the member does not

what is covered. Prior authorization

15658679 JULIE DEAUN GRAVES MD FAMILY PRACTICE DESCOVY ANTIVIRALS

15664338 CHET ALLEN THARPE JR MD	INTERNAL MEDICINE	DESCOVY	ANTIVIRALS	
15665717 DARSHAN NARENDRA SHAH MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	

15669352 KAITLIN NICOLE SISSON PA-C PHYSICIAN ASSISTANT FENOFIBRATE ANTIHYPERLIPIDEMICS E78.	- Pure hyperglycer
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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 new The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 autnorization criteria for emtricitabine/tenofovir alatenamide (DESCOVY) nave not been met. From the records we received, Descovy w 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 needed and there may be limits on the amount of drug covered at a time.
Z20.6 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been m 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 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 provid decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to b (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitt Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
Z20.6 Criteria Not Met	 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 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 m 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 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 provide decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted to be submitted to be provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted to be submitted to be provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least treatment with emtricitabine/tenofovir disoproxil fumarate (TRUVADA).
G43.709 Plan Limits Exceeded	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on we 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 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 the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, Emgality, 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 covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
ceridemia Not Covered	 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 equival (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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

ts (risperidone, aripiprazole,

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

was denied for these reasons:

hat is covered. Pre-approval may be

n met. From the information we have aber above. The criteria are listed

ovided of a renal adverse event or o be submitted for an approval); OR nitted for an approval); OR (C) east four (4) to eight (8) weeks of

what is covered. Prior authorization was denied for these reasons:

hat is covered. Pre-approval may be

n met. From the information we have aber above. The criteria are listed

ovided of a renal adverse event or b be submitted for an approval); OR nitted for an approval); OR (C) ast four (4) to eight (8) weeks of

the plan. It is used to make sure a not covered by your plan. In order for must be used to help prevent to our formulary to see what drugs are

not-covered drug can be approved.

alent) (tried), fenofibrate capsule

anted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

15670860 LUKE CONNOR JOHNSON PA-C	PHYSICIAN ASSISTANT	FENOFIBRATE	ANTIHYPERLIPIDEMICS	

15672541 LUKE PROCHNOW PHYSICIAN ASSISTANT TESTOSTERONE PUMP

15683881 ALICE DIANE FRIEDMAN MD GASTROENTEROLOGY

15686169 JENNIFER MITCHELL MD

15700538 LAURA MARIE BRYNESTAD ACNP

ADVANCED PRACTICE NURSE UBRELVY

FAMILY PRACTICE

STELARA

TRINTELLIX

MIGRAINE PRODUCTS

ANTIDEPRESSANTS

TARGETED IMMUNOMODULATORS

ANDROGENS-ANABOLIC

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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 equivaler) (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.
HLD 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
	4) Prescription drug samples were not used to establish treatment. Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Te for these reasons:
	 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. 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 and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
E29.1 Criteria Not Met	This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been me 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 exp 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
	 Member has symptoms of hypogonadism; AND TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; ANE 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 test
	with the request. Our prior authorization criteria for subcutaneous ustekinumab (STELARA SC) have not been met. From the records that we have received, Stelara 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 wha and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
K51.0 Criteria Not Met	This request has not been approved because our prior authorization criteria for subcutaneous ustekinumab (STELARA SC) have not been met. Fro 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 1) Prescribed by a Gastroenterology Specialist; AND
	 Member has a diagnosis of moderately to severely active Ulcerative Colitis (UC); AND 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 su Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on wh
	may be required and quantity limits may apply to covered drugs Our prior autrionzation criteria for mintenix nave not been met, from the records that we have received, the following caused the denial of minter
	 The drug is not being used for Major Depressive Disorder (MDD). Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxe
	for you.
	3) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not w Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what
F41.9-anxiety Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have receiv 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
	 Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).
	Sour prior authorization criteria for uprogepaht (UBRELVY) have not been this drug of the records that we have received, Uprefvy was denied for the
	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 wha and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
G43.909 Criteria Not Met	This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information
	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
	 The medication is prescribed for a diagnosis of acute migraine treatment AND 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

not-covered drug can be approved.

alent) (TRIED), fenofibrate capsule

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

Testosterone gel 1.62% was denied

hat is covered. Prior authorization

net. From the information we have plained to the member above. The

١D

stosterone must be documented

a was denied for these reasons:

hat is covered. Prior authorization

rom the information we have above. The criteria are listed here.

submitted for an approval). what is covered. Prior authorization

iteilix. etine, or paroxetine, did not work

work for you. nat is covered.

ived, the member does not meet

hese reasons: hat is covered. Prior authorization

n we have received, the member

e listed here.

15701464 MICHAEL K FLOYD	UROLOGY	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1-Testicular
15707214 SHAGUFTA R LAKHANI FNP-C	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	Chronic
15710716 JORGE LUIS ARIZMENDI PA-C	PHYSICIAN ASSISTANT	WEGOVY	ANTI-OBESITY/ANOREXIANTS	R73.03

15711586 HANA AUBRECHTOVA MD NEUROLOGY AJOVY MIGRAINE PRODUCTS

15719589 SHWOL-HUO DANNY KIANG DO DERMATOLOGY TRETINOIN DERMATOLOGICALS DERMATOLOGICALS - Male erectile dysfunction of the state of the

	Our phor authorization chiena for Androgens. Transdermal restosterone Products have not been met. From the records that we have received, in 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
	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what
	and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
ar hypofunction Criteria Not Met	This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been me
	received, the member does not meet number(s) 3 of our prior authorization criteria for TESTOSTERONE GEL 1.62%. The reason for denial is explain
	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 hypogona
	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 hear met we are upable to approve coverage for this drug at this time. Places refer to our formular, for information on we This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a new second drug second drugs and the second drugs are upable to approve the second drug second drugs are upable to approve the second drug second drugs are upable to approve the second drug second drugs are upable to approve the second drug second drugs are upable to approve the second drug second drugs are upable to approve the second drug second drug second drug second drugs are upable to approve the second drug seco
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 released and the second
	Xtampza ER (tried), oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or
	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.
pain syndrome Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptions are met.
	denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 stat
03 - Prediabetes Plan Exclusion	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
	treatments for your health issue. Our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the records that we have received, Ajovy was denied for the
	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 w
	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 bot
	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 monther drug classes did not work for you (after using it for at least 3 monther drug classes did not work for you (after using it for at least 3 monther drug classes did not work for you (after using it for at least 3 monther drug classes did not work for you (after using it for at least 3 monther drug classes did not work for you (after using it for at least 3 monther drug classes).
	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
	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
Migraine Criteria Not Met	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 c
	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
	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 wi 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 mig
	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 r
	from ONE of the following drug classes: (i) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (ii) vasoactive agent (such as proprand
	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 w
	This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/pro
wrinkles Plan Exclusion	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 s
	Your doctor or health care provider may be able to suggest other treatments for your health issue. This request cannot be approved because this drug is being used for erectile dysfunction (ED). Drugs used for this purpose are excluded from cov
ion, unspecified Plan Exclusion	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 pr
	other treatments for vour health issue. 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. Fro
	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. Fro 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 m
	Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.
Tinea unguium Formulary Alternatives Available	
-	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 r
	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

IESIUSIERUNE GEL 1.02% WdS

this drug. e what is covered. Prior authorization

net. From the information we have ained to the member above. The

adism; AND

not-covered drug can be approved.

ase (ER) (MS Contin equivalent), or Zohydro ER equivalent), tramadol

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ited in your benefit summary. ay be able to suggest other

ese reasons: will be used together with a otulinum toxin product alone.

ths): an anticonvulsant (e.g.,

hat is covered. Prior authorization

on we have received, the member criteria are listed here.

he following are met: (A) Member with a botulinum toxin product (e.g.,

igraine days per month for at least minimum three (3) month trial molol, metoprolol, etc.), OR (iii)

what is covered. Prior authorization roducts used for a cosmetic see what is covered by your plan.

overage as stated in your benefit

provider may be able to suggest

rom the records that we have

met, we are not able to approve.

received, the member does not

15742064	RANI DAS MD	NEUROLOGY	HORIZANT	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	G25.81 - Restles
15744096	JULIENNE CALAMLAM PA-C	PHYSICIAN ASSISTANT	ESTRADIOL	ESTROGENS	
15744150	CRYSTAL MELANIE BOWDEN-MCKAY MD	GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	
15746337	JENNIFER MITCHELL MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	

NURSE PRACTITIONER

CARVEDILOL PHOSPHATE ER BETA BLOCKERS

R00.1 - Bradycardia

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can 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.
	 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.
lia, unspecified Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(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.This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
	 All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 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:
legs syndrome Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
	of trial and responses, and any other evidence to 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 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:
Z79.890 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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:
K59.04 Criteria Not Met	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
	 The member is 18 years of age or older; AND 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 Trintellix nave not been met. From the records that we nave 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.
	 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.
MDD Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 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
	 Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 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 formulan for information on what is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our

f the exception policy criteria. The

s, past treatments tried with dates

not-covered drug can be approved.

(IR) (TRIED), pregabalin,

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

oral tablet, estradiol valerate valent).

nted if all conditions in our

, past treatments tried with dates

e reasons:

hat is covered. Prior authorization

ve have received, the member does re listed here.

what is covered. Prior authorization

ketine, or paroxetine, did not work

work for you. nat is covered.

ived, the member does not meet

15752112 MICHELLE LE MARKLEY MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	
15754154 NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	Other obesity due to exc
15760692 LIDYA TESHOME DO	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	
15761814 RITA IFEANYI CHUKWURAH	NURSE PRACTITIONER	OLMESARTAN MEDOXOMIL/A	I ANTIHYPERTENSIVES	l10 - Essential (primary) hy

BUPRENORPHINE HCL 15751116 JEFFREY NORMAN HIGGINBOTHAM MD ANESTHESIOLOGY ANALGESICS - OPIOID

15748540 CARMEN ELENA LANDAVERDE MD

HEPATOLOGY/LIVER MEDICINE OCALIVA

GASTROINTESTINAL AGENTS - MISC.

	Our prior authorization criteria for obeticholic acid (Ocaliva) have not been met. From the records that we have received, the following caused the 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 limits may apply to covered drugs.
primary biliary cholangitis Criteria Not Met	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 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
	 Prescribed by, of in consultation with, a nepatologist of Gastroenterologist, AND Member has a diagnosis of primary biliary cholangitis; AND 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; of intolerance to ursodiol is provided with the request (documentation is required to be submitted for an approval); AND 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
	 (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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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: buprenot 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.
20 - Opioid dependence, uncomplicated Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grante
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p of trial and responses, and any other evidence to 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 Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TES denied for these reasons:
	 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 test More information is needed to know if your low levels of testosterone are age-related.
	 Records did not show you have symptoms of low testosterone. 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 and quantity limits may apply to covered drugs.
Z79.890 Criteria Not Met	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 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 ex 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
	 Member has symptoms of hypogonadism; AND 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 test with the request This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as state
Other obesity due to excess calories Plan Exclusion	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 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 nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Emga Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
G43.909 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p
	of trial and responses, and any other evidence to 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 nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 cla hydrochlorothiazide (HCTZ)(recent claim seen) and angiotensin II receptor blockers (ARBs) combined with HCTZ (losartan/HCTZ, valsartan/HCTZ, o
	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.
110 - Essential (primary) hypertension 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 grante
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, provided why all other covered drugs cannot be tried.
	of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	4) Prescription drug samples were not used to establish treatment.

e denial of Ocaliva.

ation may be required and quantity

ved, the member does not meet

ed; OR Documentation (chart notes)

al to the upper limit of normal

not-covered drug can be approved.

norphine/naloxone tablet,

nted if all conditions in our ption policy criteria. The reason for

past treatments tried with dates

ESTOSTERONE GEL 1.62% was

tosterone.

t is covered. Prior authorization

et. From the information we have explained to the member above.

tosterone must be documented ted in your benefit summary.

ay be able to suggest other

ot-covered drug can be approved.

ility.

nted if all conditions in our otion policy criteria. The reason for

past treatments tried with dates

not-covered drug can be approved.

claim seen) along with olmesartan/HCTZ,

nted if all conditions in our ption policy criteria. The reason for

past treatments tried with dates

15763758	SARAH MICHELLE SEEGER PMHNP	ADVANCED PRACTICE NURSE	L-METHYLFOLATE CALCIUM	DIETARY PRODUCTS/DIETARY MANAGEMEN	Poly
15766723	VICTORIA IAN CHEN	FAMILY PRACTICE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	09 - Other obesity due to exce

15774990 RUMI AHMED KHAN MD

INTERNAL MEDICINE

DYMISTA

NASAL AGENTS - SYSTEMIC AND TOPICAL

15780513 SUJAATA RATNA DWADASI MD	GASTROENTEROLOGY	ZEPOSIA	MULTIPLE SCLEROSIS AGENTS	
15787954 GAIL CONDE CREAR MD	INTERNAL MEDICINE	QULIPTA	MIGRAINE PRODUCTS	R51.9 - Headacl
15788159 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 2
15791369 SONIA YOUSUF III MD	RHEUMATOLOGY	SIMPONI	TARGETED IMMUNOMODULATORS	

15791815 EMILY NADEZHDA STAHL CNS

CLINICAL NURSE SPECIALIST UBRELVY

MIGRAINE PRODUCTS

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 Therape the coverage of medical foods/nutritional products, these agents are not covered. Please refer to the formulary for specific information on what i care provider may be able to suggest other treatment options for your condition. This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as star
excess calories Plan Exclusion	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 ma 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 n 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.
R09.82 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 gran
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the exception denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 ozanimod (ZEPOSIA) have not been met. From the records that we have received, Zeposia was denied for these prior authorization criteria for ozanimod (ZEPOSIA) have not been met.
	1) Records did not show that at least two of the following drugs did not work for you: an adalimumab product (ADALIMUMAB-AATY, ADALIMUM 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 wh and quantity limits may apply to covered drugs.
K51.911 Criteria Not Met	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 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
	1) Prescribed by a Gastroenterology Specialist; AND
	 Prescribed for a diagnosis of moderately to severely active ulcerative colitis (UC); AND Trials of two (2) of the following were ineffective or not tolerated, or trials of all the following are contraindicated: an adalimumab product (AD
	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 w This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
e, unspecified Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	 Prescription drug samples were not used to establish treatment. 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.
8.0-28.9, adult Plan Exclusion	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 ma 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 n
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (adalim
	adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya, Cimzia (TRIE 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.
140.50 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
	denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 phor authomzation chiena for uprogepant (OBRELVT) have not been met. From the records that we have received, obreivy was demed for the
	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
	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 wh
	and quantity limits may apply to covered drugs.
not available 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

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

peutics (P&T) Committee policy on

t is covered. Your doctor or health

tated in your benefit summary. may be able to suggest other

not-covered drug can be approved.

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ese reasons:

JMAB-ADAZ, ADALIMUMAB-FKJP,

hat is covered. Prior authorization

we have received, the member does ed here.

DALIMUMAB-AATY, ADALIMUMAB-

what is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

tated in your benefit summary. hay be able to suggest other

not-covered drug can be approved.

mumab-fkjp (Hulio equivalent), IED), Otezla, Orencia, Rinvoq, Skyrizi,

anted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

iese reasons.

n exists for sumatriptan but your

what is covered. Prior authorization

on we have received, the member

2046 DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	DEX

15792046 DUSTIN ALLEN ZIMMERMAN	PHYSICIAN ASSISTANT	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 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 dr 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. 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 continuous for 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 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-core conditions in this policy have not been met. From the records that we have received, these reasons caused 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 exequivalent) 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin glargine-yfgn OR Semglee, Lee Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is
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-core conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-core the conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used
15806706 VANESSA LYNN MADRID	ADVANCED PRACTICE NURSE	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.9-Bipolar disorder, unspecified	Not Covered	 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

not-covered drug can be approved.

n Z equivalent), tafluprost (Zioptan

nted if all conditions in our ption policy criteria. The reason for

past treatments tried with dates

not-covered drug can be approved.

e, Levemir, Toujeo, Tresiba.

nted if all conditions in our ption policy criteria. The reason for

past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our

ption policy criteria. The reason for

past treatments tried with dates

not-covered drug can be approved.

s (risperidone, aripiprazole,

nted if all conditions in our eption policy criteria. The reason for

past treatments tried with dates

15809909 MARIA ROSE BONTRAGER	OPTOMETRIST	OXERVATE	OPHTHALMIC AGENTS	
15812798 GERMAN ECHEVERRY MD	ANESTHESIOLOGY	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obes
15814452 ANDREW ALAN COLLINS MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	

15815308 PATRICK CHRISTOPHER NOLAN N	1D NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	ı, intractable, without sta

15816851 MEREDITH LEAH COOK	PHYSICIAN ASSISTANT	IQIRVO	GASTROINTESTINAL AGENTS - MISC.	
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15818858 CLAIRE KYLANDER

NURSE PRACTITIONER

INTRAROSA

VAGINAL AND RELATED PRODUCTS

		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.
h16 222	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
1110.225		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
		 A trial of preservative-free artificial tears was ineffective; AND 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
	Dian Evolution	may be required and quantity limits may apply to covered drugs. This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary.
Obesity, unspecified	Plan Exclusion	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.
		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
G43.009	Plan Limits Exceeded	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.
		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
status migrainosus	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
J.		Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
		of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
		4) Prescription drug samples were not used to establish treatment. 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
k74.8	Not Covered	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).
		 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
		of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
		4) Prescription drug samples were not used to establish treatment.
		Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
		The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
		1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 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.
N95 2	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
1435.2		Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
		denial is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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	
15826733 KATIE LEAGH LAM PA	PHYSICIAN ASSISTANT	ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	
15826853 PATRICK CHRISTOPHER NOLAN MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	ı, intractable, without s
15830388 MICHELLE ROSE MEYSTEDT	PHYSICIAN ASSISTANT	UBRELVY	MIGRAINE PRODUCTS	

15834339 MICHAEL SIK SHIN

EMERGENCY MEDICINE

DESCOVY

ANTIVIRALS

		Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Te 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 and quantity limits may apply to covered drugs.
E29.1	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been marreceived, the member does not meet number(s) 4 and 5 of our prior authorization criteria for TESTOSTERONE GEL 1.62% PUMP. The reason for d 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; ANE 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 test with the request
e78.1	Not Covered	 with the request. 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 approved. The conditions in our icosapent exception policy have not been met. From the records that we have received, the following caused the 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 for 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 e 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
		This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of t criteria. 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 500 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 fit (Niaspan ER equivalent) and brand name Vascepa.
t 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 net The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 grant. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception is explained to the member above. The criteria from the policy are listed here.
		 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
		Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for the 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 and quantity limits may apply to covered drugs.
g43.109	9 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 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 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 we
		 Our prior authorization criteria for emtricitabine/tenofovir alatenamide (DESCOVY) have not been met. From the records we received, Descovy was 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 needed and there may be limits on the amount of drug covered at a time.
z20.6 Criteria Not Met		ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been m 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 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 provide decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted Documentation is provided (chart notes including dates of therapy) of a severe adverse event or adverse effect that did not improve after at least 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

