Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Denial Reason	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
14532743	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	NOVOLOG FLEXPEN	ANTIDIABETICS	e 1 diabetes mellitus with hyperglycemia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: Lyumjev or Insulin Lispro (Humalog/Admelog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization		
14535241	ROBERT SCOTT HUGHES MD	OBSTETRICS & GYNECOLOGY	ORILISSA	ENDOCRINE AND METABOLIC AGENTS - MIS	R10.2 - Pelvic and perineal pain	Criteria Not Met	Our prior authorization criteria for Orilissa have not been met. From the records that we have received, Orilissa was denied for these reasons: 1) The drug is not prescribed for pain associated with endometriosis. This is a health issue where tissue that normally grows in the uterus goes into other areas of the body such as the ovaries and fallopian tubes. 2) More information is needed to show you do not have osteoporosis. This is a health issue where bones become weak and brittle. 3) A hormonal contraceptive has not been tried and failed. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Orilissa 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 Orilissa. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of ONE (1) of the following: Endometriosis OR Cyclic pelvic pain suspected to be related to endometriosis; AND 2) Prescribed by, or in consultation with, an OB/GYN or other women's health/reproductive specialist; AND 3) Member does NOT have known osteoporosis; AND 4) Trials of BOTH of the following classes of medications were ineffective, contraindicated, or not tolerated: (A) Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), AND (B) a hormonal contraceptive.		
14540546	TESSA KIMBERLY NOVICK MD	INTERNAL MEDICINE	KERENDIA	ENDOCRINE AND METABOLIC AGENTS - MIS	itus with diabetic chronic kidney disease	Criteria Not Met	Our prior authorization criteria for finerenone (Kerendia) have not been met. From the records that we have received, Kerendia was denied for these reasons: 1) Records did not show that you have tried another drug called Farxiga. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for finerenone (Kerendia) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Kerendia. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of BOTH Type 2 Diabetes AND Chronic Kidney Disease (CKD); AND 2) A trial of dapagliflozin (Farxiga) was not tolerated or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
14544040	SCOTT DOUGLAS KELLY MD	OPHTHALMOLOGY	RESTASIS	OPHTHALMIC AGENTS	keratoconjunctivitis sicca	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The generic version of this drug, called cyclosporine, has not been tried and failed. 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior		
14564355	SASWATI CHAUDHURY MD	FAMILY PRACTICE	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.00 - Constipation, unspecified	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC) (a health issue of ongoing constipation without a known cause), or for irritable bowel syndrome with constipation (IBS-C) (a health issue with stomach pain and bloating associated with constipation). 2) Records did not show that another drug called plecanatide (Trulance) did not work for you. 3) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 1, 3, and (4 or 5) 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		

14595417	VEENA AJIT PATEL MD	RHEUMATOLOGY	ACTEMRA ACTPEN	TARGETED IMMUNOMODULATORS	ntiated connective tissue disease M35.9	Criteria Not Met	Our prior authorization criteria for tocilizumab SC (ACTEMRA SC) have not been met. From the records that we have received, Actemra SC was denied for these reasons: 1) Records did not show that an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization may be required. Quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for tocilizumab SC (ACTEMRA 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 Actemra SC. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) A trial of an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) was ineffective, not tolerated, or contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14600873	ROBERT JOHN KOVAL JR MD	INTERNAL MEDICINE	CIMZIA	TARGETED IMMUNOMODULATORS	RA	Criteria Not Met	Our prior authorization criteria for certolizumab pegol (CIMZIA) have not been met. From the records that we have received, Cimzia was denied for these reasons: 1) Records did not show at least TWO (2) of the following drugs did not work for you: an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA), Enbrel, Rinvoq, Xeljanz. 2) Records did not show that BOTH an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) AND Actemra did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for certolizumab pegol (CIMZIA) have not been met. From the information we have received, the member does not meet number(s) 3, 4, or 5 of our prior authorization criteria for Cimzia. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) Trials of TWO (2) of the following were ineffective or not tolerated: (A) an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA), (B) etanercept (ENBREL), (C) upadacitinib (RINVOQ), (D) tofacitinib (XELJANZ/XELJANZ XR); OR 4) Trials of BOTH an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) AND tocilizumab (ACTEMRA) were ineffective or not tolerated; OR 5) ALL untried alternatives are contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14604096	STEPHANIE WOTTRICH MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	G43.111	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Aimovig (TRIED), Ajovy, and Emgality . Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14607737	PADMA PAGADI REDDY MD	FAMILY PRACTICE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	None	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) We did not receive records from your doctor showing what health issue this drug is being used to treat. We tried to reach your doctor for those records. We did not get a reply. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin lispro/Humalog or Lyumjev. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(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 drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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
14610182	SUSAN KATHLEEN DUBOIS MD	ENDOCRINOLOGY, DIABETES & M	VYVANSE	ADHD/ANTI-NARCOLEPSY	t hyperactivity disorder, unspecified type	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show the generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1,2,3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior

14627405	JUDY LU KIM MD	FAMILY PRACTICE	ENBREL	TARGETED IMMUNOMODULATORS	L40.9	Criteria Not Met	Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reasons: 1) 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. 3) Chart notes were not sent to us to show your response to this drug. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for etanercept (ENBREL) have not been met. From the information we have received, the member does not meet number(s) 1, 2 and 3 of our prior authorization criteria for Enbrel for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14638442	VEENA AJIT PATEL MD	RHEUMATOLOGY	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES	-	Criteria Not Met	Our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta SC was denied for these reasons: 1) Records showing your health issue has been stable or has improved on Benlysta. 2) More information is needed to show you do not have severe active central nervous system (CNS) lupus. This is when your health issue is active in your brain and spinal cord. 3) More information is needed to show that Benlysta will not be taken together with another biologic drug for your health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the information we have received, the member does not meet number(s) 3, 4 and 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) Prescribed by, or in consultation with, a Rheumatologist or Dermatologist; AND 2) Prescribed for the treatment of active, autoantibody-positive, systemic lupus erythematosus (SLE); AND 3) Documentation of disease stabilization or improvement on belimumab (BENLYSTA) is provided with the request (documentation is required to be submitted for an approval); AND 4) Member does NOT have severe active central nervous system (CNS) lupus; AND 5) Medication will NOT be given in combination with other biologics. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14655254	VEENA AJIT PATEL MD	RHEUMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	M35.9	Criteria Not Met	Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these reasons:) Records did not show that at least one of the following drugs did not work for you: an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) or Enbrel. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) A trial of ONE (1) of the following was ineffective or not tolerated: (A) an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB -FKJP, HADLIMA, HUMIRA); OR (B) etanercept (ENBREL); OR (C) All untried alternatives are contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14685812	JUDY LU KIM MD	FAMILY PRACTICE	ENBREL	TARGETED IMMUNOMODULATORS	L40.9	Criteria Not Met	Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reasons: 1) The drug is not prescribed by a Dermatologist. This is a doctor that works with health problems in the skin, hair, and nails. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for etanercept (ENBREL) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Enbrel for Plaque Psoriasis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required to be submitted for an approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
14702980	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	NOVOLOG FLEXPEN	ANTIDIABETICS	us with diabetic neuropathy, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: Lyumjev OR Insulin Lispro (Humalog/Admelog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization

14703585	IKECHUKWU JOHN OBIH MD	NEUROLOGY	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	G43.009	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) 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 (TRIED), naproxen, diclofenac tablet, rizatriptan (our records show paid claims), sumatriptan, naratriptan, Reyvow, Ubrelvy, and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14703735	VEENA AJIT PATEL MD	RHEUMATOLOGY	RINVOQ	TARGETED IMMUNOMODULATORS	M06.00	Criteria Not Met	Our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the records that we have received, Rinvoq was denied for these reasons: 1) Records did not show that at least one of the following drugs did not work for you: an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, HUMIRA) or Enbrel. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for upadacitinib (RINVOQ) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Rinvoq. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of Rheumatoid Arthritis (RA); AND 3) A trial of ONE (1) of the following was ineffective or not tolerated: (A) an adalimumab product (ADALIMUMAB-ADAZ, ADALIMUMAB -FKJP, HADLIMA, HUMIRA); OR (B) etanercept (ENBREL); OR (C) All untried alternatives are contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14710113	REEMA SUJIT SHAH DO	INTERNAL MEDICINE	NOVOLOG FLEXPEN	ANTIDIABETICS	e 2 diabetes mellitus with hyperglycemia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: Lyumjev OR Insulin Lispro (Humalog/Admelog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
14712938	DEVON JACK BRANVOLD MD	INTERNAL MEDICINE	FREESTYLE LIBRE 3/SENSOR/	MEDICAL DEVICES	E11.65	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Freestyle Libre 3 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
14713879	REBECCA LOIS NEKOLAICHUK	INTERNAL MEDICINE	INVOKAMET	ANTIDIABETICS	E11.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Xigduo XR (dapagliflozin/metformin) and Synjardy XR (empagliflozin/metformin). . Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14729014	FEBA THOMAS	FAMILY PRACTICE	SEVELAMER HYDROCHLORIDE	GASTROINTESTINAL AGENTS - MISC.	N18.4 CKD Stage 4	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic kidney disease not on dialysis and does not have high levels of phosphorus. 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.

14738631	DIANA CAROLYN COOK MD	FAMILY PRACTICE	SEVELAMER HYDROCHLORIDE	GASTROINTESTINAL AGENTS - MISC.	N18.6	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lanthanum (Fosrenol equivalent), calcium acetate. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14742777	BOONE WILDER GOODGAME MD	ONCOLOGY, MEDICAL	LYNPARZA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	C09.9	Criteria Not Met	Our prior authorization criteria for olaparib (LYNPARZA) have not been met. From the records that we have received, Lynparza was denied for these reasons. 1) This drug is not being used for specific types of ovarian, fallopian tube, primary peritoneal, breast, pancreatic or prostate cancer. Additional criteria apply for each covered health issue. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. Note: Please consider joining a clinical trial if possible and appropriate. You may also contact https://www.fda.gov/about-fda/oncology-center-excellence/project-facilitate for help in appealing to the drug maker for compassionate use. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for olaparib (LYNPARZA) have not been met. From the information we have received, the member does not meet number 1, 2, 3, 4, 5, 6 and 7 of our prior authorization criteria for Lynparza. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of BRCA-mutated advanced ovarian cancer; OR 2) Member is an adult with a diagnosis of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer; OR 3) Member is an adult with a diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer; OR 4) Member has a diagnosis of deleterious or suspected deleterious germline BRCA-mutated, human epidermal growth factor receptor 2 (HER2)-negative breast cancer; OR 5) Prescribed for maintenance treatment of metastatic pancreatic adenocarcinoma; OR 6) Member has a diagnosis of metastatic castration-resistant prostate cancer (mCRPC); AND 7) Additional criteria for covered diagnosis are met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14761111	JUHI HITENDRA BHATT	PHYSICIAN ASSISTANT	NOVOLOG FLEXPEN	ANTIDIABETICS	E11.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Humalog OR Insulin Lispro (Humalog) (NDCs: 00002773701, 66733077301). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14768785	FEBA THOMAS	FAMILY PRACTICE	SEVELAMER HYDROCHLORIDE	GASTROINTESTINAL AGENTS - MISC.	N18.4 CKD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic kidney disease not on dialysis and does not have high levels of phosphorus. 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.
14773601	FARHEEN YOUSUF MD	ENDOCRINOLOGY, DIABETES & N	NOVOLOG FLEXPEN	ANTIDIABETICS	betes mellitus with hyperglycemia (HCC)	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog/Admelog equivalent).. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization

14776056	STEVEN CURTIS CROW MD	FAMILY PRACTICE	TRETINOIN	DERMATOLOGICALS	Dermatitis, unspecified	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, Tretinoin cream was denied for these reasons: 1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. These are health issues of the skin. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Acne Agents have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Tretinoin cream. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of acne vulgaris, acne rosacea, or actinic keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
14776158	DIANA MP STOUT FNP	NURSE PRACTITIONER	INSULIN ASPART FLEXPEN	ANTIDIABETICS	betic retinopathy w macular edema(HHS)	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin lispro (Humalog equivalent), Humalog, or Lyumjev. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 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
14799737	BOONE WILDER GOODGAME MD	ONCOLOGY, MEDICAL	TAGRISSO	ANTINEOPLASTICS AND ADJUNCTIVE THERA	C34.90	Criteria Not Met	Our prior authorization criteria for osimertinib (TAGRISSO) have not been met. From the records that we have received, Tagrisso was denied for these reasons: 1) Records did not show that you are being monitored, have remained stable, and that you should keep taking the 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 osimertinib (TAGRISSO) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Tagrisso. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is being monitored, has NOT experienced disease progression, and it is appropriate to continue therapy with osimertinib (TAGRISSO); AND 2) Medication will NOT be used as adjuvant therapy; OR 3) Medication prescribed for adjuvant therapy and will not be used for more than a maximum of 3 years. Since criteria have not been met, we are unable to approve coverage for this drug at this 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.
14802447	JUHI HITENDRA BHATT	PHYSICIAN ASSISTANT	NOVOLOG FLEXPEN	ANTIDIABETICS	dx E11.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Humalog 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 if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14811787	ELIZABETH CABRERA MD	DERMATOLOGY	AMZEEQ	DERMATOLOGICALS	L70.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin or erythromycin, tretinoin (TRIED), adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, sulfamethoxazole/trimethoprim, cephalexin). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
14815117	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	NOVOLOG	ANTIDIABETICS	E11.65 Type 2 diabetes mellitus	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, insulin lispro. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