TESTOSTERONE GEL 1.62% PUMP

nat is covered. Prior authorization

net. From the information we have denial is explained to the member

5

stosterone must be documented

a not-covered drug can be ne denial. found in the blood.

ethyl ester capsule (Lovaza

. Prior authorization and quantity

nted if all conditions in our the icosapent exception policy

00mg/dL). Recent triglyceride levels

fibrate (e.g. fenofibrate), niacin ER

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

hese reasons:

hat is covered. Prior authorization

n we have received, the member re listed here.

vhat is covered. Prior authorization

as denied for these reasons:

at is covered. Pre-approval may be

met. From the information we have per above. The criteria are listed

vided of a renal adverse event or be submitted for an approval); OR itted for an approval); OR (C) ast four (4) to eight (8) weeks of

15835061 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	COMBIPATCH	ESTROGENS	lenopausal and female cli
15835931 DARSHAN NARENDRA SHAH MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	

15839925 ARJUN MOHANDAS MD

INTERNAL MEDICINE

AIRSUPRA

ANTIASTHMATIC AND BRONCHODILATOR A Lobar pneumonia, unspecifie

15840880 NAWALAGE RAVI NAYANADUL COORAY 1 FAMILY PRACTICE

BUTALBITAL/ACETAMINOPHEN ANALGESICS - NONNARCOTIC

15843244	CHRISTOPHER GLENN SEEKER MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS	

acteric 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. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 equival (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 condit
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy crite denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatment of trial and responses, and any other evidence to 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 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 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, 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, 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, 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, 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, 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 is covered. Planet the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Planet quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
G43.709 Criteria Not Met	This request has not been approved because our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the information we have receind 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 topirant 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 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with a botulinum 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.
	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. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
	 This drug is being used for pneumonia. This is not an approved use. 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 equivale 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.
ied organism 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 condit Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet numbers 1 and 2 of the exception pol reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatment of trial and responses, and any other evidence to 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. 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, rizatripta 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.
r51.9 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all condit Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception poli reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatment of trial and responses, and any other evidence to 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 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, estra- 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.
z79.890 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 condit Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy crite denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatment of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

(Activella equivalent), jinteli tablet

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ese reasons: will be used together with a otulinum toxin product alone. nat is covered. Prior authorization

n we have received, the member

(such as topiramate, sodium

he following are met: (A) Member with a botulinum toxin product (e.g.,

what is covered. Prior authorization

not-covered drug can be approved.

roventil equivalent) or Ventolin HFA

nted if all conditions in our he exception policy criteria. The

, past treatments tried with dates

not-covered drug can be approved.

tablet, rizatriptan, sumatriptan,

nted if all conditions in our ne exception policy criteria. The

, past treatments tried with dates

not-covered drug can be approved.

oral tablet, estradiol valerate valent).

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

15843444 LAWRENCE TSAI MD	UROLOGY	ANDROGEL	ANDROGENS-ANABOLIC	E29.1 - Testi

15845833 STEVEN ANDREW MCDONALD MD	EMERGENCY MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity,
15847093 KOREN DINGEMAN WESTON MD	INTERNAL MEDICINE	NURTEC	MIGRAINE PRODUCTS	

15850671 RAMESH M SINGA MD ANESTHESIOLOGY NURTEC MIGRAINE PRODUCTS					
	15850671 RAMESH M SINGA MD	ANESTHESIOLOGY	NURTEC	MIGRAINE PRODUCTS	

15851590 DAVID DEE WEEKS MD	INTERNAL MEDICINE	XIFAXAN	ANTI-INFECTIVE AGENTS - MISC.	R19.7 - Diarrh

15853181 MARTIN CASTILLO PA-C	PHYSICIAN ASSISTANT	RELISTOR	GASTROINTESTINAL AGENTS - MISC.	K59.00-Constipation

GASTROINTESTINAL AGENTS - MISC. 15854027 HARINDER PREET KAUR MD FAMILY PRACTICE LINZESS

		Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, ANDI 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 and quantity limits may apply to covered drugs.
		ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
esticular hypofunction	Criteria Not Met	This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. F 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 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 testost with the request.
Obssity unspecified	Plan Evolution	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 place look at the list of coverage drugs, also known as the formulany to see what is coverad by your destar or health care provider may be
- Obesity, unspecified	Plan Exclusion	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 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-c
		The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
g43.909	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
		denial is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results have
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-c The conditions in this policy have not been met. From the records that we have received, these reasons caused 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
G43.909	Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
		denial is explained to the member above. The criteria from the policy are listed here.
		 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas
		of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
		4) Prescription drug samples were not used to establish treatment.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
Diarrhea, unspecified	Plan Limits Exceeded	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
		information about vour diagnosis. Please look at the list of covered drugs, also known as our formulary, to see what is covered. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co
		The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
nstipation, unspecified	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted
		Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
		1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these rea
		 Records did not show that another drug called plecanatide (Trulance) did not work for you. 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
		and quantity limits may apply to covered drugs.
		ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
K59.09	Criteria Not Met	This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have 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 list
		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
		 A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR
		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).

e (LINZESS) is prescribed for e bowel syndror 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

ANDROGEL was denied for these

nat is covered. Prior authorization

net. From the information we have ember above. The criteria are listed

stosterone must be documented

ated in your benefit summary. ay be able to suggest other

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates e plan. It is used to make sure a

ed by your plan without more not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

e reasons:

nat is covered. Prior authorization

ve have received, the member does re listed here.

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: 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 treid or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Uur pror autonorization criteria form the mether. 4) Prescription drug samples were not used to establish treatment. 1) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SSRI) antidepressant, such as sertraline, citalopram, escitalopram, fluoxe
15865808 JENNIFER MITCHELL MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	depressive disorder, recurrent, moderate Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 2 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD); AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI).
15865853 HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczema Criteria Not Met	 Since criteria have not hear met we are unable to approve coverage for this drue at the time. Please refer to our formuland for information on what is covered. Dipixent was denied for these reasons: Records did not show that at least 10% of your body surface area (BSA) is affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. Records did not show that sensitive areas of your body are affected by your health issue. 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. Member has a diagnosis of chronic moderate-to-severe
15866261 JOSHUA LAMAR MCKAY MD	CARDIOLOGY, INTERVENTIO	NAL ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	coronary artery without angina pectoris Not Covered	 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. 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 (Nia

15858631 LEIGHA ANA SHARP MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L21.8-Other seborrheic dermatitis Criteria Not Me	Our prior authorization criteria for roflumilast (ZORYVE) have not been met. From the records that we have received, Zoryve was denied for these reas 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 pa Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is of 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 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 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 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 autonization criteria or innteliux nave not been met. From the recoras that we nave received, the rollowing caused the denial or inntellux. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, for you.
15865808 JENNIFER MITCHELL MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	depressive disorder, recurrent, moderate Criteria Not Me	2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work f Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is
15865853 HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczema Criteria Not Me	 Member is 6 months of age or older; AND Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 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 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 (documentation is required to be submitted for an approval); AND Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (doc submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDE Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed AND
15866261 JOSHUA LAMAR MCKAY MD	CARDIOLOGY, INTERVENTION	AL ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	coronary artery without angina pectoris Not Covered	 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. 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-approved. The conditions in our ICOSAPENT exception policy have not been met. From the records that we have received, the following caused the du 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 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 of the ICOSAP The 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 a request); AND (A) Member has a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) OR a diagnosis of diabetes with 2 additional cardiovascular risk (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 (Vascepa.

15858631 LEIGHA ANA SHARP MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L21.8-Other seborrheic dermatiti	is 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 reas 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 pa Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 ha 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 treatm 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 may be required and quantity limits may apply to covered drugs.
15859650 SARA JANE PAVITT MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.709	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-control to the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 autnorization criteria for Trintellix nave not been met. From the records that we nave received, the following caused the denial or Trintellix. 1) Records did not show TWO (2) selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine, for you.
15865808 JENNIFER MITCHELL MD	FAMILY PRACTICE	TRINTELLIX	ANTIDEPRESSANTS	depressive disorder, recurrent, moderate	e Criteria Not Met	 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work is Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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, 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).
15865853 HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczema	a Criteria Not Met	 Since criteria have not have met use are unable to approve coverage for thic churn at this time. Please refer to aur formulan: for information on what i Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these 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. Immunomodul 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 resisce the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 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 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 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 provi (documentation his required to be submitted for an approval); AND 4) Documentation that frials of TWO (2) of the following t
15866261 JOSHUA LAMAR MCKAY MD	CARDIOLOGY, INTERVENTION	AL ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	coronary artery without angina pectori	is Not Covered	 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. 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 approved. The conditions in our ICOSAPENT exception policy have not been met. From the records that we have received, the following caused the d 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 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 of the ICOSAP The 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 request); AND (A) Member has a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) OR a diagnosis of diabetes with 2 additional cardiovascular risk (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 (Vascepa.

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 reas 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 pace Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is a 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 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 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 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-correct conditions in this policy have not been met. From the records that we have received, these reasons caused 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 pror autonization criteria for the use of the exception for a functionization criteria for the one met. From the records that we have received, the sertaline, citalopram, escitalopram, fluoxetine, for you.
15865808 JENNIFER MITCHELL MD	FAMILY PRACTICE TRINTELLIX	ANTIDEPRESSANTS	depressive disorder, recurrent, moderate Criteria Not Met	 2) Records did not show ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, did not work to Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is a 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, to 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).
15865853 HETU YOGESHKUMAR PAREKH MD	ALLERGY & IMMUNOLOGY DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczema Criteria Not Met	 Since criteria have not hean met we are unable to approve coverage for this drun at this time. Plasse rafe to our formulary for information on what is Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these 1) Records did not show that at least 10% of your body surface area (BSA) is affected by your health issue. 2) Records did not show that at least 10% of your body surface area (BSA) is 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. Immunomodul 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 respond more appropriately to decrease a not be to approve. Please look at our list of covered drugs, also known as the formulary, to see what is a 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 l 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 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 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 provi (documentation is required to be submitted for an approval); AND 4) Documentatio
15866261 JOSHUA LAMAR MCKAY MD	CARDIOLOGY, INTERVENTIONAL ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	coronary artery without angina pectoris Not Covered	 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. 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-approved. The conditions in our ICOSAPENT exception policy have not been met. From the records that we have received, the following caused the de 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 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 of the ICOSAP The 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 to request); AND (A) Member has a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) OR a diagnosis of diabetes with 2 additional cardiovascular risk (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 (Vascepa.

se reasons:

Yes

Yes

15867383 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES &	R 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 hear 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 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
15867485 BRIAN JAY SHIMKUS MD	HEMATOLOGY & ONCOLOGY	LUPRON DEPOT (1-MONTH)	ANTINEOPLASTICS AND ADJUNCTIVE THER	A 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 heal drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are exindicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Qua
15868401 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	disorder, predominantly hyperactive type	Not Covered	 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-or. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: dexmethylphenidate extended relear 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
						 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pase of trial and responses, and any other evidence to 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 Erieada nave not been met. From the records that we have received, the following caused the demai or Erieada. 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 limits may apply to covered drugs.
15869903 BRIAN JAY SHIMKUS MD	HEMATOLOGY & ONCOLOGY	ERLEADA	ANTINEOPLASTICS AND ADJUNCTIVE THER	A mCSPC	Criteria Not Met	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, a 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 (PSAD months; OR 3) Prescribed for a diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) and a trial of abiraterone (Zytiga) was ineffective, contraindic
						Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or 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.
15871276 GEOFFREY FULTON HUGHES NP	NURSE PRACTITIONER	CLOMID	ENDOCRINE AND METABOLIC AGENTS - MI	S -	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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pase of trial and responses, and any other evidence to 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-of The conditions in this policy have not been met. From the records that we have received, these reasons caused 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-Y 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.
15874046 JORDAN DAVID HARTMAN MD	FAMILY PRACTICE	BASAGLAR KWIKPEN	ANTIDIABETICS	betes mellitus with hyperglycemia (HCC)	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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pase of trial and responses, and any other evidence to 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	Gi 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 provid administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co 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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may This request cannot be approved because this drug is being used for weightloss. Drugs used for this purpose are excluded from coverage as stated
15880462 STEVEN ANDREW MCDONALD MD	EMERGENCY MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, unspecified	Plan Exclusion	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 treatments for your health issue.

Ir health issue may be covered by ealth care provider may be able to s drug from coverage. a health care provider. Prescription are excluded from coverage as

benefit policy to see what is covered . Quantity limits may apply to

a not-covered drug can be approved.

d release (ER) (TRIED), nine ER.

anted if all conditions in our ception policy criteria. The reason for

s, past treatments tried with dates

aua.

ization may be required and quantity

ived, the member does not meet

(PSADT) is less than or equal to 10 aindicated, or not tolerated.

n what is covered. Prior authorization a not-covered drug can be approved.

nted if all conditions in our

ception policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

INE-YFGN INJECTION (NDCs

anted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

rovider. Prescription drugs that are om coverage as indicated in your see what is covered by your health s may apply to covered drugs. ated in your benefit summary. may be able to suggest other

NBBBENER REFUNATION OF YOUR HEADER INFORMER AZATHOOPRINE Based and strength of the company of t	sed to decide if a not-covered drug can be approved. azathioprine 50mg (can take 2 tablets for 100mg), to covered drugs.
NUMBER Numer Number Number	nber 2 of the exception policy criteria. The reason for ed. ory and lab results, past treatments tried with dates
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 15885692 SHUBHADA SHRIKANT SHRIKHANDE MD HEMATOLOGY & ONCOLOGY GRANISETRON HYDROCHLORI ANTIEMETICS R11.0 - Nausea Plan Limits Exceeded 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. Ple 15885692 SHUBHADA SHRIKANT SHRIKHANDE MD HEMATOLOGY & ONCOLOGY GRANISETRON HYDROCHLORI ANTIEMETICS R11.0 - Nausea Plan Limits Exceeded 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. Ple 15885692 SHUBHADA SHRIKANT SHRIKHANDE MD HEMATOLOGY & ONCOLOGY GRANISETRON HYDROCHLORI ANTIEMETICS R11.0 - Nausea Plan Limits Exceeded 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 drug can be the list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be the covered drugs used for your health issue have not been met. From the records that we have received, these reasons caused 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 amphetamine/dextroamphetamine (Aryanse equivalent)).	
This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can b The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 dr amphetamine/dextroamphetamine ER or lisdexamfetamine (Vyvanse equivalent)).	
A BAB A BAB A DADLOAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: 15887876 CASEY EDWARD COTON DO PSYCHIATRY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY 15887876 CASEY EDWARD COTON DO PSYCHIATRY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY 15887876 CASEY EDWARD coton DO PSYCHIATRY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY 15887876 CASEY EDWARD coton DO PSYCHIATRY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY 15887876 CASEY EDWARD coton DO PSYCHIATRY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY 15887876 CASEY EDWARD coton DO PSYCHIATRY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY 15887876 CASEY EDWARD coton DO PSYCHIATRY A DADLOANTI-NARCOLEPSY A DADLOANTI-NARCOLEPSY<	TRIED) and one long-acting stimulant drug (e.g., to covered drugs. drug may be granted if all conditions in our nber 2 of the exception policy criteria. The reason for ed. ory and lab results, past treatments tried with dates
This drug is not no urilis of covered drugs, also known as a formulany. Our coverege Determinations - Exceptions policy is used to decide if a not-covered drug can be The conditions in this policy have not been met. From the information may be required and galed. Other drugs that can be used are ferrex 150 forte capsule, folbee tablets, iron polysach/ acid/12/FA cap. ferre 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. ADDITIONOF DRY CUER FERROCITE PLUS HEMATOPOIETIC AGENTS R53.83 - Other fatigue Not Covered FERROCITE PLUS HEMATOPOIETIC AGENTS R53.83 - Other fatigue Not Covered HEMATOPOIETIC MARTINE COVERENCE Stablets, 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. ADDITIONOF DRY CUER HEALTH CARE PROVIDER: Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The denial is explained to the member above. The criteria from the policy are listed of and put quintistration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should for the member.	te capsule, folbee tablets, iron polysacch/threonic to covered drugs. drug may be granted if all conditions in our nber 2 of the exception policy criteria. The reason for ed.
4) Prescription drug samples were not used use tablish treatment. 15897252 FARHEEN YOUSUF MD ENDOCRINOLOGY, DABETES & NOVOLOG FLEXPEN ANTIDIABETICS 2 diabetes melitus with hyperglycemia Not Covered 2 diabetes melitus with hyperglycemia Not Covered 4 diabetes melitus with hyperglycemia Not Cover	nsulin lispro (Humalog equivalent) OR Humalog. to covered drugs. drug may be granted if all conditions in our nber 2 of the exception policy criteria. The reason for ed. ory and lab results, past treatments tried with dates
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/haloxone tablet,	to covered drugs. drug may be granted if all conditions in our nber 2 of the exception policy criteria. The reason for ed. ory and lab results, past treatments tried with dates
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 sum 15898242 STEVEN ANDREW MCDONALD MD EMERGENCY MEDICINE ZEPBOUND ANTI-OBESITY/ANOREXIANTS E66.9 - Obesity, unspecified Plan Exclusion treatments for your health issue. 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (ca 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.
15885117 RICKY CHANDRA MEHTA	RHEUMATOLOGY	AZATHIOPRINE	MISCELLANEOUS THERAPEUTIC CLASSES	D86.9 - Sarcoidosis, unspecified	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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
15885692 SHUBHADA SHRIKANT SHRIKHANDE MD	HEMATOLOGY & ONCOLOGY	GRANISETRON HYDROCHLOF	RI ANTIEMETICS	R11.0 - Nausea	Plan Limits Exceeded	treatments for your health issue. 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 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
15887876 CASEY EDWARD COTON DO	PSYCHIATRY	QELBREE	ADHD/ANTI-NARCOLEPSY	340 - Attention and concentration deficit	Not Covered	 the list of covered drugs, also known as our formulary, to see what is covered. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-core conditions in this policy have not been met. From the records that we have received, these reasons caused 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-a 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-core the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-core the conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your heal
15897252 FARHEEN YOUSUF MD	ENDOCRINOLOGY, DIABETES &	N NOVOLOG FLEXPEN	ANTIDIABETICS	e 2 diabetes mellitus with hyperglycemia	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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 this drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 ta 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.
15898196 DAWN DESIMONE PA-C	PHYSICIAN ASSISTANT	BUPRENORPHINE HCL	ANALGESICS - OPIOID	g89.4	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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 treatments for your health issue.

not-covered drug can be approved.

ng (can take 2 tablets for 100mg),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ated in your benefit summary. ay be able to suggest other

ed by the plan. It is used to make

overed by your plan. Please look at

ong-acting stimulant drug (e.g.,

not-covered drug can be approved.

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 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 day In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug, such as Aimovig, Ajovy, or Em 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 le 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-control 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 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.
15905364 BRENT ALAN PORTER MD	INTERNAL MEDICINE	QULIPTA	MIGRAINE PRODUCTS	g43.909 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the ex reason for denial is explained to the member above. The criteria from 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 of trial and responses, and any other evidence to 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 deutetrabenazine (AUSTEDO, AUSTEDO XR) have not been met. From the records that we have received, Austedo (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 in Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is o and quantity limits may apply to covered drugs.
15906665 IRIS SOFIA WINGROVE MD	NEUROLOGY	AUSTEDO	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	g24.01 Criteria Not Met	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 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 a 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.
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 a 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.
15913412 VAMSI KRISHNA MD	CARDIOLOGY, INTERVENTION	NAL ARCALYST	TARGETED IMMUNOMODULATORS -Acute ne	onspecific idiopathic pericarditis 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-cor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 dr 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.
15915255 ALLISON LEIGH ANDERSON M	D OBSTETRICS & GYNECOLOGY	MIRABEGRON ER	URINARY ANTISPASMODICS	835.0 - Frequency of micturition 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 it Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Tremfya is being given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during 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 decidered
15916979 DANIEL ANTHONY CARRASCO	MD DERMATOLOGY	TREMFYA	TARGETED IMMUNOMODULATORS	I40.0 Plan Exclusion	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 pha authorization may be required. Quantity limits may apply to covered drugs. Please note: all doses so far have been administered by a health care prov administered moving forward, we need documentation showing this as well as chart notes that document if there is been significant improvement.

e plan. It is used to make sure a 30 days is not covered by your plan. , or Emgality, must be used to help ease look at our formulary to see

not-covered drug can be approved.

lrugs that can be used for migraine

administered moving forward, we need documentation showing this as well as chart notes that document if there is been significant improvement.

nted if all conditions in our the exception policy criteria. The

, past treatments tried with dates

stedo (XR) was denied for these ue is impacting you.

at is covered. Prior authorization

Yes From the information we have mber above. The criteria are listed

not-covered drug can be approved.

such as prednisone), and one

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved. ther drugs for your health issue,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

t, during an emergency room visit, lecided by your health plan. Please our pharmacy benefit. Prior Yes

e provider. If it will be self-

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-control of the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 -52.0 - Hypoact	ive 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 heal 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 c 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
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 real 1) Records did not show that another drug called an adalimumab product (adalimumab-aaty, adalimumab-adaz, adalimumab-fkjp, Hadlima, Simland Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 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 her 1) Prescribed by a Gastroenterology Specialist; AND
					 Member has a diagnosis of moderately to severely active Ulcerative Colitis (UC); AND A trial of an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI) was ineffective, contrain Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i may be required and quantity limits may apply to covered drugs. Our prior autionization criteria for Androgens: fransdermal restosterone Products have not been met, from the records that we have received, testos reasons: 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 and quantity limits may apply to covered drugs.
15929202 ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	E34.9 Criteria Not Met	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. Fr 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 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 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 sriteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 defined on the set of the prove. Please look at our list of covered drugs, also known as the formulary, to see what defined and response look at our list of covered drugs, also known as the formulary, to see what defined and response look at our list of covered drugs, also known as the formulary, to see what defined and response look at our list of covered drugs, also known as the formulary, to see what defined and response look at our list of covered drugs, also known as the formulary, to see what defined and response look at our list of covered drugs, also known as the formulary to see what defined and response look at our list of covered drugs, also known as the formulary, to see what defined and response look at our list of covere
15935706 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & I	N DEXCOM G7 SENSOR	MEDICAL DEVICES	E11.65 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 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 of 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 authorization may be required and quantity limits may apply. 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
15936200 DAVID CABELL GRAY MD	INTERNAL MEDICINE	MOUNJARO	ANTIDIABETICS	E66.09 Plan Exclusion	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 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-correct drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray (RHINOCOR) 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 is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 -52.0 -	- Hypoactive sexual desire disorder Plan	n Exclusion	This request cannot be approved because your plan has chosen this drug/product to be excluded from coverage. Other drugs/products for your heal 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 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
15926141 KRISTINA KAY BURTON FNP	NURSE PRACTITIONER	XELJANZ	TARGETED IMMUNOMODULATORS	K51.90 Crite	eria 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 rea 1) Records did not show that another drug called an adalimumab product (adalimumab-aaty, adalimumab-adaz, adalimumab-fkjp, Hadlima, Simland Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 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, contrai Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is may be required and quantity limits may apply to covered drugs. Our prior autionization criteria for Androgens: transdermal restosterone Products have not been met. From the records that we have received, testos 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 and quantity limits may apply to covered drugs.
15929202 ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	TESTOSTERONE	ANDROGENS-ANABOLIC	E34.9 Crite	eria Not Met	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. Preceived, the member does not meet number(s) 1 of our prior authorization criteria for testosterone. The reason for denial is explained to the member 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 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. Cince criteria have not been met, we are unable to approve for this drug at this time. Places refer to aux formulaes for information on what is 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 d
15935706 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	N DEXCOM G7 SENSOR	MEDICAL DEVICES	E11.65 Crite		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 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 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 wha authorization may be required and quantity limits may apply.
15936200 DAVID CABELL GRAY MD	INTERNAL MEDICINE	MOUNJARO	ANTIDIABETICS	E66.09 Plan		This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated i 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 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (RHINOCOR 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

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15939289 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & N	FREESTYLE LIBRE 3/SENSOR/	MEDICAL DEVICES	
15946440 DONALD ROBERT BRODE MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	
15948393 DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES & N	чН-Е-В IN CONTROL PEN NEED	MEDICAL DEVICES	

PERCENDENT SPREET PROF 152 NUMBER 251 NUMBER 251 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 1540 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 15400 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 154000 PERCENDENT PROF 1540000 PERCENDENT PROF 1540000 PERCENDENT PROF 15400000 PERCENDENT PROF 154000 PERCENDENT PROF 15400000 PERCENDENT PROF 154000000000000000000000000000000000000	15939289 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & N	NFREESTYLE LIBRE 3/SENSOR/	MEDICAL DEVICES	E11.65 Criteria Not Met	This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been me 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 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
Hann DALE AND ALL AND	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 a 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 provi
1985 MP 200 MERSON IP NRSE PACTIONER RARE PACTORER ARRECISC CODE CREAD CODE	15948393 DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES & N	\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-The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, par of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
No.2007 MIN INSURA NAME MANULINE NAME SCI-0000 ORAL Sci-00000 Oral Sci-00000 Oral Sci-000000 Oral Sci-000000000000000000000						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, but
PSRVD7 PRENA LARA PORTER MD NURRC MGRAME PPODUCIS titteetable, whoth taxus nigoinoss N Coveed Disrugations fails yee net refers the induction to explore the date of the monther date of the induction to explore the date of the monther date of the induction to explore the date of the monther date of the induction to explore the date of the monther date. Disrugation tail the induction the policy are listed here. Disrugation tail the induction the policy are listed here. Disrugation tail the induction the induction tail the induction the induction tail the induction the induction tail the induction the inductin the inductin the induction tail the inductin the induction tail	15949505 RANDY WAYNE BRYSON NP	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4 Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, part of trial and responses, and any other evidence to 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-interval.
15954121 CRYSTAL MELANIE BOWDEN-MCKAY MD GASTROENTEROLOGY DEXLANSOPRAZOLE ULCER DRUGS/ANTISPASMODICS/ANTICHO GERD Not Covered This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be coverage of a non-formulary drug may be coverage of a non-formulary. An exception to allow coverage of a non-formulary drug may be coverage of a non-formulary. An exception to allow coverage of a non-formulary drug may be coverage of a non-formulary. An exception to allow coverage of a non-formulary drug may be coverage of a non-formulary. An exception to allow coverage of a non-formulary drug may be coverage of a non-formulary. An exception to allow coverage of a non-formulary drug may be coverage of a non-formulary. An exception to allow coverage of a non-formulary drug may be coverage of a non-formulary. An exception drug samples have been received to the member above. The criteria from the policy are met. From the information we have received, the member does not meet number 2 of the coverage of a non-formulary. In exception drug samples have been provided why all other covered drugs cannot be tried. 159556 Seconds have been received showing the requested drug is medically necessary. These should include relevant medical history and be received showing the requested drug is medically necessary. These should include relevant meetical history and be received showing the requested drug is neglicial necessary. These should from the policy are meet. 159556 SRLAKSHMI VALLABHANENI MD CARDIOLOGY OZEMPIC ANTIDIABETICS Obesity Plan Exclusion This request has not been approved because this drug is not on formulary, to sew that is covered drugs, also known as the formulary, to sew that is	15950797 BRENT ALAN PORTER MD	INTERNAL MEDICINE	NURTEC	MIGRAINE PRODUCTS	t intractable, without status migrainosus Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, part of trial and responses, and any other evidence to 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-The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, pantoprazole, pantoprazole, pantoprazole, pantoprazole, pantoprazole, pantoprazole, pantoprazole drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole (TRIED), pantoprazole, pan
15955366 SRILAKSHMI VALLABHANENI MD CARDIOLOGY OZEMPIC ANTIDIABETICS obesity Plan Exclusion 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 is sue. 15955666 RAMESH MSINGA MD ANESTHESIOLOGY MIGRAINE PRODUCTS Gasant drug is used the right way. We will cover Nurtec at 10 tablets per 30 days with 6 fills per year for this use. The higher number of 16 tablets event 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 that may be used for migraine prevention are Aimovig, Ajovy, and Emgality. Please look at the list of covered drugs that may be used for migraine prevention are Aimovig, Ajovy, and Emgality. Please look at the list of the drug shat may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy, and Emgality. Please look at the list of the drugs that may be used for migraine prevention are Aimovig. Ajovy and Emgal	15954121 CRYSTAL MELANIE BOWDEN-MCKAY MD	GASTROENTEROLOGY	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHC	GERD Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, par of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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tormulary, to see what is covered by your plan. Prior authorization and quantity limits may apply to covered drugs	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 pla 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 c 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 formulary. to see what is covered by your plan. Prior authorization and quantity limits may apply to covered drugs.

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anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

erage as stated in your benefit provider may be able to suggest

e plan. It is used to make sure a y 30 days is not a covered amount of vered drugs, also known as the

					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered d The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15958592 MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	QUVIVIQ	HYPNOTICS/SEDATIVES/SLEEP DISORDER A	G G47.00 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 cond Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy of
					 denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatme of trial and responses, and any other evidence to 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
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 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 other treatments for your health issue.
					Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin I 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.
15966717 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & I	N DEXCOM G7 SENSOR	MEDICAL DEVICES	e 2 diabetes mellitus with hyperglycemia Criteria Not Met	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 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 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 ar 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 cover
					authorization may be required and quantity limits may apply. 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. and quantity limits may apply to covered drugs.
15967962 RITA IFEANYI CHUKWURAH	NURSE PRACTITIONER	LINZESS	GASTROINTESTINAL AGENTS - MISC.	table bowel syndrome with constipation Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have receive 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered d The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 ed
					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.
15968692 SAPNA RANI BHAGAT MD	OBSTETRICS & GYNECOLOGY	IMVEXXY MAINTENANCE PAC	K VAGINAL AND RELATED PRODUCTS	n95.1 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 cond Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy of
					denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
					 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatment of trial and responses, and any other evidence to 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 d 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.
15969570 MIREYA ADAME APRN	NURSE PRACTITIONER	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	MDD Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all cond Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 and 5 of the Rexulti exce 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
					 Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with medication.

not-covered drug can be approved.

n, trazodone (tried), eszopiclone.

granted if all conditions in our exception policy criteria. The reason for

s, past treatments tried with dates what is covered. Prior authorization age as stated in your benefit

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior se reasons:

nat is covered. Prior authorization we have received, the member does

what is covered. Prior authorization not-covered drug can be approved. em, Vagifem equivalents), estradiol

nted if all conditions in our

ption policy criteria. The reason for

s, past treatments tried with dates not-covered drug can be approved.

nted if all conditions in our ne Rexulti exception policy criteria

when used with an antidepressant

15971916 ELISABETH RUTH BLANK	NURSE PRACTITIONER	AZELASTINE HYDROCHLORIDE	NASAL AGENTS - SYSTEMIC AND TOPICAL	

15974663 LIDYA TESHOME DO NEUROLOGY EMGALITY MIGRAINE PRODUCTS

15980330	ELISABETH ANNE CLAYTON MD	ALLERGY & IMMUNOLOGY	AZELASTINE HYDROCHLORIDE	E NASAL AGENTS - SYSTEMIC AND TOPICAL	

 15985999 MANUEL JOSEPH MARTIN MD
 FAMILY PRACTICE
 TESTOSTERONE
 ANDROGENS-ANABOLIC

 15990481
 LAM MCCOMB
 PHYSICIAN ASSISTANT
 LINEZOLID
 ANTI-INFECTIVE AGENTS - MISC.

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 r The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (azelastim azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua equiv 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excee denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results of trial and responses, and any other evidence to 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 authonization criteria for galcanezumab (EWGALTY 120mg) have not been met. From the records that we have received, Emgality 120mg) 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 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 when the criteria have not been met, we are not able to approve.
g43.909 Criteria Not Met	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 member does not meet number 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The cr 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 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 to the followin
j30.89 Not Covered	 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 Emgality, AND (B) 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 Emgality, AND (B) 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 formulary is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a response to the out of the second the decide. 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are anasal antihistamines (azelastime azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceed denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history
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, t 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 wh 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 n 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 ab 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; AN 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 te 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 v may be required and quantity limits may apply to covered drugs. Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, Linezolid was denied for this 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 when the related have not been met, we are not able to approve. Please look at our
L03.116 Criteria Not Met	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 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 version of the second

a not-covered drug can be approved.

tine 0.1% (Astelin equivalent),

ivalent), fluticasone (Flonase

ranted if all conditions in our ception policy criteria. The reason for

s, past treatments tried with dates

umg was denied for these reasons:

ve had at least a three (3) month trial

what is covered.

e information we have received, the

e criteria are listed here. Yes

ts (such as topiramate, sodium

following are met: (A) Member has with a botulinum toxin (BOTOX,

a not-covered drug can be approved.

tine 0.1% (Astelin equivalent), uivalent), fluticasone (Flonase

.

ranted if all conditions in our ception policy criteria. The reason for

s, past treatments tried with dates

, test was denied for these reasons:

what is covered. Prior authorization

met. From the information we have

above. The criteria are listed here.

ND

testosterone must be documented n what is covered. Prior authorization

eacon.

vhat is covered.

e have received, the member does

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 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.
15994240 MELISSA RENEE GABRIELLI	NURSE PRACTITIONER	AUVELITY	ANTIDEPRESSANTS	MDD Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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:
15996074 MICHAEL ALAN FULLER MD	PSYCHIATRY	BUPROPION HYDROCHLORIE	DE ANTIDEPRESSANTS	f31.9 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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.
15998093 PATRICIA SHEA RODRIGUEZ NP	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	R73.03 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
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.
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
16002601 DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES	S & N H-E-B IN CONTROL PEN NEEI	D MEDICAL DEVICES	E11.65 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 5) 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 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.
16004565 ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	BASAGLAR KWIKPEN	ANTIDIABETICS	E11.9 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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	вотох	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.

						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), AN norepinephrine reuptake inhibitor (SNRI) (e.g. desvenlafaxine extended release (ER) (Pristiq equivalent), venlafaxine, duloxetine), AND two selective s (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.
15994240 MELISSA RENEE GABRIELLI	NURSE PRACTITIONER	AUVELITY	ANTIDEPRESSANTS	MDE	D Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (7 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.
15996074 MICHAEL ALAN FULLER MD	PSYCHIATRY	BUPROPION HYDROCHLORID	E ANTIDEPRESSANTS	f31.5	9 Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 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 re 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 o
15998093 PATRICIA SHEA RODRIGUEZ NP	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	R73.03	3 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the memb 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
16000529 MARYANN CECELIA GAMBLE	FAMILY PRACTICE	FINASTERIDE	DERMATOLOGICALS	.65.9 - Nonscarring hair loss, unspecified	d 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 hea 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 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
16002601 DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES &	k N H-E-B IN CONTROL PEN NEEL	9 MEDICAL DEVICES	E11.65	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-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 need Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
						 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what
						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), Levem Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16004565 ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	BASAGLAR KWIKPEN	ANTIDIABETICS	E11.5	9 Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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
16006483 ANDREW ALAN COLLINS MD	NEUROLOGY	вотох	NEUROMUSCULAR AGENTS	t intractable, without status migrainosus	s 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. Prese administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co 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 whet plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may

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-our The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), AN norepinephrine reuptake inhibitor (SNRI) (e.g. desvenlafaxine extended release (ER) (Pristiq equivalent), venlafaxine, duloxetine), AND two selective set (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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
15996074 MICHAEL ALAN FULLER MD	PSYCHIATRY	BUPROPION HYDROCHLORID	E ANTIDEPRESSANTS	f31.9	Not Covered	 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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-core conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (150 mg 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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
15998093 PATRICIA SHEA RODRIGUEZ NP	NURSE PRACTITIONER	OZEMPIC	ANTIDIABETICS	R73.03	Criteria Not Met	 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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 reapply. 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 constructed to be approved because our Restricted Diagnosis criteria have not been met. From the member out set to the member out Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here.
16000529 MARYANN CECELIA GAMBLE	FAMILY PRACTICE	FINASTERIDE	DERMATOLOGICALS	.65.9 - Nonscarring hair loss, unspecified	Plan Exclusion	 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 This request cannot be approved because your plan has chosen this drug/product to be excluded from coverage. Other drugs/products for your heal 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 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
16002601 DEVIKA MARANGATTU MADHAVAN	ENDOCRINOLOGY, DIABETES & I	N 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- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 need Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 i
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-complete coverage of the drugs are covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin glargine-yfgn (TRIED), Leveminations at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 5) Ince criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what i
16006483 ANDREW ALAN COLLINS MD	NEUROLOGY	вотох	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. Presc administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from con- 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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may

16004565 ROBERT WILLIAM NORRIS MD	FAMILY PRACTICE	BASAGLAR KWIKPEN	ANTIDIABETICS	

not-covered drug can be approved.