14821255	BOONE WILDER GOODGAME MD	ONCOLOGY, MEDICAL	LYNPARZA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	C61	Criteria Not Met	Our prior authorization criteria for olaparib (LYNPARZA) have not been met. From the records that we have received, Lynparza was denied for these reasons: 1)Documentation showing the presence of a deleterious or suspected deleterious BRCA mutation was not received. 2) Records do not show that this drug will be used together with other drugs called abiraterone and either prednisone or prednisolone. Since the criteria have not been met, 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 olaparib (LYNPARZA) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Lynparza. 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 castration-resistant prostate cancer (mCRPC); AND 3) Member had disease progression following prior treatment with an androgen-directed therapy (abiraterone (ZYTIGA) or enzalutamide (XTANDI)), AND Documentation of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutation is provided with the request (documentation is required to be submitted for an approval); OR 4) Member has not had prior antiandrogen therapy (abiraterone or enzalutamide), AND Documentation of deleterious or suspected deleterious BRCA-mutation is provided with the request (documentation is required to be submitted for an approval), AND this drug will be used in combination with abiraterone and prednisone or prednisolone. Since criteria have not been met, we are unable to approve coverage for this drug at this 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.
14822054	FRANCISCA ADA IFESINACHUKWU MD	PSYCHIATRY	CEREFOLIN	DIETARY PRODUCTS/DIETARY MANAGEMEN	E55.9	Plan Exclusion	This request cannot be approved because this drug/product is in a class of drugs/products called Dietary Supplement. 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.
14826002	SHANTISONY POTUREDDY NAGAVARAPU	INTERNAL MEDICINE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	DM2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Humalog (vials may not be covered), Inuslin Lispro, or Lyumjev. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 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
14833201	RAJESH ANAND SHETTY MD	PULMONARY DISEASE	OFEV	RESPIRATORY AGENTS - MISC.	J84.9	Criteria Not Met	Our prior authorization criteria for nintedanib (OFEV) have not been met. From the records that we have received, Ofev was denied for these reasons: 1) Records did not show that your health issue is getting worse, or progressive. 2) More information is needed to know about the specific testing that was done to confirm your health issue. 3) Records did not show that your breathing problems have gotten worse. 4) Records did not show that changes have been seen on a chest X-Ray or CT scan. 5) Records did not show that one of the following drugs did not work for you: azathioprine, cyclosporine, mycophenolate mofetil, oral corticosteroids (e.g. more than 20mg of prednisone per day), cyclophosphamide, OR rituximab, OR tacrolimus. Prior authorization may be required and quantity limits may apply. 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 nintedanib (OFEV) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for Ofev for Chronic Fibrosing Interstitial Lung Disease. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Pulmonologist; AND 2) Member has a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype; AND 3) Disease is progressive, as defined by two (2) of the following occurring within the past 12 months with no alternative explanation: (A) Worsening respiratory symptoms, or (B) Absolute decline in forced vital capacity (FVC) of greater than or equal to 5% predicted within one (1) year of follow-up, and FVC values and dates are provided, or (C) Absolute decline in diffusing capacity for carbon monoxide (DLCO) (corrected for hemoglobin) of greater than or equal to 10% predicted within one (1) year of follow-up, and DLCO values and dates are provided, or (D) Radiological evidence of disease progression, as evidenced by at least one (1) of the following is provided with the request (documentation is required to be submitted for an approval: increased extent or severity of traction bronchiectasis and bronchiolectasis or new ground-glass opacity with traction bronchiectasis or new fine reticulation or increased extent or increased coarseness of reticular abnormality, or new or increased honeycombing, or increase lobar volume loss. 4) Progression occurred despite treatment with at least one (1) of the following: (A) azathioprine, (B) cyclophosphamide, (C) cyclosporine, (D) mycophenolate mofetil, (E) oral corticosteroids equivalent to prednisone dose of greater than (>) 20 mg per day, (F) rituximab, OR (H) tacrolimus.
14838631	DIANA REYES PA-C	PHYSICIAN ASSISTANT	BIMZELX	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Enbrel (TRIED), an adalimumab product (i.e. Adalimumab-adaz, Adalimumab-fkjp, Hadlima or Humira), Taltz, Tremfya, Cimzia, Otezla Skyrizi, Stelara. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

14847813	EMILY JEAN MOORE NP	ADVANCED PRACTICE NURSE	AUSTEDO XR PATIENT TITRAT	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	dx G24.01	Criteria Not Met	Our prior authorization criteria for deutetrabenazine (AUSTEDO, AUSTEDO XR) have not been met. From the records that we have received, Austedo (XR) was denied for these reasons: 1) Records did not show that your health issue is causing functional disability for you. More information is needed to show how your health issue is impacting you. 2) Records did not show that you have not responded to a change in medications or that you are unable to change your current medication which is causing tardive dyskinesia. This is a health issue that causes uncontrolled, stiff, jerky movements. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for deutetrabenazine (AUSTEDO, AUSTEDO XR) have not been met. From the information we have received, the member does not meet number(s) 3,4 of our prior authorization criteria for Austedo (XR). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with a Psychiatrist or Neurologist; AND 2) Member has a diagnosis of tardive dyskinesia; AND 3) Member has a functional disability due to tardive dyskinesia; AND 4) Member has failed to respond to a change or is unable to switch current antidopaminergic therapy.
14864086	EMILY JEAN MOORE NP	ADVANCED PRACTICE NURSE	AUSTEDO XR PATIENT TITRAT	PSYCHOTHERAPEUTIC AND NEUROLOGICAL	tardive dyskinesia	Criteria Not Met	Our prior authorization criteria for deutetrabenazine (AUSTEDO, AUSTEDO XR) have not been met. From the records that we have received, Austedo (XR) was denied for these reasons: 1) Records did not show that your health issue is causing functional disability for you. More information is needed to show how your health issue is impacting you. 2) Records did not show that you have not responded to a change in medications or that you are unable to change your current medication which is causing tardive dyskinesia. This is a health issue that causes uncontrolled, stiff, jerky movements. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for deutetrabenazine (AUSTEDO, AUSTEDO XR) have not been met. From the information we have received, the member does not meet number(s) 3, 4 of our prior authorization criteria for Austedo (XR). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with a Psychiatrist or Neurologist; AND 2) Member has a diagnosis of tardive dyskinesia; AND 3) Member has a functional disability due to tardive dyskinesia; AND 4) Member has failed to respond to a change or is unable to switch current antidopaminergic therapy.
14877211	SIMONA MARIANA SCUMPIA MD	ENDOCRINOLOGY, DIABETES & M	NOVOLOG	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog/Admelog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
14895810	KATHRYN CHRISTEN SIEMS PA-C	PHYSICIAN ASSISTANT	TRETINOIN	DERMATOLOGICALS	ders of the skin and subcutaneous tissue	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
14911860	KRISTY MICHELLE MARKELL PA	PHYSICIAN ASSISTANT	DICLOFENAC EPOLAMINE	DERMATOLOGICALS	M47.816	Plan Exclusion	The requested amount of diclofenac 1.3% patches 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 diclofenac 1.3% patches at 30 patches per fill for this use. The higher amount of 60 patches per fill is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.
14960716	SHAWN MARIE KRAUS NP	NURSE PRACTITIONER	ZTLIDO	DERMATOLOGICALS	b02.29	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lidocaine ointment, lidocaine patch, gabapentin, amitriptyline, nortriptyline, pregabalin. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14964896	ANOKHI JAMBUSARIA-PAHLAJANI MD	DERMATOLOGY	UREA	DERMATOLOGICALS	pecified congenital malformations of skin	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include ¿urea cream, lotion, gel, ointment, emulsion, and suspension at strengths up to 40%. 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.

14967074	MARY JANE WARREN APN	ADVANCED PRACTICE NURSE	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG	insomnia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ramelteon, zolpidem (TRIED), zaleplon, trazodone, eszopiclone (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14971815	THERESE MARIE VIDAL MD	INTERNAL MEDICINE	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR A	j43.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Incruse Ellipta, Anoro Ellipta, Stiolto Respimat. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
14982414	AMAYRANY MAYA-MORA NP	NURSE PRACTITIONER	NOVOLOG FLEXPEN	ANTIDIABETICS	e11.65-type 2 DM	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15017622	JAY LANCE GREGSTON MD	EMERGENCY MEDICINE	AZSTARYS	ADHD/ANTI-NARCOLEPSY	f90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent), lisdexamfetamine (Vyvanse equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15017729	ALYSON DANELLE GARCIA MD	OBSTETRICS & GYNECOLOGY	UBRELVY	MIGRAINE PRODUCTS	g43.819	Criteria Not Met	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for these reasons: 1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan, rizatriptan, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply. 2) Two triptan medications (e.g. sumatriptan, rizatriptan(TRIED), or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second triptan was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15050799	MICHAEL MARSHALL MITCHELL DO	PEDIATRICS	VENCLEXTA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	c91.02	Criteria Not Met	Our prior authorization criteria for venetoclax (VENCLEXTA) have not been met. From the records that we have received, Venclexta was denied for these reasons: 1) The drug is not being used for Chronic Lymphocytic Leukemia (CLL), Small Lymphocytic Lymphoma (SLL), or Acute Myeloid Leukemia (AML). CLL and AML are different types of cancer that affect the bone marrow, and SLL is a type of cancer that affects the body's germ-fighting system. NOTE: Additional criteria apply for each covered health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 venetoclax (VENCLEXTA) have not been met. From the information we have received, the member does not meet numbers 1 and 2 of our prior authorization criteria for Venclexta. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Lymphocytic Leukemia (CLL), Small Lymphocytic Lymphoma (SLL), or Acute Myeloid Leukemia (AML); AND 2) Additional criteria for covered health issue 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.	Yes
15051600	OM NARAYAN PANDEY MD	INTERNAL MEDICINE	LYNPARZA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	ecified site of unspecified female breast	Criteria Not Met	Our prior authorization criteria for olaparib (LYNPARZA) have not been met. From the records that we have received, Lynparza was denied for these reasons: 1) Records showing presence of a deleterious or suspected deleterious germline BRCA mutation 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for olaparib (LYNPARZA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Lynparza. 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 deleterious or suspected deleterious germline BRCA-mutated, human epidermal growth factor receptor 2 (HER2)-negative breast cancer; AND 3) Documentation of a deleterious or suspected deleterious germline BRCA mutation is provided with the request (documentation is required to be submitted for an approval); AND 4) Lynparza is being used for high risk early-stage breast cancer, with previous neoadjuvant or adjuvant chemotherapy treatment; OR 5) Lynparza is being used for metastatic breast cancer, with previous neoadjuvant, adjuvant, or metastatic chemotherapy treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15052277	JORDAN DAVID HARTMAN MD	FAMILY PRACTICE	DEXCOM G7 SENSOR	MEDICAL DEVICES	betes mellitus with hyperglycemia (HCC)	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Dexcom G7 Sensor(08627007701), DEXCOM G6, FREESTYLE LIBRE 2, FREESTYLE LIBRE 3. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
15059694	AMAYRANY MAYA-MORA NP	NURSE PRACTITIONER	NOVOLOG FLEXPEN	ANTIDIABETICS	diabetes mellitus w hyperglycemia(HHS)	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro vial (Humalog equivalent) OR Humalog pen. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
15106472	NATHAN HENRY PEKAR MD	FAMILY PRACTICE	DICLOFENAC SODIUM	DERMATOLOGICALS	M72.2-Plantar fascial fibromatosis	Criteria Not Met	Our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the records that we have received, diclofenac 3% gel was denied for these reasons: 1) This drug is not being used to treat actinic keratosis. This is a skin issue caused by too much sun. It causes scaly, rough, or bumpy spots on the skin. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for diclofenac 3% gel. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for the treatment of Actinic Keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	
15110186	OM NARAYAN PANDEY MD	INTERNAL MEDICINE	KISQALI	ANTINEOPLASTICS AND ADJUNCTIVE THERA	ecified site of unspecified female breast	Criteria Not Met	Our prior authorization criteria for ribociclib (KISQALI) have not been met. From the records that we have received, Kisqali was denied for these reasons: 1) The drug is not being used together with hormone therapy (i.e. a drug called fulvestrant or an aromatase inhibitor drug such as letrozole). Hormone therapy helps to slow or stop the growth of breast cancer by blocking or lowering the amount of a hormone called estrogen in the body. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. 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 ribociclib (KISQALI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Kisqali. 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) Prescribed for a diagnosis of advanced or metastatic hormone receptor-positive (HR+), human epidermal growth factor receptor 2-negative (HER2-) breast cancer; AND 3) The medication will be used in combination with endocrine therapy (aromatase inhibitor or fulvestrant); AND 4) Member has not experienced disease progression on a previous cyclin-dependent kinase 4/6 (CDK4/6) inhibitor. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	Yes