L), AND one serotonin-

16013371 RITA IFEANYI CHUKWURAH	NURSE PRACTITIONER	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	
16015375 CLAIRE KYLANDER	NURSE PRACTITIONER	INTRAROSA	VAGINAL AND RELATED PRODUCTS	enopausal and perimenopausa
16029138 GREG LOUIS WESTMORELAND MD 16032432 STACIA CHRISTINE MILES MD	SURGERY, ORTHOPEDIC	HYMOVIS ADAPALENE	MUSCULOSKELETAL THERAPY AGENTS	81.4 - Other melanin hyperpig
16036027 COURTNEY SHAWN KYLE PA-C	PHYSICIAN ASSISTANT	UBRELVY	MIGRAINE PRODUCTS	t intractable, without status m
16043171 AGEZI CHINWE IGBOKO	NURSE PRACTITIONER	WINLEVI	DERMATOLOGICALS	L70.0 - Acr

16045779 CLAIRE MCDONOUGH PMHNPBC

ADVANCED PRACTICE NURSE REXULTI

ANTIPSYCHOTICS/ANTIMANIC AGENTS

		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.
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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
ausal disorder I	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
M17.11 I	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
pigmentation I	Plan Exclusion	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 ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubreivy was denied for these reasons:
s migrainosus (Criteria Not Met	 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
Acne vulgaris I	Not Covered	 may be required and quantity limits may apply to covered drugs. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 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. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the
F33.8 I	Not Covered	 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 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
16051212 RENE BADILLO II	PHYSICIAN ASSISTANT	KAPSPARGO SPRINKLE	BETA BLOCKERS

16053415	TAMILSELVI	PERIASAMY	MD

INTERNAL MEDICINE

16053449 FEROZ OSMANI MD ANESTHESIOLOGY

BUPRENORPHINE HCL

ANALGESICS - OPIOID

ANTIASTHMATIC AND BRONCHODILATOR A structive pulmonary disease SPIRIVA HANDIHALER

	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for the
	 Records show that you may not be able to use light therapy, methotrexate, or acitretin, but more information is needed to show why these treat 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
	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 informatior
PP Criteria Not Met	does not meet number(s) 3 of our prior authorization criteria for Stelara for Plaque Psoriasis (Initial Coverage). The reason for denial is explained t 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 seve
	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
	(B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified
	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 whe This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a new The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, b
	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:
palpitations Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 no
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Stio
	Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
e, unspecified Not Covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception to an one of the exception of the
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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
	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 released
	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.
low back pain 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 grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 & 2 of the exceptions for denial is explained to the member above. The criteria from the policy are listed have
	reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

hese reasons:

eatments are not right for you.

hat is covered.

on we have received, the member to the member above. The criteria

Yes

evere plaque psoriasis (PP) (greater

of 15 sessions of phototherapy; OR fied. NOTE: A contraindication or

what is covered. Prior authorization not-covered drug can be approved.

bisoprolol, metoprolol, and

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

iolto Respimat.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

lease (IR), oxycodone (currently

nted if all conditions in our exception policy criteria. The

DERMATOLOGY

PHYSICIAN ASSISTANT

DUPIXENT

SOLOSEC

16054839 CHERYL ANN JOHNSTON PA

16054684 ELIZABETH HAVEY MILLER MD

GASTROENTEROLOGY 16070030 SUJAATA RATNA DWADASI MD LINZESS GASTROINTESTINAL AGENTS - MISC.

16070331 ANUREKHA BONGU CHADHA MD RHEUMATOLOGY GAMMAGARD LIQUID PASSIVE IMMUNIZING AND TREATMENT AG

16075147 RACHEL ELIZABETH DOCKRAY PA-C PHYSICIAN ASSISTANT

TESTOSTERONE

ANDROGENS-ANABOLIC

DERMATOLOGICALS

AMEBICIDES

1° male hyp

	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for the 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), to (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. Immunomod 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 i 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 w
L20.9 Criteria Not Met	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 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 a rea (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 pro
	(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 (d submitted for an approval):
	(A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIE Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies list AND
	5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis.
	Our prior authorization criteria for secnidazole (SOLOSEC) have not been met. From the records that we have received, Solosec was denied for these 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 ide
	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
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
Acute vaginitis Criteria Not Met	This request has not been approved because our prior authorization criteria for secnidazole (SOLOSEC) have not been met. From the information w 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 liste
	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) Ho
	discharge that smoothly coats the vaginal walls; (B) More than 20% cue cells (e.g., vaginal epithelial cells studded with adherent coccobacilli) on mic 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); A
	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
	may be required and quantity limits may apply to covered drugs. Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these re
	1) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritab
	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 i and quantity limits may apply to covered drugs.
k59.00 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
KSS.00 Chicha Hot Met	This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we h
	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 ar 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
	 A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 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 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 provide
M33.20 Plan Exclusion	administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from co 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 w
	plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testo
	for these reasons:
	 More information is needed to know if your low levels of testosterone are age-related. 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 i
	and quantity limits may apply to covered drugs.
ale hypogonadism Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testesterone Products have not been met
	This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. 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 expla
	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
	 Member has symptoms of hypogonadism; AND 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 testos

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 reauest.

these reasons:

), topical calcineurin inhibitors

nodulator drugs help your body

nat is covered. Prior authorization

n we have received, the member are listed here.

an or equal to 10% body surface provided with the request

t (documentation is required to be

(ELIDEL)), or (C) Narrow band s listed above are contraindicated;

hese reasons:

r identify your health issue, such as

at is covered.

n we have received, the member

listed here. Homogeneous, thin, white n microscopic examination; (C) pH of t); AND

what is covered. Prior authorization

e reasons: itable bowel syndrome with

nat is covered. Prior authorization

ve have received, the member does a are listed here.

what is covered. Prior authorization rovider. Prescription drugs that are m coverage as indicated in your ee what is covered by your health may apply to covered drugs. testosterone gel 1.62% was denied

Yes

nat is covered. Prior authorization

net. From the information we have plained to the member above. The

חו

						 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-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 table 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.
16076139 CLAYTON WARREN ADAMS MD	ANESTHESIOLOGY	BUTALBITAL/ACETAMINOPHE	N ANALGESICS - NONNARCOTIC	t intractable, without status migrainosus	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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exc reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 3) Records that the received showing caused the optimized by the covered drugs are likely to be ineffective or unsafe for the member.
						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 limits may apply to covered drugs.
16078070 ISELA ARRIETA WERCHAN MD	PSYCHIATRY	LUCEMYRA	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	L opioid withdrawa	Criteria Not Met	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 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. 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 recapply. 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 contract of the covered drugs.
16080933 ELIZABETH LYNN POLLOCK MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	R73.03	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member 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 it
16084862 NAWALAGE RAVI NAYANADUL COORA	AY 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 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
						treatments for vour health issue. Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these re 1) Records did not show that an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI, HUM Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
16087764 JAMES LUDWIG WISE MD	GASTROENTEROLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	Ulcerative Colitis (UC	Criteria Not Met	This request has not been approved because our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the information we 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 lister 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 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 may be required and quantity limits may apply to covered drugs.
						Our prior authorization criteria for Ophthalmic Prostagianding nave not been met. From the records that we have received, tafluprost (Zioptan equiva 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 limits may apply to covered drugs.
16091895 HALEY NGUYEN OD	OPTOMETRIST	TAFLUPROST	OPHTHALMIC AGENTS	H40.1131	Criteria Not Met	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 member does not meet number 1 of our prior authorization criteria for tafluprost (Zioptan equivalent). The reason for denial is explained to the mem listed here. 1) Trials of ALL the following were ineffective, contraindicated, or not tolerated: (A) bimatoprost ophthalmic solution (LUMIGAN 0.01%); AND (B) latar 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
16093998 SAMI MOHAMAD ABOUMATAR MD	NEUROLOGY	FYCOMPA	ANTICONVULSANTS	epilepsy and epileptic syndromes with se	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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
						4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

tablet, rizatriptan, sumatriptan,

nted if all conditions in our ne exception policy criteria. The

, past treatments tried with dates

emyra.

zation may be required and quantity

eived, the member does not meet

itment.

what is covered Drier authorization e required and quantity limits may

t is covered.

ember does not meet number 1 of what is covered. Prior authorization ated in your benefit summary.

ay be able to suggest other ese reasons: HUMIRA) did not work for you.

at is covered. Prior authorization

n we have received, the member e listed here.

) that was ineffective, what is covered. Prior authorization

quivalent) was denied for these

zation may be required and quantity ation we have received, the

member above. The criteria are latanoprost ophthalmic solution;

what is covered Prior authorization not-covered drug can be approved.

nted if all conditions in our ption policy criteria. The reason for

, past treatments tried with dates

16094181 AGEZI CHINWE IGBOKO	NURSE PRACTITIONER	WINLEVI	DERMATOLOGICALS	
16096235 PATIENCE HARRIET READING MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	
16098414 JOSEPH EDWARD GARCIA MD	SURGERY, GENERAL	LINZESS	GASTROINTESTINAL AGENTS - MISC.	

16106902 STEVEN ZACHARY POWELL MD

FAMILY PRACTICE

LOPERAMIDE HYDROCHLORID ANTIDIARRHEAL/PROBIOTIC AGENTS

16111799 KIMBERLY MICHELLE CATAHAN NP

16112255 SUJAATA RATNA DWADASI MD GASTROENTEROLOGY

NURSE PRACTITIONER

SKYRIZI

LUBIPROSTONE

TARGETED IMMUNOMODULATORS

GASTROINTESTINAL AGENTS - MISC.

Constipation, un

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
L70.0 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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.
G43.011 Plan Limits Exceeded	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.
	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.
	and quantity innits may apply to covered drugs.
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 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
	 A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
K58.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates
	of trial and responses, and any other evidence to 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 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:
K51.90 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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.
	Since the criteria have not been met, 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:
unspecified Criteria Not Met	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 (1) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated; (A) stimulants (bisacodyl, sepposides), or (B) PEG 3350
	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

not-covered drug can be approved.

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 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), top (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. 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 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 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 a 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 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 prov (documentation has trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (do submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDE Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotr
16114377 YUE DENG MD	INTERNAL MEDICINE	JUBLIA	DERMATOLOGICALS	B35.1 Not Covered	AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for atopic dermatitis. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Penla 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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-co- The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pass of trial and responses, and any other evidence to 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 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 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 reflicted in the prevention 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 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, 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, 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, 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, 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, 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, records drugs, also known as the formulary, to see what is 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 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 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 migr

Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

these reasons:), topical calcineurin inhibitors

ssue. Immunomodulator drugs

hat is covered. Prior authorization

n we have received, the member eria are listed here.

han or equal to 10% body surface provided with the request

t (documentation is required to be

(ELIDEL)), or (C) Narrow band s listed above are contraindicated;

not-covered drug can be approved.

Penlac equivalent), terbinafine

Yes

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

r your health issue, such as

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ated in your benefit summary. ay be able to suggest other

ese reasons: will be used together with a otulinum toxin product alone.

hat is covered. Prior authorization

on we have received, the member iteria are listed here.

he following are met: (A) Member with a botulinum toxin product (e.g.,

igraine days per month for at least minimum three (3) month trial nolol, metoprolol, etc.), OR (iii)

					Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 dr
16125629 EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	DEXCOM G7 SENSOR	MEDICAL DEVICES	tes mellitus without complications (HCC) 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. 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 continuous of the second of the second of the member above. The context of the second of th
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
16126388 DIANA NATHALIE ANDINO MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.009 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (E Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro EF 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.
16126669 ASAD NAWAZ MD	ANESTHESIOLOGY	BELBUCA	ANALGESICS - OPIOID	M54.12 - Radiculopathy, cervical region 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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	 4) Prescription and samples were not used to establish treatment. This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/product 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 w Your doctor or health care provider may be able to suggest other treatments for your health issue. Our prior authorization criteria for subcutaneous belimumab (BENLYSTASC) have not been met. From the records that we have received, BenlystaSC 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 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 tiss 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 of the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is of the criteria have not been met, we are not able to approve.
16135189 SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	M32.9 Criteria Not Met	 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 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 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-doub 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) m 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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-control of the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
16148673 MARJAN ABEDI LINNELL MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, combined type Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

16126388 DIANA NATHALIE ANDINO MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS

					Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using 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 de
16125629 EMMY JO GALVAN FN	P-C NURSE PRACTITIONER	DEXCOM G7 SENSOR	MEDICAL DEVICES	tes mellitus without complications (HCC) 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 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 of 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 authorization may be required and quantity limits may apply.
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
16126388 DIANA NATHALIE AND	INO MD NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.009 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (R Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro El 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.
16126669 ASAD NAWAZ MD	ANESTHESIOLOGY	BELBUCA	ANALGESICS - OPIOID	M54.12 - Radiculopathy, cervical region 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
16129672 LINDSAY KAY BRETTMA	ANN MD INTERNAL MEDICINE	TRETINOIN	DERMATOLOGICALS	Epidermal cyst Plan Exclusion	 4) Prescription drug samples were not used to establish treatment. This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/product 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 v Your doctor or health care provider may be able to suggest other treatments for your health issue. Our prior authorization criteria for subcutaneous belimumab (BENLYSTASC) have not been met. From the records that we have received, BenlystaSC 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 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 tiss 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
16135189 SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	M32.9 Criteria Not Met	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 th 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 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-doul 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) m 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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 relea 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.
16148673 MARJAN ABEDI LINNEI	L MD PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	cit hyperactivity disorder, combined type Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

16135189 SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES

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 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 device will be request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met 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 continuous Glucose 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 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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (E Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro El 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.
16126669 ASAD NAWAZ MD	ANESTHESIOLOGY	BELBUCA	ANALGESICS - OPIOID	M54.12 - Radiculopathy, cervical region 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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/product 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 v Your doctor or health care provider may be able to suggest other treatments for your health issue. Our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta SC 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 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 tiss 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
16135189 SONIA YOUSUF III MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	M32.9 Criteria Not Met	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 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 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-doukd 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) methoric 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 relea 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

using insulin before the requested

hat drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

ease (ER) (MS Contin equivalent), dro ER equivalent), tramadol ER

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

roducts used for a cosmetic see what is covered by your plan.

ta SC was denied for these

test for anti-smith antibodies. These wn tissues and organs, causing

hat is covered.

om the information we have mber above. The criteria are listed

-double stranded DNA (anti-

, (D) mycophenolate mofetil, or (E)

not-covered drug can be approved.

l release (ER), methylphenidate ER,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

16148979 AMY ROMINGER MASON MD	DERMATOLOGY	TRETINOIN	DERMATOLOGICALS	
16154954 CATHERINE CELESTE LEWIS NP	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	
16155494 JIHONG KIM NP	NURSE PRACTITIONER	TIOTROPIUM BROMIDE	ANTIASTHMATIC AND BRONCHODILATOR A	

16155871 NEERAJ MANCHANDA MD NEUROLOGY XYREM PSYCHOTHERAPEUTIC AND NEUROLOGICAL

16159161 JAMES COCHRAN ANDERSON IV MD PEDIATRICS LURASIDONE HYDROCHLORID ANTIPSYCHOTICS/ANTIMANIC AGENTS 16166684 WILLIAM MARC LEWIS DO INTERNAL MEDICINE WEGOVY ANTI-OBESITY/ANOREXIANTS E66.9 - Obesity, u

16168129 DARSHAN NARENDRA SHAH MD NEUROLOGY AJOVY MIGRAINE PRODUCTS

DIETARY PRODUCTS/DIETARY MANAGEMEN ency of other specified B grou 16172703 TRAVIS MICHAEL COX MD HEMATOLOGY & ONCOLOGY METAFOLBIC

	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.
L98.8 Criteria Not Met	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 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 a 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.
L30.9 Criteria Not Met	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 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
	 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 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.
J42 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the exception policy criteria. T denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
	 4) Prescription drug samples were not used to establish treatment. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 s 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.
G47.419 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. T denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
F34.81 Plan Limits Exceeded	4) Prescription drug samples were not used to establish treatment. 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 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 r 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 mareviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatment 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 plant.
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 su 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 treatments for your health issue. 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
	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 Since the criteria have not been met, 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 at and quantity limits may apply to covered drugs.
G43.709 Criteria Not Met	This request has not been approved because our prior authorization criteria for fremanezumab (AJOVY) have not been met. From the information we have received, t 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, s 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: 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 Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with Ajovy
	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 a may be required and quantity limits may apply to covered drugs.
oup 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 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 ma 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.

received, the member does not

what is covered. Prior authorization for these reasons:

the skin. at is covered.

received, the member does not are listed here.

what is covered. Prior authorization

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates not-covered drug can be approved.

Sodium Oxybate oral solution,

anted if all conditions in our ception policy criteria. The reason for

, past treatments tried with dates

the drug allowed by the plan. It is of 2 tablets per day is not an lished studies from major peer er drugs and treatments that have at is covered by your plan. tated in your benefit summary. may be able to suggest other

ese reasons: y will be used together with a potulinum toxin product alone. hat is covered. Prior authorization

tion we have received, the member eria are listed here.