15122058	RAJESH MOOLJIBHAI MEHTA MD	GASTROENTEROLOGY	EPCLUSA	ANTIVIRALS	B18.2 - Chronic viral hepatitis C	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ledipasvir/sofosbuvir (Harvoni equivalent), SOFOSBUVIR/VELPATASVIR TABLET, Mavyret, and Vosevi. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15141786	ALMA DELIA CARTER	PHYSICIAN ASSISTANT	DESLORATADINE	ANTIHISTAMINES	Seasonal allergies	Criteria Not Met	Our prior authorization criteria for desloratadine have not been met. From the records that we have received, the following caused the denial of desloratadine. 1) Fexofenadine has not been tried and failed. 2) Cetirizine has not been tried and failed. 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 desloratadine have not been met. From the information we have received, the member does not meet number 2,3 of our prior authorization criteria for desloratadine. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has tried and failed a minimum 30 day trial of loratadine; AND 2) Member has tried and failed a minimum 30 day trial of fexofenadine; AND 3) Member has tried and failed a minimum 30 day trial of cetirizine.
15151278	JAMES ALLEN ZACHARY MD	INFECTIOUS DISEASES	TESTOSTERONE	ANDROGENS-ANABOLIC	E34.9	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Testosterone was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism. This is a condition in which the body does not make enough testosterone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has been established on testosterone replacement therapy; AND 3) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15175904	MELANIE MARIE PICKETT MD	DERMATOLOGY	EUCRISA	DERMATOLOGICALS	L20.89 - Other atopic dermatitis	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Eucrisa exception policy have not been met. From the records that we have received, the following caused the denial. 1) Records did not show tacrolimus ointment (Protopic equivalent) and pimecrolimus cream (Elidel equivalent) did not work for you. 2) Records did not show Opzelura cream did not work for you. Prior authorization may be required and quantity limits may apply. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 4 of the Eucrisa exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Member has a diagnosis of mild to moderate atopic dermatitis; AND 2) Member has tried and failed all formulary topical calcineurin inhibitors (tacrolimus and pimecrolimus); OR Member is less than 2 years of age; AND 3) Member has tried and failed one (1) very high potency topical steroid; OR If a very high potency topical steroid is not clinically appropriate, the highest potency steroid that can appropriately be used must be tried; AND 4) Member has tried and failed Opzelura.
15184606	ZAYD ZAKARIA SIDDIQ	NEUROLOGY	EMGALITY	MIGRAINE PRODUCTS	G43.009	Criteria Not Met	Our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the records that we have received, Emgality 120mg was denied for these reasons: 1) Records show Emgality will be used together with a botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) but do not show you have had at least a three (3) month trial of Emgality alone. 2) Records show Emgality will be used together with a botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) but do not show you have had at least a three (3) month trial of a botulinum toxin product (such as Botox, Dysport, Xeomin, etc.) alone. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for galcanezumab (EMGALITY 120mg) have not been met. From the information we have received, the member does not meet number(s) 4 or 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Member has four (4) or more migraine days per month for at least the previous three (3) months; AND 3) A minimum three (3) month trial from ONE of the following drug classes was ineffective, not tolerated, or contraindicated: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.); AND 4) Emgality will NOT be used concomitantly with a botulinum toxin (BOTOX, DYSPORT, MYOBLOC, XEOMIN) for chronic migraine; OR

15194287	OM NARAYAN PANDEY MD	INTERNAL MEDICINE	FRUZAQLA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	C18.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lonsurf (TRIED) and Stivarga. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15201049	BOONE WILDER GOODGAME MD	ONCOLOGY, MEDICAL	RUBRACA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	gnant neoplasm of pharynx, unspecified	Criteria Not Met	Our prior authorization criteria for rucaparib (RUBRACA) have not been met. From the records that we have received, Rubraca was denied for these reasons: 1) This drug is not being used for a specific type prostate cancer or for epithelial ovarian, fallopian tube, primary peritoneal cancer. Please note that additional criteria apply for each covered heath 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. Note: Please consider joining a clinical trial if possible and appropriate. You may also contact https://www.fda.gov/about-fda/oncology-center-excellence/project-facilitate for help in appealing to the drug maker for compassionate use. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for rucaparib (RUBRACA) have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Rubraca. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of recurrent epithelial ovarian, fallopian tube, primary peritoneal cancer, or for metastatic castration-resistant prostate cancer (mCRPC); AND 2) Additional criteria for each covered diagnosis are met. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15226035	MELANIE MARIE PICKETT MD	DERMATOLOGY	EUCRISA	DERMATOLOGICALS	L20.89 - Other atopic dermatitis	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Eucrisa exception policy have not been met. From the records that we have received, the following caused the denial. 1) Records did not show pimecrolimus cream (Elidel equivalent) did not work for you. 2) Records did not show Opzelura cream did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 2 and 4 of the Eucrisa exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Member has a diagnosis of mild to moderate atopic dermatitis; AND 2) Member has tried and failed all formulary topical calcineurin inhibitors (tacrolimus and pimecrolimus); OR Member is less than 2 years of age; AND 3) Member has tried and failed one (1) very high potency topical steroid; OR If a very high potency topical steroid is not clinically appropriate, the highest potency steroid that can appropriately be used must be tried; AND 4) Member has tried and failed Opzelura.
15246876	ALMA DELIA CARTER	PHYSICIAN ASSISTANT	LEVOCETIRIZINE DIHYDROCHL	ANTIHISTAMINES	NA	Plan Exclusion	This request cannot be approved because this drug can be purchased over the counter (OTC) without a prescription. Drugs or products available OTC 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.
15252513	JORDAN DAVID HARTMAN MD	FAMILY PRACTICE	NOVOLOG MIX 70/30 PREFILL	ANTIDIABETICS	betes mellitus with hyperglycemia (HCC)	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog equivalent)/Humalog. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
15255610	AUDREY ANN BAUM WHNPBC	ADVANCED PRACTICE NURSE	URO-MP	ANTI-INFECTIVE AGENTS - MISC.	titial cystitis (chronic) without hematuria	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are methenamine, hyoscyamine, and phenazopyridine tablet (Pyridium equivalent).. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

15286593	SHAHBAZ ASIF MALIK MD	INTERNAL MEDICINE	PREVYMIS	ANTIVIRALS	C91.0	Criteria Not Met	Our prior authorization criteria for letermovir (PREVYMIS) have not been met. From the records that we have received, Prevymis was denied for these reasons: 1) This drug is not being used to prevent an infection from a virus called cytomegalovirus (CMV) after an allogeneic stem cell transplant. An allogeneic stem cell transplant is when your stem cells are replaced with healthy stem cells from another person, or donor. 2) More information is needed to know if this drug will be started within 30 days after your stem cell transplant. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for letermovir (PREVYMIS) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Prevymis. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Hematologist, Oncologist, Transplant, or Infectious Disease Specialist; AND 2) Member is cytomegalovirus (CMV)-seropositive; AND 3) Prescribed for the primary prophylaxis in an adult of CMV infection or disease after an allogeneic hematopoietic stem cell transplant, AND letermovir (PREVYMIS) will be initiated within 30 days after transplant; OR 4) Prescribed for secondary prophylaxis in an adult of CMV infection or disease following pre-emptive therapy for post-hematopoietic stem cell transplant CMV infection; AND 5) Prescribed therapy is limited to one tablet daily for up to 200 days without renewal. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	Yes
15302543	ALINA MILIAN RAMOS MD	INTERNAL MEDICINE	LEVOCETIRIZINE DIHYDROCHL	ANTIHISTAMINES	Allergy, unspecified, initial encounter	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 tablet (Clarinex equivalent), Clarinex syrup. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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	
15323140	MEGHAN ELIZABETH HUGHES PA-C	PHYSICIAN ASSISTANT	NOVOLOG FLEXPEN	ANTIDIABETICS	F11.3312	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
15344417	ANDREA SALINAS RAYMOND MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	G43.009	Criteria Not Met	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for these reasons: 1) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second triptan was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	
15356330	JACQUELINE ROSE KARATHRA MD	FAMILY PRACTICE	NOVOLOG FLEXPEN	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Insulin Lispro (Humalog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	

15376365	CHARLES THOMAS SWEET MPH	PSYCHIATRY	VYVANSE	ADHD/ANTI-NARCOLEPSY	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show the generic version of this drug, called lisdexamfetamine (Vyvanse equivalent), did not work for you. 2) Records did not show that all other covered drugs used for your health issue did not work for you. Other drugs that can be used are ¿dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equivalent). 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior
15426418	MARY JANE WARREN APN	ADVANCED PRACTICE NURSE	QUVIVIQ	HYPNOTICS/SEDATIVES/SLEEP DISORDER AG	F51.01	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ramelteon, zolpidem (tried), zaleplon, trazodone, eszopiclone (tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15445189	SHAWN MARIE KRAUS NP	NURSE PRACTITIONER	ZTLIDO	DERMATOLOGICALS	B02.29	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lidocaine ointment, lidocaine patch, gabapentin (TRIED), amitriptyline (TRIED), nortriptyline, pregabalin (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15449335	MONICA RENEE SCHEPP	PHYSICIAN ASSISTANT	COSENTYX SENSOREADY PEN	TARGETED IMMUNOMODULATORS	PSORIASIS VULGARIS	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Enbrel, an adalimumab product (adalimumab-adaz, adalimumab-fkjp, Hadlima, Humira), Taltz (TRIED), Tremfya, Cimzia, Otezla, Skyrizi, Stelara. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15460254	RAJESH MOOLJIBHAI MEHTA MD	GASTROENTEROLOGY	STELARA	TARGETED IMMUNOMODULATORS	of small intestine without complications	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. STELARA 5MG/ML injection is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
15473010	SUSAN KATHLEEN DUBOIS MD	ENDOCRINOLOGY, DIABETES & M	INSULIN ASPART FLEXPEN	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