(such as topiramate, sodium AND

the following are met: (A) Member with a botulinum toxin product (e.g.,

what is covered. Prior authorization

Ir health issue may be covered by ealth care provider may be able to

Particle Sector Sect							
No.2012 Description Description <thdescription< th=""> <thdescription< th=""> <th< td=""><td>16173183 GRACE WHITNEY KIMMEL MD</td><td>DERMATOLOGY</td><td>OPZELURA</td><td>DERMATOLOGICALS</td><td>L80 - Vitiligo</td><td>o Criteria Not Met</td><td> 2) Records did not show that a topical steroid (e.g., betamethasone, triamcinolone) OR a topical calcineurin inhibitor (e.g., pimecrolimus cream, tacroli 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 a 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 l 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 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 to 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 a contraindication to both. </td></th<></thdescription<></thdescription<>	16173183 GRACE WHITNEY KIMMEL MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS	L80 - Vitiligo	o Criteria Not Met	 2) Records did not show that a topical steroid (e.g., betamethasone, triamcinolone) OR a topical calcineurin inhibitor (e.g., pimecrolimus cream, tacroli 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 a 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 l 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 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 to 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 a contraindication to both.
International services Internatin services Internatin services	16175273 SHAGUFTA R LAKHANI FNP-C	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4-Chronic Pain Syndrome	e Not Covered	 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused 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, bupr 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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
1 1887B 2AVD NAUBAT NASULAT ND INTERNAL MEDICINE SLIDENAL CITATE CARDIOVASCULAR AGDITS - MSC. CD Puin Ecklusion summary. Plasse lock at the form days, basis hown as the formulary, to see what is covered by your pain. Your doctor or health can provide may be international pain pain. The second mark tan parenet at mainted in parenet a	16180654 GRACE WHITNEY KIMMEL MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS	L80) Criteria Not Met	 Records did not show that a topical steroid (e.g., betamethasone, triamcinolone) OR a topical calcineurin inhibitor (e.g., pimecrolimus cream, tacroli 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 a 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 l 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 liss Prescribed by, or in consultation with, a Dermatologist; AND Member has a diagnosis of nonsegmental vitiligo; AND 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 to on non-facial areas is depigmented; AND The total affected body surface area (BSA) is less than or equal to 10%; AND Phototherapy trial was ineffective, contraindicated, or not tolerated; AND A trial of ONE (1) of the following was ineffective or not tolerated; (A) medium potency or stronger topical corticosteroid, OR (B) topical calcineurin a contraindication to both.
Istability NUDOCRINULOGY, DLATIETS & VICOVY ANTI-DASTIV/ANDRIXANTS PP - Other debuily due to excess calories Put acducant Process books	16180919 ZAYD NAJDAT NASHAAT MD	INTERNAL MEDICINE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ED	Plan Exclusion	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 provid
Total Description Description Description ANTIDIARRHEAL/PROBIDITC AGENTS e gastreenteritis and cellitis, unspecified tot Covered This drug is not on our sour formulary. Similar drug are not covered by yous used for this contained are reparative. The second	16182030 SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES &	& N WEGOVY	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 ir 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
16187089 LINDSAY KAY BRETIMANN MD INTERNAL MEDICINE TRETINOIN DERMATOLOGICALS L72.0 Plan Exclusion puppose are excluded from coverage as stated in your benefits summary. Please look at the list of covered dugs, also known as the formulary, to see what is covered by your plan. Your obcorr or health sage. This request a non-top wide trans the side is upgis to being used for weight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for veight loss. Only used for delay is being used for delay. Being used for delay. Being used for veight loss. Only used for delay is being used for veight loss. Delay used for delay is being used for veight loss. Delay used for delay is being used for delay. Being used for delay is being used for delay. Being used for delay is being used for delay. Being used for delay is being used for delay. Being used for delay is being used for delay. Being used	16185929 JARED KEALY MD	FAMILY PRACTICE	LOPERAMIDE HCL	ANTIDIARRHEAL/PROBIOTIC AGENTS	ve gastroenteritis and colitis, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) we other drugs include loperamide. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for spe
16187462 SHEARREN VONSHAY JOHNSON NURSE PRACTITIONER ZEPBOUND ANTI-OBESIT//ANOREXIANTS E66.3 - Overweight Plan Exclusion The request cannot be approved because this drug is being used for weight loss. Drugs used for such loss. Drugs used for suc	16187089 LINDSAY KAY BRETTMANN MD	INTERNAL MEDICINE	TRETINOIN	DERMATOLOGICALS	L72.0) Plan Exclusion	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 w Your doctor or health care provider may be able to suggest other treatments for your health issue.
16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVATTANAKUL MD NEUROLOGY QULIPTA MIGRAINE PRODUCTS , intractable, without status migrainosus Not Covered 16187498 SRIVADEE ORAVIVAT	16187462 SHEARREN VONSHAY JOHNSON	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweight	t 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 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 treatments for vour 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
	16187498 SRIVADEE ORAVIVATTANAKUL MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	ı, intractable, without status migrainosus	s Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

tnese reasons:

acrolimus ointment) did not work

nat is covered. Prior authorization

n we have received, the member riteria are listed here.

eater than or equal to 3% total BSA

neurin inhibitor, OR (C) member has

what is covered. Prior authorization not-covered drug can be approved.

, buprenorphine/naloxone film, or

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates these reasons:

acrolimus ointment) did not work nat is covered. Prior authorization

n we have received, the member

are listed here.

eater than or equal to 3% total BSA

eurin inhibitor, OR (C) member has what is covered. Prior authorization ige as stated in your benefit provider may be able to suggest

ited in your benefit summary. ay be able to suggest other TC) without a prescription. These

or specific information on what is roducts used for a cosmetic see what is covered by your plan.

ated in your benefit summary. ay be able to suggest other not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

1	6194303 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) of other drugs include ferrous sulfate, ferrous gluconate, and others. Please note these other drugs are not covered by your prescription drug benefit. Please for this condition on what is covered. **Please note, the formulary does cover ferrex 150 forte capsules, Multigen tablets, Multigen Plus tablets, ar
1	6200511 SHEARREN VONSHAY JOHNSON	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweigh	t 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 i 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 treatments for your health issue.
1	6201186 EDGAR NOE NAVARRO GARZA MD	PEDIATRICS	SENNA	LAXATIVES	К59.00) 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) of other drugs include Senna liquid, Senna-Lax tabets, bisacodyl/tablet/suppository, Miralax, and others. Please note these other drugs are not covered benefit. Please refer to the formulary for specific information on what is covered. Please note, polyethylene glycol 3350 powder (MIRALAX equivalent This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 - A 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 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.
1	6203822 ELIZABETH CABRERA MD	DERMATOLOGY	ABSORICA LD	DERMATOLOGICALS	L70.0) Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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
1	6204228 MATTHEW A BARTOW MD	FAMILY PRACTICE	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MI	S Osteoporosis	s Not Covered	 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 1) Ins 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 can be approace of the member.
1	6206340 ISELA ARRIETA WERCHAN MD	PSYCHIATRY	SUBLOCADE	ANALGESICS - OPIOID	F11.20	Plan Exclusion	that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded 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 health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limi
1	6211365 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 i 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 treatments for your health issue.
1	6215106 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 reasonable in 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 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 hav 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
1	6215445 KARISA RAE STANCIL FNP-C	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	09 - Other obesity due to excess calories	s 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 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
1	6216565 MICHAEL CHRISTOPHER STEFANOWICZ	D FAMILY PRACTICE	PREGABALIN	ANTICONVULSANTS	munodeficiency virus (HIV) disease(HHS)	Plan Limits Exceeded	treatments for your health issue. 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 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 capsul 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,
1	6219052 AMMAR MOIN AHMED MD	DERMATOLOGY	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	PF	? Criteria Not Met	to see what drucs are covered. Our prior authorization criteria for subcutaneous risankizumab-rzaa (SKYRIZI SC) have not been met. From the records that we have received, Skyrizi 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 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. Fro 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 ab 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 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i may be required and quantity limits may apply to covered drugs.
1	6219993 SHEARREN VONSHAY JOHNSON	NURSE PRACTITIONER	SAXENDA	ANTI-OBESITY/ANOREXIANTS	E66.3 - Overweigh	t 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 i 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 treatments for your health issue.

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) of other drugs include ferrous sulfate, ferrous gluconate, and others. Please note these other drugs are not covered by your prescription drug benefit. Please for this covered. **Please note, the formulary does cover ferrex 150 forte capsules, Multigen tablets, Multigen Plus tablets, are 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 i 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 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) of other drugs include Senna liquid, Senna-Lax tabets, bisacodyl/tablet/suppository, Miralax, and others. Please note these other drugs are not covered benefit. Please refer to the formulary for specific information on what is covered. Please note, polyethylene glycol 3350 powder (MIRALAX equivalent This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused 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 - A 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 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.
16203822 ELIZABETH CABRERA MD	DERMATOLOGY	ABSORICA LD	DERMATOLOGICALS	L70.0	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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
16204228 MATTHEW A BARTOW MD	FAMILY PRACTICE	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MI	S 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-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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 1) Ins 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 can be approace of the member.
16206340 ISELA ARRIETA WERCHAN MD	PSYCHIATRY	SUBLOCADE	ANALGESICS - OPIOID	F11.20	Plan Exclusion	that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded 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 se health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limit
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 i 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 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 reasonable in 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 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 hav 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
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 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
16216565 MICHAEL CHRISTOPHER STEFANOWICZ	D FAMILY PRACTICE	PREGABALIN	ANTICONVULSANTS	munodeficiency virus (HIV) disease(HHS)	Plan Limits Exceeded	treatments for your health issue. 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 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 capsul 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,
16219052 AMMAR MOIN AHMED MD	DERMATOLOGY	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	PF	^o Criteria Not Met	to see what drucs are covered. Our prior authorization criteria for subcutaneous risankizumab-rzaa (SKYRIZI SC) have not been met. From the records that we have received, Skyrizi 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 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. Fro 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 ab 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 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what i 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 i 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 treatments for your health issue.

DTC) without a prescription. These efit. Please refer to the formulary for ts, and other products that contain

ated in your benefit summary. ay be able to suggest other

DTC) without a prescription. These vered by your prescription drug valent) is covered on your formulary. not-covered drug can be approved.

nt - Amnesteem, Claravis, Myorisan, your plan, certain isotretinoin 30

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

th care provider. Prescription drugs uded from coverage as indicated in to see what is covered by your y limits may apply to covered

ated in your benefit summary. nay be able to suggest other

reason:

nat is covered.

e have received, the member does

what is covered. Prior authorization atted in your benefit summary. nay be able to suggest other

drug allowed by the plan. It is used apsules per day. This drug comes in rugs, also known as the formulary,

xyrizi was denied for these reasons:

nat is covered. Prior authorization

et. From the information we have er above. The criteria are listed

to be submitted for an approval). what is covered. Prior authorization

ated in your benefit summary. nay be able to suggest other

16221307 LEAH MELLO MD	OBSTETRICS & GYNECOLOGY	СОМВІРАТСН	ESTROGENS

16221586	CARMEN	ELENA	LANDAVERDE	MD

HEPATOLOGY/LIVER MEDICINE REZDIFFRA

EDICINE REZDIFFRA

GASTROINTESTINAL AGENTS - MISC.

K76.0, K

16221803 CLAIRE KYLANDER	NURSE PRACTITIONER	ADDYI	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	⁻ 52.0 - Hypoactive sexual d
16224332 JORDAN REYES KRIEGER MD	UROLOGY	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	
16227807 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	LURASIDONE HYDROCHLORID	ANTIPSYCHOTICS/ANTIMANIC AGENTS	

16238307 ANDRES DARIO PARDO-AGILA MD	FAMILY PRACTICE	CARVEDILOL PHOSPHATE ER	BETA BLOCKERS	betes mellitus with hyperglyce

16242738 COLL	IN MARSHALL MCKENZIE MD	OBSTETRICS & GYNECOLOGY	GEMTESA	URINARY ANTISPASMODICS	N32.81 - Overa
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		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (A (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.
n95.1	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
		 denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 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.
K74.00, R74.8	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1,2 of the exce for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
desire disorder I	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 h 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 heal suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this d 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. Fro
		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 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 me Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.
bph I	Formulary Alternatives Available	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 remeet 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 where the required and guentity limits may each to express drugs.
F41.1	Plan Limits Exceeded	may be required and quantity limits may apply to covered drugs. 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 allow 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 c 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 known as the formulary, to see what drugs are covered.
		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a normalized the conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
llycemia (HCC)	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
active bladder I	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 a) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. b) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. c) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

(Activella equivalent), jinteli tablet

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

. nted if all conditions in our

ception policy criteria. The reason

s, past treatments tried with dates

r health issue may be covered by ealth care provider may be able to drug from coverage. From the records that we have

ab, silodosin cap, or tamsulosin cap. met, we are not able to approve.

received, the member does not

what is covered. Prior authorization

wed by the plan. It is used to make) days, then 1 tablet per day for 10 ok at the list of covered drugs, also

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

or your health issue, such as

your neurin issue, such us

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

16245421	STEVEN JONATHAN DELL	MD
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OPHTHALMOLOGY

VEVYE

OPHTHALMIC AGENTS

16261716 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	AZSTARYS	ADHD/ANTI-NARCOLEPSY	
16262142 JACQUELINE ROSE KARATHRA MD	FAMILY PRACTICE	TRETINOIN	DERMATOLOGICALS	
16266320 MOLLY THOMPSON CAMPA	DERMATOLOGY	AKLIEF	DERMATOLOGICALS	

16267978 CHERYL ANN JOHNSTON PA	PHYSICIAN ASSISTANT	CLIMARA PRO	ESTROGENS	Hormone replac
16273563 JAMES COCHRAN ANDERSON IV MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	

16273720 MATTHEW A BARTOW MD FAMILY PRACTICE PROLIA ENDOCRINE AND METABOLIC AGENTS - MIS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are cyclosporine (Restasis equivalent Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
H04.123 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptionarial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 whether the drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a new type conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
F90.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
L85.8 Plan Exclusion	4) Prescription drug samples were not used to establish treatment. This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/propurpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to s 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 norther conditions in this policy have not been met. From the records that we have received, these reasons caused 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 erver (Differin equivalent) (tried) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazor Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
Acne vulgaris 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 whether the drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a new transformation on this policy have not been met. From the records that we have received, these reasons caused 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 (A (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.
placement therapy 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 no
	This drug is not on our list of covered drugs, also known as a formulary. Our coverage Determinations - Exceptions policy is used to decide if a more than the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 reasons 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.
f90.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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. Pre administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits r

not-covered drug can be approved.

nt)(TRIED), Xiidra, Miebo, Tyrvaya.

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

release (ER) (TRIED),

nted if all conditions in our ption policy criteria. The reason for

, past treatments tried with dates

roducts used for a cosmetic see what is covered by your plan.

not-covered drug can be approved.

ythromycin, tretinoin, adapalene zole/trimethoprim, cephalexin).

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

(Activella equivalent), jinteli tablet

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

release (ER), methylphenidate ER,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

rescription drugs that are m coverage as indicated in your ee what is covered by your health 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 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 provid 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 provi are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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 wh plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may
16290827 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	I40.0 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 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 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 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 abov 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 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what may be required and quantity limits may apply to covered drugs.
16292522 MATTHEW A BARTOW MD	FAMILY PRACTICE	PROLIA	ENDOCRINE AND METABOLIC AGENTS - I	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. Prese administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from con 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 plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these real plan.
					 Records did not show that another drug called plecanatide (Trulance) did not work for you. 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 and quantity limits may apply to covered drugs.
16297240 FLORENCE OLABISI FALOLA NP	NURSE PRACTITIONER	LINZESS	GASTROINTESTINAL AGENTS - MISC.	CIC 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 had 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 list 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
					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), lak 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:
16300212 ANDRES DARIO PARDO-AGILA MD	FAMILY PRACTICE	CARVEDILOL PHOSPHATE ER	BETA BLOCKERS	betes mellitus with hyperglycemia (HCC) Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 i 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 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 covera 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 provid other treatments for your health issue.

ige as stated in your benefit provider may be able to suggest

provider. Prescription drugs that I from coverage as indicated in your ee what is covered by your health may apply to covered drugs.

kyrizi was denied for these reasons:

hat is covered. Prior authorization

et. From the information we have r above. The criteria are listed here.

d to be submitted for an approval). what is covered. Prior authorization

Prescription drugs that are m coverage as indicated in your ee what is covered by your health may apply to covered drugs. se reasons:

hat is covered. Prior authorization

ve have received, the member does re listed here.

what is covered. Prior authorization not-covered drug can be approved.

२), labetalol, atenolol, metoprolol IR

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ated in your benefit summary. ay be able to suggest other

overage as stated in your benefit provider may be able to suggest

16310810 JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	INVEGA SUSTENNA	ANTIPSYCHOTICS/A

16312577 AMISA PATEL DO	FAMILY PRACTICE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	- Body	

16314793 RAISSA MIJARES BEHM FNP	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS

					Our prior authorization criteria for erenumab (AlMOVIG) have not been met. From the records that we have received, Almovig 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 lead 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) anticonvulcants (such as toniramete, codium values at c.). (b) vascastive accents (such as propreheld, atc.), 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 the 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 bar office setting.
16310810 JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F25.0 Plan Exclusion	benefit summary.
16312577 AMISA PATEL DO	FAMILY PRACTICE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	- Body mass index [BMI] 28.0-28.9, adult Plan Exclusion	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 a 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 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 lissue. Our prior autionization criteria for emitricitabine/tenorovir alarenamice (DESCOVT) nave 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 you had a severe side effect after taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada) for at least 4 weeks. 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. 5) 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.
16314793 RAISSA MIJARES BEHM FNP	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	Z72.51 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for emtricitabine/tenofovir alafenamide (DESCOVY) have not been met. From the information we hav 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
16315317 RAISSA MIJARES BEHM FNP	NURSE PRACTITIONER	DESCOVY	ANTIVIRALS	Z72.51 Criteria Not Met	 Our bit/Paulitolization on this/Pione matchability/Lenviron allatename (DESCOV 1) 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 bones got weaker while taking a drug called emtricitabine/tenofovir disoproxil fumarate (Truvada). 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 hav 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) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of a real adverse ethic classing/tenofovir disoproxil fumarate (TRUVADA). Disce criteria have not been miler and proval; OR (C) Documentation is provided of an estimated creatinine clearance between 30 and 6
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 (OIC) 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.

FERRETTS

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

ese reasons:

Aimovig will be used together with alone AND a three (3) month trial

Yes

nigraine days per month for at least ted from trying a minimum three as propropolal material atc.) or are provider. Prescription drugs that from coverage as indicated in your

by your health plan. Please look at ed drugs. overage as stated in your benefit

net. From the information we have er above. The criteria are listed

what is covered. Prior authorization . Drugs/products of this type are e what is covered by your plan.

This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are bupropion XL at a dose of 450 mg (150 mg + 300 mg 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: ADVANCED PRACTICE NURSE BUPROPION HYDROCHLORIDE ANTIDEPRESSANTS 16320105 RICHARD DOUGLAS SAMBROOK MDD Not Covered This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These 16324323 ALMA DELIA CARTER PHYSICIAN ASSISTANT UREA DERMATOLOGICALS L21.9 Not Covered 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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 16326440 BRUCE MICHAEL DOXEY MD FAMILY PRACTICE IVERMECTIN DERMATOLOGICALS L71.9 - Rosacea, unspecified Not Covered Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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 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. 16327411 KAITLIN NICOLE SISSON PA-C PHYSICIAN ASSISTANT FENOFIBRATE ANTIHYPERLIPIDEMICS E78.1 - Pure hyperglyceridemia Not Covered ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 and 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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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: 16328764 JAVIER ARMENTA PA-C NASONEX NASAL AGENTS - SYSTEMIC AND TOPICAL J30.2 Not Covered This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our PHYSICIAN ASSISTANT Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates

of trial and responses, and any other evidence to 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
16330676 AMANDA KAY WATERMAN	FAMILY PRACTICE	OPZELURA	DERMATOLOGICALS

16334941	ANABEL GRAY WINIECKI NP	ADVANCED PRACTICE NURSE	NAPROXEN DR	ANALGESICS - ANTI-INFLAMMATORY	
16339658	SHATANIEL TAYLOR NP	NURSE PRACTITIONER	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesity, u

16339960 LAURA KATE EASTEP MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS

16346662 CONNOR THOMAS HUGHES MD DERMATOLOGY OPZELURA

DERMATOLOGICALS

	Our prior authorization criteria for iremanezumab (AGOVT) have not been met. From the records that we have received, Ajovy was defined for these 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 we 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 bot Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what 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 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 a
	1) Prescribed for the prevention of migraine; AND
G43.719 Criteria Not Met	 Member has experienced a meaningful improvement in frequency and/or severity of migraine; AND 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 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) 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 Ajovy, AND (B) Member has failed at least three (3) months of individual therapy with Ajovy, Ajovy
	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 mig 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 r from ONE of the following drug classes: (i) anticonvulsant (such as topiramate, sodium valproate, etc.), OR (ii) vasoactive agent (such as proprano antichereresent (such as anticipated as topicated)
	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 wh
	Dur prior authorization criteria for ruxolitinib (UPZELUKA) drive not been met. From the records that we have received, Upzelura was denied for the
	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
	and quantity limits may apply to covered drugs.
vitiligo 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
	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 an 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 wh
	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 no
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), 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.
C 42 000 Net Coursed	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
G43.909 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	4) Prescription drug samples were not used to establish treatment.
, 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 consummary. 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 pr
•	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 no 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 or
	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.
Z79.890 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the
	reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 autnorization criteria for ruxolitiniti (OPZELUKA) nave not been met. From the records that we have received, Opzeiura was denied for the
	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 and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
L20.9 Criteria Not Met	This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the information 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 a
	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 in Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on whether the second secon
	Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on will may be required and quantity limits may apply to covered drugs.

ese reasons. will be used together with a otulinum toxin product alone. hat is covered. Prior authorization

on we have received, the member a are listed here.

he following are met: (A) Member with a botulinum toxin product (e.g.,

igraine days per month for at least a minimum three (3) month trial nolol, metoprolol, etc.), OR (iii)

what is covered. Prior authorization these reasons:

hat is covered. Prior authorization

n we have received, the member are listed here.

what is covered. Prior authorization

not-covered drug can be approved.

t), ibuprofen, diclofenac tablet,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

overage as stated in your benefit provider may be able to suggest

not-covered drug can be approved.

oral tablet, estradiol valerate

nted if all conditions in our ne exception policy criteria. The

, past treatments tried with dates

tnese reasons:

hat is covered. Prior authorization

n we have received, the member are listed here.

inhibitor. what is covered. Prior authorization

16354700 ALLEN LEE DENNIS MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID
16355864 SOROUSH BAHNAMIRI AZADI OD	OPTOMETRIST	AVENOVA	DERMATOLOGICALS

16359955	5 MICHELLE LE MARKLEY MD	FAMILY PRACTICE	XYOSTED	ANDROGENS-ANABOLIC	Z79.890 - Hormone replacement

16361619 STANLEY SUCHY WANG MD	CARDIOLOGY	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	

16363716 EDWARD LEWIS LAIN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS

16364216 RAJESH MOOLJIBHAI MEHTA	MD

GASTROENTEROLOGY

DUPIXENT

DERMATOLOGICALS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohyd 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.
G89.4 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	 Prescription drug samples were not used to establish treatment. This request has not been approved because this product was approved by the United States Food and Drug Administration (FDA) as a medical d
H01.009 Plan Exclusion	drug products that are meant to help diagnose and treat health issues. Medical devices cannot be approved and are excluded from coverage unc product may be covered under your medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is cover
	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 formula 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
	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.
	 All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone cypionate(tried), tes
	gel packet or pump 1% (Androgel equivalent), testosterone gel packet or pump 1.62% (Androgel equivalent).
	 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.
ent therapy 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet numbers 1, 2, 3 of the
	reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. Fro
	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 m
ED Formulary Alternatives Available	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 r 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 we Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the c
	 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
	and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
AD Criteria Not Met	This request has not been approved because our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the information 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 a
	1) Member has a diagnosis of moderate to severe atopic dermatitis at baseline; AND
	 Documentation with chart notes of a positive clinical response has been provided (documentation is required to be submitted for an approval) 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 whether the second s
	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the output of the drug is not being used for chronic rhinosinusitis with nasal polyps, atopic dermatitis (eczema), asthma, eosinophilic esophagitis, or prurigo
	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 wha
K29.70 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 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 criter 1) Member has a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis, Atopic Dermatitis, Asthma, Eosinophilic Esophagitis, or Prurigo Nodula
	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

not-covered drug can be approved.

ase (ER) (MS Contin equivalent), rdro ER equivalent), tramadol ER

anted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

l device. Medical devices are nonnder your pharmacy benefit. This overed by your health plan. There Ilary to see what drugs are covered

not-covered drug can be approved.

stosterone enanthate, testosterone

nted if all conditions in our

e exception policy criteria. The

, past treatments tried with dates

rom the records that we have

met, we are not able to approve.

received, the member does not

what is covered. Prior authorization

hat is covered. Prior authorization

n we have received, the member are listed here.

); AND

what is covered. Prior authorization

denial of Dupixent. o nodularis. Please note: Additional

hat is covered.

n we have received, the member teria are listed here. laris; AND

16372657 MOE HEIN AUNG MD OPHTHALMOLOGY QULIPTA MIGRAINE PRODUCTS	
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16377325 CHRISTINE ANN TREVINO DO	PEDIATRICS	QUILLIVANT XR	ADHD/ANTI-NARCOLEPSY	
16377546 SHATANIEL TAYLOR NP	NURSE PRACTITIONER	MOUNJARO	ANTIDIABETICS	E66.9 - (

16385341 DANIEL NEIL SKOGLUND MD	PSYCHIATRY	QUVIVIQ	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG

16385680 MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AC	: F51.01 - Pri
16387394 MARCO ARTURO URIBE JR MD	OBSTETRICS & GYNECOLOGY	DIVIGEL	ESTROGENS	

16388006 BILLIE KAREN MARTIN PA-C

PHYSICIAN ASSISTANT

SANTYL

DERMATOLOGICALS

fungating

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
G43.701 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 nor 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.
F90.2 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of th reason for denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
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 state 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 treatments for vour 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 no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), zalep
	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.
G47.00 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
.01 - Primary insomnia 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 or injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalent) and two-times weekly estradiol patch (Vivelle-Dot equivalent).
N95.1 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 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 p
fungating breast mass Plan Limits Exceeded	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 of 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 reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other or 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 it is the set of

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our the exception policy criteria. The

, past treatments tried with dates

ated in your benefit summary.

ay be able to suggest other not-covered drug can be approved.

plon(tried), trazodone,

nted if all conditions in our ption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

e appropriate), zaleplon(may not

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

oral tablet, estradiol valerate valent).

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

plan. It is used to make sure a drug d dose for your health issue. For the ed studies from major peer r drugs and treatments that have at is covered by your plan.

16388196 JOE HIDROGO III DO	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	
16388262 JOE HIDROGO III DO	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	
16388326 DAWN CAROLINE PEASE APN	NURSE PRACTITIONER	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MIS	
16389090 JENNEY SONEHUANG VONGPRATHOUM	FAMILY PRACTICE	ALBUTEROL SULFATE HFA	ANTIASTHMATIC AND BRONCHODILATOR A	derate persistent asthma, u
16389189 MICHAEL ANDREW MUSGROVE MD	PSYCHIATRY	RAMELTEON	HYPNOTICS/SEDATIVES/SLEEP DISORDER AC	G47.00 - Insomn
16389875 MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	TAVABOROLE	DERMATOLOGICALS	
16398083 KEN LIN FNP-C	NURSE PRACTITIONER	ΒΟΤΟΧ	NEUROMUSCULAR AGENTS	
16399138 LAURA KATE EASTEP MD	OBSTETRICS & GYNECOLOGY	ESTRADIOL	ESTROGENS	Z79.890 - Hormone replace
16400543 SHATANIEL TAYLOR NP	NURSE PRACTITIONER	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.9 - Obesit

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: G43.901 Criteria Not Met 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Migraine Not Covered Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. 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. M81.0 Plan Exclusion 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. 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 , uncomplicated Plan Limits Exceeded 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. 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 mnia, unspecified Plan Limits Exceeded 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. 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. L62.2 Formulary Alternatives Available 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. 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. G43.909 Plan Exclusion 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 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 acement therapy Not Covered Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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. esity, unspecified Plan Exclusion 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.

16401025 MEGHAN ELIZABETH HUGHES PA-C

16403613 DONALD ROBERT BRODE MD FAMILY PRACTICE

16404440 ZAYD NAJDAT NASHAAT MD

16406089 JAMES LUDWIG WISE MD

GASTROENTEROLOGY

PHYSICIAN ASSISTANT

INTERNAL MEDICINE BUDESONIDE

MAVYRET

SILDENAFIL CITRATE

CARDIOVASCULAR AGENTS - MISC.

ANORECTAL AND RELATED PRODUCTS

16407941 KYLA RENEE ASCHENBECK MD

OPHTHALMOLOGY

CEQUA

OPHTHALMIC AGENTS

eye syndrome of bilateral lacri

TRUE METRIX BLOOD GLUCOS DIAGNOSTIC PRODUCTS

ANTIVIRALS

diabetes mellitus without con

	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 approved. The conditions in our Not Covered Diabetic Glucose Meters and Supplies exception policy have not been met. From the records that we l 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 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 product
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
complications Not Covered	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 g 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 t
	Glucose Meters and Supplies exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed
	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 l 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 CG
	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 w Our prior authorization criteria for giecaprevir/pibrentasvir (MAVYREI) nave not been met. From the records that we have received, Mavyret was de 1) The drug is not prescribed by, or together with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist. These are doctors v
	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 sca
	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 i
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
HCV Criteria Not Met	This request has not been approved because our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the in
	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 at 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);
	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 genotyp
	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
	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage a
N52.9 Plan Exclusion	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 prov
	other treatments for vour health issue. Our prior authorization criteria for budesonide (UCERIS) have not been met. From the records that we have received, the following caused the denia
	 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 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 i
	and quantity limits may apply to covered drugs.
K51.90 Criteria Not Met	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 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 as
	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 verg
	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
	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-
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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) (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:
acrimal glands Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa
	, and the second s

3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

le if a not-covered product can be we have received, these reasons

eters and supplies. Quantity limits

oducts.

be granted if all conditions in our of the Not Covered Diabetic sted here.

eter has connectivity with the insulin

s CGM has a built-in blood glucose

on what is covered. Prior s denied for these reasons: ors who specialize in your health

h scarred liver tissue and your liver

nat is covered.

e information we have received,

er above. The criteria are listed here.

/al); AND

otype 3, and (B) Member has no

what is covered. Prior authorization

ige as stated in your benefit provider may be able to suggest

lenial of budesonide rectal foam. our digestive system.

nat is covered. Prior authorization

we have received, the member er above. The criteria are listed here. verge; AND

what is covered. Prior authorization

not-covered drug can be approved.

t) (TRIED), Xiidra (TRIED), Miebo,

nted if all conditions in our eption policy criteria. The reason for

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 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 auth 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, Linz 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 F 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 is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, 3 of the excreasion 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, or medical reasons have been provided why all other covered drugs cannot be tried; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has b
						with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formularv for specific information 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 provide
16417526 JAZMINE NICOLE ALANIS PA	PHYSICIAN ASSISTANT	INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	f20.9	Plan Exclusion	are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from 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
						our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drug This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
						 All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are a trial of one of the following: buprer 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:
16420305 ALLEN LEE DENNIS MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4	Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 0.19 azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua equivalent 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.
16427397 VASUDHA MANTRAVADI MD	PEDIATRICS	RYALTRIS	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.9 - Allergic rhinitis, unspecified	Not Covered	 ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-conditions in this policy have not been met. From the records that we have received, these reasons caused 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
						injection (Delestrogen equivalent), one-time weekly estradiol patch (Climara equivalent), and two-times weekly estradiol patch (Vivelle-Dot equivalen Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
16427398 TARA AUTUMN CHERRY MD	OBSTETRICS & GYNECOLOGY	CLIMARA PRO	ESTROGENS	N95.1	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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or upsafe for the member.

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

a not-covered drug can be

r authorization* e, Linzess (TRIED). t the FDA of efficacy and safety

nted if all conditions in our he exception policy criteria. The

has been completed and submitted ta.fda.gov/scripts/medwatch/. ation on what is covered. Prior provider. Prescription drugs that I from coverage as indicated in your

by your health plan. Please look at ed drugs.

not-covered drug can be approved.

uprenorphine/naloxone tablet,

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

e 0.1% (Astelin equivalent), valent), fluticasone (Flonase

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

oral tablet, estradiol valerate valent).

nted if all conditions in our eption policy criteria. The reason for

16430643	3 JEFFREY STEVEN ROSENBLOOM MD	OTOLARYNGOLOGY	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J33.1 - Polypoid sinus de
16431238	3 PATIENCE HARRIET READING MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	
16431325	5 ARPITA VIKRAMBHAI PATEL MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	t intractable, without status n
16431501	1 APRIL WEST FOX MD	SURGERY, COLON & RECTAL	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	
16432943	3 KRISTINA KAREN JULICH MD	NEUROLOGY	JORNAY PM	ADHD/ANTI-NARCOLEPSY	t hyperactivity disorder, unsp

16436298 CLAYTON WARREN ADAMS MD

ANESTHESIOLOGY

BUTALBITAL/ACETAMINOPHEN ANALGESICS - NONNARCOTIC

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 the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (RHINOC 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 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 not covered by your plan. In order for the higher quantity to be approved for the treatment of acute migraine headaches, another injectable drug 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 for authorization may be required. Quantity limits may apply to
s 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 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 nor
К64.9	Not Covered	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
specified 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 The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 re (Concerta, Metadate CD, Ritalin LA), amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent), dext Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 whe
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 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, diclofenact to 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

CORT AQUA equivalent),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

the plan. It is used to make sure a days, more than 6 fills per year is ıg, such as Aimovig, Ajovy,

vear did not work for you. Please to covered drugs.

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

C equivalent),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

release (ER), methylphenidate ER xtroamphetamine ER.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

what is covered. Prior authorization not-covered drug can be approved.

tablets, rizatriptan, sumatriptan,

nted if all conditions in our ne exception policy criteria. The

					This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-or The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 relea 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.
16438700 ANNA PATRICK LINCOLN MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	disorder, predominantly inattentive type Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to 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 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 s 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 o
16443081 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	Chloasma Criteria Not Met	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 recein 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 formulant for information on what
					 Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what Inis drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not of 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 antide 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. 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.
16449329 AMELIE GARZA NP	NURSE PRACTITIONER	VRAYLAR	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F32.A 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 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 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
16450486 KARTHIK VENKATA GARAPATI MD	GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	table bowel syndrome with constipation Criteria Not Met	 And the provided of the provided
					 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
16450547 MELANIE JOYCE FROGOZO OD	OPTOMETRIST	VEVYE	OPHTHALMIC AGENTS	eye syndrome of bilateral lacrimal glands Not Covered	1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are cyclosporine (Restasis equivalent)(TF Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here.
					 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pas of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what This request cannot be approved because this drug/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/product
16451918 KAITLIN EILEEN GASTINGER NP	NURSE PRACTITIONER	BIMATOPROST	DERMATOLOGICALS	Nonscarring hair loss, unspecified Plan Exclusion	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 Your doctor or health care provider may be able to suggest other treatments for your health issue.

release (ER), methylphenidate ER,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ons: the skin.

at is covered.

received, the member does not

what is covered. Prior authorization not-covered arug can be approved.

ntidepressant to help treat your

e, or others) /ou.

anted if all conditions in our and 5 of the Vraylar exception

ation was ineffective or not

hat is covered. Prior authorization

ve have received, the member does re listed here.

what is covered. Prior authorization not-covered drug can be approved.

nt)(TRIED), Xiidra, Miebo, Tyrvaya. .

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates what is covered. Prior authorization

/products used for a cosmetic to see what is covered by your plan.

16451997	JAMES LUDWIG WISE MD	GASTROENTEROLOGY	BUDESONIDE ER	CORTICOSTEROIDS	of small intestine withou

16457317 ANNA PATRICK LINCOLN MD	PEDIATRICS	JORNAY PM	ADHD/ANTI-NARCOLEPSY	disorder, predominantly ina
16457461 DANA MARIE GARCIA MD	FAMILY PRACTICE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	services in other specified c

16	5466746 BINACA GAGLANI MD	ALLERGY & IMMUNOLOGY	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J32.9 - Chronic sinusitis

16467009 CHRISTINE ANN TREVINO DO	PEDIATRICS	QUILLIVANT XR	ADHD/ANTI-NARCOLEPSY	
16469306 DAMIAN G LARA MD	FAMILY PRACTICE	DEXCOM G7 SENSOR	MEDICAL DEVICES	

16478488 KATHRYN CHRISTEN SIEMS PA-C

PHYSICIAN ASSISTANT

TRETINOIN

DERMATOLOGICALS

plasm of skin of unspecifie

	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 wha and quantity limits may apply to covered drugs.
complications Criteria Not Met	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 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 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 up are upable to approve coverage for this drug at this time. Please refer to our formular, for information on whe This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a normalized drugs in this policy have not been met. From the records that we have received, these reasons caused 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 re (Aptensio XR, Concerta, Metadate CD, Ritalin LA), amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equidextroamphetamine 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.
nattentive type Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 state 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 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 no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (RHINOC 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.
tis, unspecified Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
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 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
E11.9 Criteria Not Met	 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be u 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 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 have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. T 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 version.
ied part of face Criteria Not Met	authorization may be required and quantity limits may apply. Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, Tretinoin Cream 0.025% was denied 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 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 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 for Acne Agents have not been met.

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nat is covered. Prior authorization

we have received, the member

plained to the member above. The

not-covered drug can be approved.

release (ER), methylphenidate ER quivalent)(TRIED), and

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

rated in your benefit summary. hay be able to suggest other

not-covered drug can be approved. OCORT AQUA equivalent),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

inted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

using insulin before the requested that drugs are covered.

n met. From the information we The criteria are listed here.

what is covered. Prior

d for these reasons: the skin. at is covered.

received, the member does not ria are listed here.

what is covered. Prior authorization

16479561 RANI DAS MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS

16481778 MELISSA ANN FROST PA-C	PHYSICIAN ASSISTANT	ENSTILAR	DERMATOLOGICALS	
16484504 MARCO ARTURO URIBE JR MD	OBSTETRICS & GYNECOLOGY	IMVEXXY MAINTENANCE PACK	VAGINAL AND RELATED PRODUCTS	95.2 - Postmenopausal atrophic
16490036 BRANDON SHAUN ALTILLO	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	

16491170 ALINDA ROBERTA COX MD	OBSTETRICS & GYNECOLOGY	INTRAROSA	VAGINAL AND RELATED PRODUCTS

16491612 NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
G43.719 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
	 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can 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.
E85.4 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
E65.4 Not Covered	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.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND
	 Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
hic vaginitis Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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.
E66.01 Plan Exclusion	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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved.
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
N95.1 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
ED Plan Exclusion	4) Prescription drug samples were not used to establish treatment. 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 vour health issue.

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eption policy criteria. The reason for

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not-covered drug can be approved.

nted if all conditions in our

the exception policy criteria. The

, past treatments tried with dates

not-covered drug can be approved. ol cream (Estrace equivalent),

nted if all conditions in our

, past treatments tried with dates

ited in your benefit summary.

ay be able to suggest other not-covered drug can be approved.

ol cream (Estrace equivalent),

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ige as stated in your benefit provider may be able to suggest

16492272 SRIVADEE ORAVIVATTANAKUL MD	NEUROLOGY	AJOVY	MIGRAINE PRODUCTS	۱, intractable, without status migrainosus o	Criteria Not Met	 Out prior aution/zation cherta for mentalezanitab (ADOV 1) have not been met, from the records that we have received, Agory was derived for these received, agory was derived for the prevention is needed to know if this drug will be used together with a botulinum toxin product (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 Agory will be botulinum toxin product, records must show that you have had at least a three (3) month trial of Agory alone AND a three (3) month trial of a botulin. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is 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 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 criter 1) Prescribed for the prevention of migraine; AND Member has had four (4) or more migraine days per month for at least the previous three (3) months; AND A minimum three (3) month trial from ONE of the follo
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 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 provid other treatments for vour 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-control drugs 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.
16503723 RUBY NOEMI MEYER APRN	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	headache I	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 is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the excereason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-core the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
16505337 FARHEEN YOUSUF MD	ENDOCRINOLOGY, DIABETES &	& N DEXCOM G7 SENSOR	MEDICAL DEVICES	Prediabetes	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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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 provide 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-control conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

ese reasons. nths): an anticonvulsant (e.g.,

will be used together with a otulinum toxin product alone. hat is covered. Prior authorization

on we have received, the member e criteria are listed here.

(such as topiramate, sodium ND

he following are met: (A) Member with a botulinum toxin product (e.g.,

what is covered. Prior authorization

ige as stated in your benefit provider may be able to suggest

not-covered drug can be approved.

nted if all conditions in our

ne exception policy criteria. The

s, past treatments tried with dates

not-covered drug can be approved.

e pack sensors are covered),

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

age as stated in your benefit provider may be able to suggest

not-covered drug can be approved.

gality(TRIED).

nted if all conditions in our eption policy criteria. The reason for

16515212 MICHAEL ALAN FULLER MD	PSYCHIATRY	BUPROPION HYDROCHLORIDE ANTIDEPRESSANTS

SILDENAFIL CITRATE 16516327 ERNESTO AARON GONZALEZ MD FAMILY PRACTICE CARDIOVASCULAR AGENTS - MISC.

16517330 SHAWN ROBERT AGENBROAD-ELANDER NURSE PRACTITIONER TRINTELLIX ANTIDEPRESSANTS

16517980 MICHAEL ANDREW MUSGROVE MD PSYCHIATRY TRINTELLIX ANTIDEPRESSANTS

16520465 STEPHANIE BROOKE KNIGHT NP NURSE PRACTITIONER **BUPRENORPHINE HCL** ANALGESICS - OPIOID DERMATOLOGICALS 16533094 RONALD LEE COX MD ALLERGY & IMMUNOLOGY DUPIXENT K20.0 - Eosinophilic esop

		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approx The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
F31.9	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat of trial and responses, and any other evidence to 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 Pulmonary Arterial Hypertension have not been met. From the records that we have received, the following caused the denial of Sildenafil ta
		 The drug was not prescribed by, or together with, a heart or lung specialist. 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.
N52.9	Criteria Not Met	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 qua limits may apply to covered drugs.
NSE.5		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. 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.
F32.a	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meen number 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here.
		 Member has a diagnosis of Major Depressive Disorder (MDD); AND Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 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 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 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.
MDD	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meen 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 authorizat This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be appro The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial:
		 All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buprenorphine/naloxone tablet, buprenorphine/naloxone 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:
F11.20	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dat of trial and responses, and any other evidence to 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, 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.
ophagitis	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(s) 5 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here.
, agitis		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 po 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 authorizat

not-covered drug can be approved.

mg (150mg + 300mg OR three

nted if all conditions in our ption policy criteria. The reason for

, past treatments tried with dates

aused the denial of Sildenafil tablet.

e blood vessels that go from the

zation may be required and quantity

nformation we have received, the isted here.

vhat is covered. Prior authorization

ellix. work for you.

nat is covered.

ived, the member does not meet

what is covered. Prior authorization

n, fluoxetine, or paroxetine, did not

nat is covered.

ived, the member does not meet

hat is covered Prior authorization not-covered drug can be approved.

, buprenorphine/naloxone film, or

nted if all conditions in our

eption policy criteria. The reason for

Yes

, past treatments tried with dates

denial of Dupixent.

nat is covered. Prior authorization

n we have received, the member

are listed here.

equal to 15 eosinophils/high power

what is covered. Prior authorization

16538315 BRANDON SHAUN ALTILLO	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	E66.01-obesity P	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 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
16541102 MARTHA NICOLE MENEFEE NP	CLINICAL NURSE SPECIALIST	OTEZLA	TARGETED IMMUNOMODULATORS	L40.50 C	Criteria Not Met	 Your health issue. Your health issue.
						Cinco criteria base part we are upable to approve coverage for this days at this time. Place refer to any formular, for information on what is This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (adalimumal adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia, Or 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.
16541868 SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	COSENTYX UNOREADY	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris N	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 i Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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
16544438 OSCAR AARON MOLINA MD	FAMILY PRACTICE	NUZYRA	TETRACYCLINES	of right lower leg with fat layer exposed C	Criteria Not Met	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 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 i
						This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (RHINOCOR 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.
16555937 NANCY ANN DASSO NP	NURSE PRACTITIONER	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J01.00 N	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 is Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/product
16561174 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	181.1 P	Plan Exclusion	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 v 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 i
16567404 SUZANNE SINGERMAN ALBERT FNP-C	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	Migraines N	Not Covered	 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

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 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
16541102 MARTHA NICOLE MENEFEE NP	CLINICAL NURSE SPECIALIST	OTEZLA	TARGETED IMMUNOMODULATORS	L40.50) Criteria Not Met	 Your health issue. Nore 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 of 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 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 A trial of ONE (1) of the following was ineffective or not tolerated: (A) methotrexate; OR (B) sulfasalazine; OR (C) Member has contraindication to BC is specified; AND A premilast (OTEZLA) will not be used in combination with biologic therapy.
						Since criteria have not have not use the uppelle to approve coverage for this drug at this time. Place refer to our formular, for information on what is This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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- adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia, Ot 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.
16541868 SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	COSENTYX UNOREADY	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	s 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 it Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, NUZYRA was denied for this reaso 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 of
16544438 OSCAR AARON MOLINA MD	FAMILY PRACTICE	NUZYRA	TETRACYCLINES	of right lower leg with fat layer exposed	d Criteria Not Met	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 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co
						The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
16555937 NANCY ANN DASSO NP	NURSE PRACTITIONER	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J01.00) 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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/product is being used for a cosmetic purpose, such as improving your appearance. Drugs/product
16561174 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	181.1	Plan Exclusion	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 w 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
16567404 SUZANNE SINGERMAN ALBERT FNP-C	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	Migraine	s Not Covered	Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16538315 BRANDON SHAUN ALTILLO	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	E66.01-obesity	y 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 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
16541102 MARTHA NICOLE MENEFEE NP	CLINICAL NURSE SPECIALIST	OTEZLA	TARGETED IMMUNOMODULATORS	L40.5(0 Criteria Not Met	 Your health issue. Your health is drug is being used together with biologic therapy.
						 Cince criteria have not have not use an unable to approve coverage for this drug at this time. Place refer to our formular, for information on what is This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-construction on the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 adalimumab-adaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia, Ot 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.
16541868 SHWOL-HUO DANNY KIANG DO	DERMATOLOGY	COSENTYX UNOREADY	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgari	s 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 it Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, NUZYRA was denied for this reaso 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 of
16544438 OSCAR AARON MOLINA MD	FAMILY PRACTICE	NUZYRA	TETRACYCLINES	of right lower leg with fat layer exposed	d Criteria Not Met	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 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-co
						The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
16555937 NANCY ANN DASSO NP	NURSE PRACTITIONER	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J01.00	0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted it Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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	181.	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/product 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 w 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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
16567404 SUZANNE SINGERMAN ALBERT FNP-C	NURSE PRACTITIONER	NURTEC	MIGRAINE PRODUCTS	Migraine	s Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

No. 19 Control Control <th< th=""><th>16538315 BRANDON SHAUN ALTILLO</th><th>INTERNAL MEDICINE</th><th>OZEMPIC</th><th>ANTIDIABETICS</th><th>E66.01-obesity Plan Exclusion</th><th>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 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</th></th<>	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 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
No. 100, NO. 100	16541102 MARTHA NICOLE MENEFEE NP	CLINICAL NURSE SPECIALIST	OTEZLA	TARGETED IMMUNOMODULATORS	L40.50 Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is of 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 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
height har						4) Apremilast (OTEZLA) will not be used in combination with biologic therapy.
Distance Distance <th< td=""><td>16541868 SHWOL-HUO DANNY KIANG DO</td><td>DERMATOLOGY</td><td>COSENTYX UNOREADY</td><td>TARGETED IMMUNOMODULATORS</td><td>L40.0 - Psoriasis vulgaris Not Covered</td><td> This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-core The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia, Ot 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, NUZYRA was denied for this reason </td></th<>	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-core The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia, Ot 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, NUZYRA was denied for this reason
Build of the second displayed by the second displayed displayed by the second displayed displayed displ	16544438 OSCAR AARON MOLINA MD	FAMILY PRACTICE	NUZYRA	TETRACYCLINES	of right lower leg with fat layer exposed Criteria Not Met	Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is a 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 not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here.
16561174 CODY PAULINE SEEL PA PHYSICIAN ASSISTANT TRETINOIN DERMATOLOGICALS I81. Plan Exclusion 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 wor and the list of coverage betterminations - Exceptions policy is used to decide if a not-complex policy policy network policy pol	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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
Image: Note of the condition of the conduction of the conduction of the conduction of the condition of the conditin the condition of the condition of the condition of the conditio	16561174 CODY PAULINE SEEL PA	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	181.1 Plan Exclusion	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 w
	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-core the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

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not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

16583246	SARAH	MICHELLE	SEEGER	PMHNP

16585003 BROCK EVAN HARPER MD

RHEUMATOLOGY

ADVANCED PRACTICE NURSE REXULTI

BIMZELX

TARGETED IMMUNOMODULATORS

ANTIPSYCHOTICS/ANTIMANIC AGENTS

 16585199
 CHELLYANNE COLLEEN HINDS FA
 PHYSICIAN ASSISTANT
 MAVYRET
 ANTIVIRALS
 Chronic viral hep

 16586129
 MICHAEL RIE MD
 FAMILY FRACTICE
 ICOSAFENT ETHYL
 ANTIHYPERLIPIDEMICS
 E78.2 - Mixed hy

16590228 SELINA KAY CHRANE PA

PHYSICIAN ASSISTANT

UBRELVY

MIGRAINE PRODUCTS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a nortice 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.
MDD Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 5 of the Rexul
	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; AND4) 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) wh medication. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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), 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.
AS 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 gran
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptions
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 autnorization criteria for giecaprevir/piprentasvir (ΜΑΥΥΚΕΙ) nave not been met. From the records that we have received, Mavyret was 1) Records do not show a recent viral level. This must be from within the past 6 months.
	 More information is needed to know if you have taken other drugs for hepatitis C in the past. 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
atitis C(HHS) Criteria Not Met	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 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 memb here.
	 Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 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) 4) Member does NOT have decompensated cirrhosis (Child-Pugh B or C); AND 5) Member had an prior tractment with direct action antiviral (a) (DAA) for HCV AND duration of the provided to the prior tractment with direct action antiviral (a) (DAA) for HCV AND duration of the provided to the prior of the prior of the provided to the prior of th
	 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 genot 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 formulan, for information on whether the 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 approved. The conditions in our icosapent (Vascepa equivalent) exception policy have not been met. From the records that we have received, the
	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 e 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.
	limits may apply to covered drugs.
perlipidemia 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 gran
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 of the ico exception policy criteria. 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 500 must be submitted with the request; AND
	 All of the following drugs have been tried and failed: omega-3 acid ethyl ester capsule (Lovaza equivalent), one statin (e.g. rosuvastatin) (TRIED)
	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 w Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for th
	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 and quantity limits may apply to covered drugs.
Migraines 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 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 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 grup at this time. Please refer to our formulary for information on w

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

not-covered drug can be approved.

anted if all conditions in our sulti exception policy criteria for

when used with an antidepressant

not-covered drug can be approved.

), Enbrel (TRIED), Rinvoq (TRIED),

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

s denied for these reasons:

nat is covered.

ne information we have received, nber above. The criteria are listed

/al); AND

otype 3, and (B) Member has no

what is covered. Prior authorization a not-covered drug can be ne following caused the denial. I ethyl ester capsule (Lovaza

Prior authorization and quantity

nted if all conditions in our osapent (Vascepa equivalent)

00mg/dL). Recent triglyceride levels

ED), one fibrate (e.g. fenofibrate),

what is covered. Prior authorization hese reasons:

hat is covered. Prior authorization

n we have received, the member re listed here. Yes

16590407 ANNA NICOLE WENDEL FNP-C	NURSE PRACTITIONER	BUPRENORPHINE HCL	ANALGESICS - OPIOID	
16599452 DAVID EDWARD O'CONNOR MD	PSYCHIATRY	QELBREE	ADHD/ANTI-NARCOLEPSY	
16619423 MARIAH ANN SIMMS	NURSE PRACTITIONER	TRETINOIN	DERMATOLOGICALS	

16625596 SHWOL-HUO DANNY KIANG DO DERMATOLOGY

COSENTYX UNOREADY

TARGETED IMMUNOMODULATORS

16625653 EMILY LYNN RAMIREZ DO

PEDIATRICS

FYCOMPA

ANTICONVULSANTS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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: bupren 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.
G89.4 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 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.
f90.2 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 Acne Agents have not been met. From the records that we have received, tretinoin was denied for these reasor 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 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
170.8 Criteria Not Met	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 remeet 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 whe This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (adalimu adalimumab-aaty (Yuflyma equivalent), adalimumab-adaz (Hyrimoz equivalent), Hadlima, Humira, Simlandi), Enbrel, Taltz, Tremfya (TRIED), Cimzia 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.
140.0 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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 no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (TRIE Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
g40.a19 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the excep
	denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.

4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

norphine/naloxone tablet,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

ng stimulant drug (e.g.,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ons: the skin.

at is covered.

received, the member does not

what is covered. Prior authorization not-covered drug can be approved.

numab-fkjp (Hulio equivalent), zia, Otezla (TRIED), Skyrizi, and an

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

IED).

nted if all conditions in our ption policy criteria. The reason for

16634055 SABA ZABETIAN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczem	a Criteria Not Met	Our prior autonization chiena for oupliantab (DOFLEENT) have not been met. From the records that we have received, Duplicent was denied for these 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 calci 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 of 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 le 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 list 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 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 provide (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 (doc submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDEE) Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed AND 5) Dupilumab (DUPIXENT) will NOT be used in combination with
16643125 CHRISTY TAYLOR RISINGER MD	INTERNAL MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	coronary artery without angina pector	is 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 healt 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 ca 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
16646197 CHRISTY TAYLOR RISINGER MD	INTERNAL MEDICINE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	coronary artery without angina pector	is 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 healt 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 ca 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 for the suggest other treatments for your health issue.
16648430 ROSIE AUGUSTIN-WHEELER MD	FAMILY PRACTICE	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	IB	S 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 the 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induce 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., bisacody) (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 of 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. The reason for denial is explained to the member above. The criteria 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR 2) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sen (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon).
16663401 BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	LEVOCETIRIZINE DIHYDROCH	HL ANTIHISTAMINES	Allergic Rhinit	is Not Covered	 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-contract the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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-correct the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 ta 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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	C) 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 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 treatments for your health issue.
16669375 BRIAN TERRY MILLER DO	ALLERGY & IMMUNOLOGY	XOLAIR	ANTIASTHMATIC AND BRONCHODILATOR A	A: L50.	1 Plan Limits Exceeded	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 or 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 should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this 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 d formulary, to see what is covered by your plan.

16634055 SABA ZABETIAN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczem	a Criteria Not Met	 Our prior autionization criteria for suppliminab (DOPIXENT) have not been met. From the records that we have received, Dupixent was denied for these 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 calcid 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 the 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 lidoes 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 list 1) Member is 6 months of age or older; AND Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 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 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 provil (documentation is required to be submitted for an approval); AND A) Documentation that trials of TWO (2) of the following therapies were ineffective, contraindicated, or not tolerated is provided with the request (doc submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDE Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies listed AND 5)
16643125 CHRISTY TAYLOR RISINGER MD	INTERNAL MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	coronary artery without angina pectori	s 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 healt 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 can 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
16646197 CHRISTY TAYLOR RISINGER MD	INTERNAL MEDICINE	ZEPBOUND	ANTI-OBESITY/ANOREXIANTS	coronary artery without angina pectori	s 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 healt 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 can 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
16648430 ROSIE AUGUSTIN-WHEELER MD	FAMILY PRACTICE	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	ΙΒ	S 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 the 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induce 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., bisacody (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 of 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 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 crit 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 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sen (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon).
16663401 BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	LEVOCETIRIZINE DIHYDROCH	L ANTIHISTAMINES	Allergic Rhiniti	is 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-core conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
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-co The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 ta 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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	C) 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 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 treatments for your health issue.
16669375 BRIAN TERRY MILLER DO	ALLERGY & IMMUNOLOGY	XOLAIR	ANTIASTHMATIC AND BRONCHODILATOR A	A L50.	1 Plan Limits Exceeded	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 o 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 should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this 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 d formulary, to see what is covered by your plan.

16663401 BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	LEVOCETIRIZINE DIHYDROCHL ANTIHISTAMINES

16634055 SABA ZABETIAN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	L20.84-Intrinsic (allergic) eczema	Criteria Not Met	 Our prior automization criteria for oupplumate (DOFIXENT) have not been met. From the records that we have received, Duplixent was demed for these 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 calcit 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 of 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 lease 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 list 1) Member is 6 months of age or older; AND Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 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 area (ISA) is affected, and percent BSA is provided, OR (B) The BSA affected is less than 10%, but documentation of severity in sensitive areas is provid (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 (doc submitted for an approval): (A) medium to very high potency topical steroid, or (B) topical calcineurin inhibitor (e.g., tacrolimus ointment (PROTOPIC), pimecrolimus cream (ELIDE) Ultraviolet B (UVB) phototherapy, or (D) azathioprine, or (E) cyclosporine, or (F) methotrexate, or (G) mycophenolate mofetil, or (H) ALL therapies lister AND 5) Dup
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 healt 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 can 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
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 healt 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 ca 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
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 the 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induct 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., bisacody (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 of 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 I 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 1) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 3) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sen (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon).
16663401 BRUCE MICHAEL DOXEY MD	FAMILY PRACTICE	LEVOCETIRIZINE DIHYDROCHI	L ANTIHISTAMINES	Allergic Rhinitis	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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-core conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment.
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-core the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 tainjection (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 in Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past of trial and responses, and any other evidence to 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 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
16669375 BRIAN TERRY MILLER DO	ALLERGY & IMMUNOLOGY	XOLAIR	ANTIASTHMATIC AND BRONCHODILATOR	A: L50.1	Plan Limits Exceeded	treatments for your health issue. Ine 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 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 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 should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this 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 d formulary, to see what is covered by your plan.

triese reasons. l calcineurin inhibitors (such as

nat is covered. Prior authorization

n we have received, the member are listed here.

an or equal to 10% body surface provided with the request

t (documentation is required to be

ELIDEL)), or (C) Narrow band listed above are contraindicated;

what is covared Brier authorization health issue may be covered by ealth care provider may be able to drug from coverage.

r health issue may be covered by ealth care provider may be able to

drug from coverage. for these reasons: -induced constipation (OIC). These

codyl, sennosides), or PEG 3350

at is covered. Prior authorization

n we have received, the member e criteria are listed here.

osage escalation; AND yl, sennosides), or (B) PEG 3350

what is covered. Prior authorization not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

oral tablet, estradiol valerate alent).

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

ated in your benefit summary. ay be able to suggest other

e arug allowed by the plan. It is nber of 2 injections per 28 days is ed for your health issue. This or this health issue, chart notes ered drugs, also known as the

16669873 MIRANDA JO HARDEE MD	UROLOGY	GEMTESA	URINARY ANTISPASMODICS
16678468 SABA ZABETIAN MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS
16682191 KIMBERLY ANNE GUAJARDO PA-C	PHYSICIAN ASSISTANT	DICLOFENAC SODIUM	DERMATOLOGICALS

16684376 RANI DAS MD NEUROLOGY NURTEC MIGRAINE PRODUCTS

16684543 SONIA SHARON DURAIRAJ MD INTERNAL MEDICINE IMVEXXY STARTER PACK VAGINAL AND RELATED PRODUCTS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
N39.8 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. From the records that we have received, Duptxent was defined 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
AD Criteria Not Met	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.
	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.
M19.09 Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
W15.05 Citteria Not Wet	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:
Migraines Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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.
N95.8 Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

what is covered Drier authorization s denied for these reasons:

16688182	ELISABETH ANNE CLAYTON	MD

16690237 ELIZABETH YIM MPH

DERMATOLOGY

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JUBLIA

ALLERGY & IMMUNOLOGY AZELASTINE HYDROCHLORIDE NASAL AGENTS - SYSTEMIC AND TOPICAL

DERMATOLOGICALS

 16690362
 RANI DAS MD
 NEUROLOGY
 XYWAV
 PSYCHOTHERAPEUTIC AND NEUROLOGICAL

 16695126
 RICHARD DOUGLAS SAMBROOK
 ADVANCED PRACTICE NURSE
 BUPROPION HYDROCHLORIDE ANTIDEPRESSANTS

16695145 SIMONA MARIANA SCUMPIA MD

ENDOCRINOLOGY, DIABETES & N SANDOSTATIN LAR DEPOT ENDOCRINE AND METABOLIC AGENTS - MIS

16695324	RANI DAS MD	NEUROLOGY	FIORICET	ANALGESICS - NONNARCOTIC	

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 azelastine 0.15% (Astepro equivalent), olopatadine (Patanase equivalent)) used with formulary nasal steroids (budesonide (Rhinocort Aqua equiv 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.
J30.89 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Prescription drug samples were not used to establish treatment. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ciclopirox topical nail solution (P terbinafine tablet (TRIED), itraconazole capsule, and griseofulvin.
B35.1 Not Covered	Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grar
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 n The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, S 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.
G47.419 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
F33.2 Not Covered	 of trial and responses, and any other evidence to 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 r The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 n 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 grar Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
D35.2 Plan Exclusion	4) Prescription drug samples were not used to establish treatment. 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 that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are exclu 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 our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covere This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a n 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 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.
R51 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2 of the ex- for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

ne 0.1% (Astelin equivalent),

valent), fluticasone (Flonase

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

(Penlac equivalent) (TRIED),

ranted if all conditions in our ception policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

Sodium Oxybate oral solution,

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

mg (150mg + 300mg OR three

anted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

lth care provider. Prescription drugs cluded from coverage as indicated in

ed by your health plan. Please look at ered drugs. a not-covered drug can be approved.

tablets, rizatriptan, sumatriptan,

nted if all conditions in our ception policy criteria. The reason

16695333 JOSHUA PAUL MANISCALCO MD	PSYCHIATRY	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS
16695383 DAWN CAROLINE PEASE APN	NURSE PRACTITIONER	PROLIA	ENDOCRINE AND METABOLIC AGENTS - MIS

16703147 CHRISTOPHER JAMES O'CONNOR PA PHYSICIAN ASSISTANT BUPRENORPHINE HCL ANALGESICS - OPIOID

16705206 TESSA KIMBERLY NOVICK MD INTERNAL MEDICINE KERENDIA ENDOCRINE AND METABOLIC AGENTS - MIS

16706231 SERENA HON MD FAMILY PRACTICE QELBREE ADHD/ANTI-NARCOLEPSY disorder, predominantly inatten

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not 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:
F33.9 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2, 5 of the Rexul 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) whe medication.
	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. Presc administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from c benefit summary.
M81.0 Plan Exclusion	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 our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered or This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Xtampza ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent),
	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:
Z79.891 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
	denial is explained to the member above. The criteria from the policy are listed here.
	 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa
	of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	 Prescription drug samples were not used to establish treatment. Our prior authorization criteria for finerenone (KERENDIA) have not been met. From the records that we have received, Kerendia was denied for the 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 f
	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
	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
T2DM Criteria Not Met	This request has not been approved because our prior authorization criteria for finerenone (KERENDIA) have not been met. From the information w
	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
	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 contraine Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on wha
	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
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 s 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:
ttentive type Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	 All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. Records have been received showing the requested drug is medically percessary. These should include relevant medical history and lab results as
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, pa

of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

+) Prescription drug samples were not used to establish treatment

not-covered drug can be approved.

nted if all conditions in our exulti exception policy criteria for

when used with an antidepressant

rescription drugs that are m coverage as indicated in your

by your health plan. Please look at ed drugs.

not-covered drug can be approved.

ease (ER) (MS Contin equivalent), ent), tramadol ER tablet (Ultram ER

anted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

these reasons: to filter blood and remove extra

hat is covered.

n we have received, the member are listed here.

aindicated. what is covered. Prior authorization

not-covered drug can be approved.

ing stimulant drug (e.g.,

anted if all conditions in our eption policy criteria. The reason for

16710025 STEVEN KIRK FOSTER MD

GENERAL PRACTICE

TALTZ

TARGETED IMMUNOMODULATORS

16710372 HYMAN DEMARCUS THOMPSON MD FAMILY PRACTICE BUPRENORPHINE HCL ANALGESICS - OPIOID 11.21 - Opioid dependence,

16711404 RANI DAS MD NEUROLOGY XYREM PSYCHOTHERAPEUTIC AND NEUROLOGICAL

16711438JOHN KAI-LING TSAI MDGASTROENTEROLOGYMOTEGRITYGASTROINTESTINAL AGENTS - MISC.16712410GRACE WHITNEY KIMMEL MDDERMATOLOGYTRETINOINDERMATOLOGICALS

16713548 MARIAH ANN SIMMS NURSE PRACTITIONER TRETINOIN DERMATOLOGICALS

L40.9 Criteria Not Met	 Our prior autionization criteria for ixekizumab (TALT2) have not been met. From the records that we have received, raitz was defined for these received, is and the second of these received is a second of the second of
	 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 (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin. Since criteria have not been met we are upable to approve coverage for this drug at this time. Please refer to our formular, for information on whether the approve coverage for this drug at this time. Please refer to our formular, for information on whether the approve coverage for this drug at this time. Please refer to our formular, for information on whether the approve coverage for this drug at this time. Please refer to our formular, for information on whether the approve coverage for this drug at this time. Please refer to our formular, for information on whether the approve coverage for this drug at this time. Please refer to our formular, for information on whether the approve coverage for this drug at this time. Please refer to our formular, for information on whether the approve coverage drug at this time. Please refer to our formular, for information on whether the approve coverage drug at this time.
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Subuprenorphine/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.
in remission 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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 ne The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, So 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.
G47.419 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 gran Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 autionization chemical for processing (MOLEGERTY) maye not been met, from the records that we have received, inforeignty was demed
	 This drug is not being used for chronic idiopathic constipation. This is a health issue with ongoing constipation that has no known cause. 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 another drugs.
K59.00 Criteria Not Met	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 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 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 will may be required and quantity limits may apply to coverage for this drug at this time. Please refer to our formulary for information on will may be required and quantity limits may apply to coverage for this drug at this time. Please refer to our formulary for information on will may be required and quantity limits may apply to coverage for this drug at this time. Please refer to our formulary for information on will may be required and quantity limits may apply to coverage for this drug at this time. Please refer to our formulary for information on will may be required and quantity limits may apply to coverage for this drug at this time. Please refer to our formulary for information on will may be required and quantity limits may apply to coverage for this drug at this time. Please refer to our formulary for information on will be the provide the drug of the plane.
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/propurpose 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 Your doctor or health care provider may be able to suggest other treatments for your health issue. Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin cream was denied for these 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 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
L70.8 Criteria Not Met	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 no meet number 1 of our prior authorization criteria for tretinoin cream. The reason for denial is explained to the member above. The criteria are liste 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

asons.

r health issue is impacting your day-

cales on the palms of the hands and

ek, OR (C) acitretin. hat is covered. Prior authorization

e have received, the member does re listed here.

vere plaque psoriasis (PP) (greater

of 15 sessions of phototherapy; OR field. NOTE: A contraindication or

what is covered Brier authorization not-covered drug can be approved.

Suboxone Film),

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

Sodium Oxybate oral solution,

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

a for these reasons.

nat is covered. Prior authorization

ation we have received, the ove. The criteria are listed here.

what is covered. Prior authorization

roducts used for a cosmetic see what is covered by your plan.

e reasons: the skin. at is covered.

received, the member does not ted here.

	16737765 JOHN COOPER HALL MD INTERNAL MEDICINE STEGLATRO ANTIDIABETICS diabetes mellitus witho
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16742209 QUAN TRAN DANG MD	INTERNAL MEDICINE	OXYCONTIN	ANALGESICS - OPIOID	eoplasm of overlapping si

16745378 ANDREW CHRISTIAN PELPHREY MD	NEPHROLOGY/RENAL MEDICINE	DAPAGLIFLOZIN PROPANEDIO	ANTIDIABETICS	

16750047 YUE DENG MD	INTERNAL MEDICINE	JUBLIA	DERMATOLOGICALS

16752799 EMMANUEL CHUKWUKELO EDOKA MD	GERIATRIC MEDICINE	LEVOCETIRIZINE DIHYDROCH	L ANTIHISTAMINES	
16753780 LISA M BOURBEAU DO	OBSTETRICS & GYNECOLOGY	ANNOVERA	CONTRACEPTIVES	
16753836 ALBERTO GLENDALYZ MD	GERIATRIC MEDICINE	OZEMPIC	ANTIDIABETICS	

16753886 JOE HIDROGO III DO

NEUROLOGY

NURTEC

MIGRAINE PRODUCTS

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a nor The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Jardian Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER:
out complications Not Covered	 This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, polytical and responses, and any other evidence to 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 wh This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Xtampza ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER equivalent), tramadol ER 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.
g sites of pancreas 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 coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, polytical and responses, and any other evidence to 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 no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 nam Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
CKD IV 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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, polytical and responses, and any other evidence to 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 no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Pe 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.
B35.1 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. Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, poly of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
T78.40XA Not Covered	4) Prescription drug samples were not used to establish treatment. 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 other drugs include loratadine, fexofenadine, cetirizine, levocetirizine, and others. Please note these other drugs are not covered by your prescription the formulary for specific information on what is covered. 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
Z30.018 Plan Limits Exceeded	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 p
E66.01 Plan Exclusion	covered drugs, also known as our formulary, to see what is covered. This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as state 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
migraine Not Covered	treatments for vour 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 no The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, p of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

not-covered drug can be approved.

ance or Synjardy (XR).

nted if all conditions in our eption policy criteria. The reason for

past treatments tried with dates

.

what is covered. Prior authorization not-covered drug can be approved.

ase (ER) (MS Contin equivalent), R tablet (Ultram ER equivalent),

nted if all conditions in our eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

ime only).

nted if all conditions in our

ption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved. Penlac equivalent), terbinafine

. nted if all conditions in our eption policy criteria. The reason for

ts, past treatments tried with dates

DTC) without a prescription. These ption drug benefit. Please refer to

the plan. It is used to make sure a ur plan. Please look at the list of

ated in your benefit summary. ay be able to suggest other not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

16753900 JEFFREY NORMAN HIGGINBOTHAM MD	ANESTHESIOLOGY	BUPRENORPHINE HCL	ANALGESICS - OPIOID

16756081 LEIGHA ANA SHARP MD	DERMATOLOGY	COSENTYX UNOREADY	TARGETED IMMUNOMODULATORS

16761004 BRAD ERIC VENGHAUS MD	INTERNAL MEDICINE	NURTEC	MIGRAINE PRODUCTS	

16763369 EMMY JO GALVAN FNP-C	NURSE PRACTITIONER	DEXCOM G7 SENSOR	MEDICAL DEVICES	e 2 diabetes mellitus v

16766841	KATHARINE HOPE JONES ARNP	NURSE PRACTITIONER	AIRSUPRA	ANTIASTHMATIC AND BRONCHODILATOR A	
16766931	SYLVIA GARCIA-BEACH MD	FAMILY PRACTICE	OZEMPIC	ANTIDIABETICS	

		This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a normalized to covered drugs in this policy have not been met. From the records that we have received, these reasons caused 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/naloxor 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.
F11.20	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception denial is completed to the member above. The criteria from the policy are listed have
		 denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 the conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (adalimut 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:
173.2	Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here.
		 The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 northe conditions in this policy have not been met. From the records that we have received, these reasons caused 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.
G43.909	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
		3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to 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 Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be u 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.
s with hyperglycemia	Criteria Not Met	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 whe
s with hypergiveening		This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. T 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 v
		authorization may be required and quantity limits may apply. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Pro 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.
J45.20	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 grant Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exceptional is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
		 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
Z68.41	Plan Exclusion	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 stat. 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
		treatments for your health issue.

one tablet, buprenorphine/naloxone

nted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

mumab-adaz (Hyrimoz equivalent),

nted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our

eption policy criteria. The reason for

, past treatments tried with dates

using insulin before the requested

vhat drugs are covered.

n met. From the information we The criteria are listed here.

n what is covered. Prior

not-covered drug can be approved.

roventil equivalent) or Ventolin HFA

nted if all conditions in our

eption policy criteria. The reason for

s, past treatments tried with dates

ated in your benefit summary.

ay be able to suggest other

16772233 BRIAN TERRY MILLER DO	ALLERGY & IMMUNOLOGY	MOMETASONE FUROATE	NASAL AGENTS - SYSTEMIC AND TOPICAL	
16775467 SCOTT ADAM BORUCHOW MD	NEUROLOGY	QULIPTA	MIGRAINE PRODUCTS	t intractable, without status n
16781891 KATHARINE HOPE JONES ARNP	NURSE PRACTITIONER	AIRSUPRA	ANTIASTHMATIC AND BRONCHODILATOR A	Mild intermittent asthma, unc

	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 equ
	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:
j30.2 Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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:
s migrainosus Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
s migramosus not covered	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results,
	of trial and responses, and any other evidence to 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
	The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Pro
	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:
ncomplicated Not Covered	This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be grant
	Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the except
	denial is explained to the member above. The criteria from the policy are listed here.
	1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA).
	2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried.
	3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, j
	of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member.
	4) Prescription drug samples were not used to establish treatment.

uivalent), fluticasone (Flonase

nted if all conditions in our eption policy criteria. The reason for

, past treatments tried with dates

not-covered drug can be approved.

nted if all conditions in our eption policy criteria. The reason for

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past treatments tried with dates

not-covered drug can be approved.

roventil equivalent) or Ventolin HFA

nted if all conditions in our

eption policy criteria. The reason for