15480555	JOSHUA ENDE RPA-C	PHYSICIAN ASSISTANT	INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS		F31.81	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. INVEGA SUSTENNA is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
15487619	STANLEY SUCHY WANG MD	CARDIOLOGY	EDARBYCLOR	ANTIHYPERTENSIVES		I10	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are angiotensin II receptor blockers (ARBs) (irbesartan, losartan, valsartan, olmesartan, telmisartan, candesartan) along with chlorthalidone or hydrochlorothiazide (HCTZ). Additionally, other combination medications are available on formulary including losartan/HCTZ, valsartan/HCTZ, olmesartan/HCTZ, irbesartan/HCTZ. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15488551	AMSALU ERKO MD	NEPHROLOGY/RENAL MEDICINE	BENLYSTA	MISCELLANEOUS THERAPEUTIC CLASSES		M32.14	Criteria Not Met	Our prior authorization criteria for subcutaneous belimumab (BENLYSTA SC) have not been met. From the records that we have received, Benlysta SC was denied for these reasons: 1) More information is needed to show you do not have severe active central nervous system (CNS) lupus. This is when your health issue is active in your brain and spinal cord. 2) More information is needed to show Benlysta will not be taken together with another biologic drug, or with a drug called Lupkynis. Since the criteria have not been met, 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 and 4 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 lupus nephritis (LN) and is receiving standard therapy; AND 2) Prescribed by, or in consultation with, a Rheumatologist or Nephrologist; AND 3) Member does NOT have severe active central nervous system (CNS) lupus; AND 4) Medication will NOT be given in combination with other biologics or voclosporin (LUPKYNIS). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15491933	SUSAN KATHLEEN DUBOIS MD	ENDOCRINOLOGY, DIABETES & N	NOVOLOG FLEXPEN	ANTIDIABETICS		E11.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Insulin Lispro (Humalog equivalent) OR Lyumjev. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15524409	KEITH HARVEY LAMY MD	FAMILY PRACTICE	REPATHA PUSHTRONEX SYSTE	ANTIHYPERLIPIDEMICS		HLD	Criteria Not Met	Our prior authorization criteria for evolocumab (REPATHA) have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show your low-density lipoprotein-cholesterol (LDL-C) is at least 190 mg/dL when you are not taking cholesterol-lowering drugs. The LDL-C is a blood test that measures the amount of lipid, or fat, in the blood. 2) More information is needed to know that a statin drug, atorvastatin 40 mg per day or more or rosuvastatin 20 mg per day or more, or a combination drug with a strong statin, did not work for you after taking it regularly for at least eight (8) weeks. Since the criteria have not been met, 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 evolocumab (REPATHA) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria for Repatha. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a confirmed diagnosis of primary hyperlipidemia (other than heterozygous or homozygous familial hypercholesterolemia); AND 2) Untreated low-density lipoprotein-cholesterol (LDL-C) is greater than or equal to 190 mg/dL; AND 3) A trial of greater than or equal to eight (8) weeks of ONE (1) of the following high-intensity statin therapies was ineffective or not tolerated: (A) atorvastatin greater than or equal to 40 mg, or (B) rosuvastatin greater than or equal to 20 mg, or (C) A combination product containing a high-intensity statin; AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 70 mg/dL while on high-intensity or maximally-tolerated statin therapy, or a combination product containing a high-intensity statin. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15538734	KATHLEEN LESLIE KRAFT	NURSE PRACTITIONER	LINZESS	GASTROINTESTINAL AGENTS - MISC.		K59.09	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); AND 2) The member is 18 years of age or older; AND 3) A trial of plecanatide (TRULANCE) was ineffective, not tolerated, or contraindicated; AND 4) A trial of lubiprostone (AMITIZA) was ineffective, not tolerated or contraindicated; OR 5) Linaclotide (LINZESS) is prescribed for a male member with irritable bowel syndrome with constipation (IBS-C). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15547786	FAUSTIN MURHUBUBA BAHIZI	PHYSICIAN ASSISTANT	TESTOSTERONE PUMP	ANDROGENS-ANABOLIC		r89.1	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testoterone 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. 2) More information is needed to know if your low levels of testosterone are age-related. 3) Records did not show you have symptoms of low testosterone. 4) Two low testosterone blood levels have not been sent to us. The labs must be drawn in the morning and must be from two different days. 5) The testosterone blood levels provided were not drawn in the morning. 6) Two low testosterone blood levels, drawn on different days, were not provided. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3, 4, 5 of our prior authorization criteria for testoterone 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.
15563268	KATHLEEN LESLIE KRAFT	NURSE PRACTITIONER	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.		K59.09	Criteria Not Met	Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons: 1) Records did not show that taking one of the following over-the-counter (OTC) drugs for one month did not work for you: stimulants (e.g., bisacodyl, sennosides), or PEG 3350 (e.g., Miralax), or bulk-forming laxatives (e.g., Metamucil, Citrucel, Fibercon). Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 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
15573678	NATHAN HENRY PEKAR MD	FAMILY PRACTICE	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.		K58.9	Criteria Not Met	Our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the records that we have received, lubiprostone was denied for these reasons: 1) This drug is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female, or opioid-induced constipation (OIC). These are specific health issues that make it difficult to have a bowel movement. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for lubiprostone (AMITIZA) have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3 of our prior authorization criteria for lubiprostone. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in an adult female member; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member who does not require frequent (e.g., weekly) opioid dosage escalation; AND 4) A minimum one-month trial of ONE (1) of the following medications was ineffective, contraindicated or not tolerated: (A) stimulants (bisacodyl, sennosides), or (B) PEG 3350 (Miralax, Glycolax), or (C) bulk-forming laxatives (Metamucil, Citrucel, Fibercon). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15576204	RABIN KHERADPOUR MD	INTERNAL MEDICINE	INSULIN ASPART FLEXPEN	ANTIDIABETICS		E11.40	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev or insulin lispro (Humalog equivalent) or Humalog Kwikpen. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

15577829	FAUSTIN MURHUBUBA BAHIZI	PHYSICIAN ASSISTANT	TESTOSTERONE PUMP	ANDROGENS-ANABOLIC	R89.1	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone gel 1.62% was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism in a male. This is a health issue where the body does not make enough testosterone. 2) More information is needed to know if your low levels of testosterone are age-related. 3) Records did not show you have symptoms of low testosterone. 4) Two low testosterone blood levels have not been sent to us. The labs must be drawn in the morning and must be from two different days. 5) Two low testosterone blood levels, drawn on different days, were not provided. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3, 4, 5 of our prior authorization criteria for testosterone gel 1.62%. The reason for denial is explained to the member above. The criteria are listed here. 1) Male member has a diagnosis of primary or secondary hypogonadism (ICD 10 Codes: E29.1, E23.0); AND 2) Member does NOT have age-related hypogonadism; AND 3) Member has symptoms of hypogonadism; AND 4) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 5) TWO (2) lab values are submitted and date levels were taken, time levels were drawn, lab reference range, and whether level is total or free testosterone must be documented with the request
15587278	KATHLEEN LESLIE KRAFT	NURSE PRACTITIONER	AMITIZA	GASTROINTESTINAL AGENTS - MISC.	CIC	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lubiprostone capsule (AMITIZA equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15593224	MICHAEL MILES ALBRECHT MD	SURGERY, ORTHOPEDIC	SYNVISC ONE	MUSCULOSKELETAL THERAPY AGENTS	- Bilateral primary osteoarthritis of knee	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Synvisc one is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.
15601215	ZAYD NAJDAT NASHAAT MD	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	pre-diabetes	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, Ozempic was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15601885	SHANNON MITCHELL COHN MD	HEMATOLOGY & ONCOLOGY, PE	VALTOCO 15 MG DOSE	ANTICONVULSANTS	G40.909	Criteria Not Met	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, VALTOCO was denied for this reason: 1) The drug is not prescribed by a(n) Neurology Specialist. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted to Specialist prior authorization criteria have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The provider's specialty matches the Restricted Specialty requirements per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15628017	MARK ARNOLD CORREA MD	DERMATOLOGY	OPZELURA	DERMATOLOGICALS	L80	Criteria Not Met	Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons: 1) Records did not show that light therapy (phototherapy) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the information we have received, the member does not meet number(s) 6 of our prior authorization criteria for Opzelura. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Dermatologist; AND 2) Member has a diagnosis of nonsegmental vitiligo; AND 3) Member is 12 years of age or older; AND 4) Member meets ONE (1) of the following: (A) greater than or equal to 0.5% total body surface area (BSA) of the face is depigmented, or (B) greater than or equal to 3% total BSA on non-facial areas is depigmented; AND 5) The total affected body surface area (BSA) is less than or equal to 10%; AND 6) Phototherapy trial was ineffective, contraindicated, or not tolerated; AND 7) A trial of ONE (1) of the following was ineffective or not tolerated: (A) medium potency or stronger topical corticosteroid, OR (B) topical calcineurin inhibitor, OR (C) member has a contraindication to both. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization

15652083	CHRISTOPHER JAMES O'CONNOR PA	PHYSICIAN ASSISTANT	BELBUCA	ANALGESICS - OPIOID	G89.4	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
15662592	ALEXANDRA SMITH-STOCKER NP	NURSE PRACTITIONER	LEVOCETIRIZINE DIHYDROCHL	ANTIHISTAMINES	J30.9 - Allergic rhinitis, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include loratadine, fexofenadine, cetirizine, levocetirizine and others. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.	
15690217	MICHAEL CHRISTOPHER STEFANOWICZ D	FAMILY PRACTICE	CABENUVA	ANTIVIRALS	munodeficiency virus (HIV) disease(HHS)	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. CABENUVA 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.	
15714839	BRANDON SHAUN ALTILLO	INTERNAL MEDICINE	BISMUTH SUBCITRATE POT/ME	ULCER DRUGS/ANTISPASMODICS/ANTICHOI	B96.81	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 2 combinations of covered drugs including (A) Bismuth (available over-the-counter without a prescription) with Metronidazole, Tetracycline and a proton pump inhibitor such as Omeprazole, (B) Amoxicillin with Clarithromycin and a proton pump inhibitor such as Lansoprazole. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
15770320	HARRY FRANKLIN GOSS JR MD	NEPHROLOGY/RENAL MEDICINE	VELTASSA	MISCELLANEOUS THERAPEUTIC CLASSES	E87.5	Criteria Not Met	Our prior authorization criteria for patiromer (VELTASSA) have not been met. From the records that we have received, Veltassa was denied for these reasons: 1) More information is needed to know if you cannot take a water pill (diuretic) to help lower your blood potassium level. Since the criteria have not been met, 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 patiromer (VELTASSA) 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 Veltassa. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication prescribed by, or in consultation with, a Nephrologist, Cardiologist, or Endocrinologist; AND 2) Hyperkalemia (greater than 5.3 mmol/L) persists despite dietary management; AND 3) Hyperkalemia (greater than 5.3 mmol/L) persists despite use of diuretics; OR 4) Use of diuretics is NOT appropriate. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	Yes
15805539	SONIA YOUSUF III MD	RHEUMATOLOGY	ENBREL	TARGETED IMMUNOMODULATORS	I40.50	Criteria Not Met	Our prior authorization criteria for etanercept (ENBREL) have not been met. From the records that we have received, Enbrel was denied for these reasons: 1) Records did not show that other drugs called methotrexate or sulfasalazine did not work for you OR that you have a clinical reason why they cannot be 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 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 etanercept (ENBREL) have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Enbrel. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of ONE (1) of the following: (A) Peripheral Ankylosing Spondylitis (AS); OR (B) Psoriatic Arthritis (PsA); OR (C) Reactive Arthritis; AND 3) A trial of ONE (1) of the following was ineffective or not tolerated: (A) methotrexate; OR (B) sulfasalazine; OR (C) Member has contraindication to BOTH and the contraindication is specified. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	
15808223	ERNEST ALAN HAEUSSLEIN MD	CARDIOLOGY	WINREVAIR	CARDIOVASCULAR AGENTS - MISC.	I27.0 - Primary pulmonary hypertension	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are sildenafil(TRIED), tadalafil, Uptravi(TRIED), Opsumit(TRIED), ambrisentan, bosentan, Ventavis, Tyvaso(TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	

15816304	KALPANA KASALA JATLA MD	OPHTHALMOLOGY	VYZULTA	OPHTHALMIC AGENTS	her eye disorders, right eye, severe stage	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are latanoprost (TRIED), travoprost (Travatan Z equivalent), tafluprost (Zioptan equivalent) and bimatoprost (Lumigan equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15818603	TARA AUTUMN CHERRY MD	OBSTETRICS & GYNECOLOGY	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	G44.89-Other headache syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for headache in pregnancy. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15853411	ANOKHI JAMBUSARIA-PAHLAJANI MD	DERMATOLOGY	DUPIXENT	DERMATOLOGICALS	L28.1 - Prurigo nodularis	Criteria Not Met	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, Dupixent was denied for these reasons: 1) Records did not show that one of the following drugs did not work for you: gabapentin, pregabalin, duloxetine, amitriptyline or 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. 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number(s) 7 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 18 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 prurigo nodularis persisting for greater than or equal to six (6) weeks; AND 4) Greater than or equal to 20 nodules are present at baseline; AND 5) Disease burden has resulted in impaired quality of life, sleep deprivation, missed work or school, or negative emotional or social impact; AND 6) Documentation that a trial of ONE (1) of the following was ineffective 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)/ Psoralen plus ultraviolet A (PUVA) phototherapy, or (D) Cyclosporine, or (E) Methotrexate, or (F) Azathioprine, or (G) All therapies were contraindicated; AND 7) Documentation that a trial of ONE (1) of the following was ineffective or not tolerated is provided with the request (documentation is required to be submitted for an approval): (A) Gabapentin, or (B) Pregabalin, or (C) Duloxetine, or (D) Amitriptyline, or (E) Paroxetine, or (F) All therapies were contraindicated; AND 8) Dupilumab (DUPIXENT) will NOT be used in combination with another targeted immunomodulator product used for prurigo nodularis or atopic dermatitis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
15857419	RUMI AHMED KHAN MD	INTERNAL MEDICINE	PULMICORT FLEXHALER	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) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Arnuity Ellipta, Asmanex HFA or twisthaler, fluticasone inhaler, Qvar Redihaler, and Alvesco. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

15876991	DIANA REYES PA-C	PHYSICIAN ASSISTANT	BIMZELX	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are an adalimumab product (ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, HADLIMA, SIMLANDI, HUMIRA), Enbrel(tried), Taltz, Tremfya, Cimzia, Otezla, Skyrizi, Stelara. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
15877397	JARROD PAUL HERTZLER NP	NURSE PRACTITIONER	LOKELMA	MISCELLANEOUS THERAPEUTIC CLASSES	E87.5 HYPERKALEMIA	Criteria Not Met	Our prior authorization criteria for sodium zirconium cyclosilicate (LOKELMA) have not been met. From the records that we have received, Lokelma was denied for these reasons: 1) More information is needed to know if you cannot take a water pill (diuretic) to help lower your blood potassium level. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for sodium zirconium cyclosilicate (LOKELMA) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Lokelma. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Nephrologist, Cardiologist, or Endocrinologist; AND 2) Member is greater than or equal to 18 years of age; AND 3) Hyperkalemia (greater than 5.3 mmol/L) continues to persist despite dietary management; AND 4) Member meets ONE (1) of the following: (A) Hyperkalemia (greater than 5.3 mmol/L) continues to persist despite use of diuretics; OR (B) Use of diuretics is NOT appropriate. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	Yes
15896181	SHANTISONY POTUREDDY NAGAVARAPU	INTERNAL MEDICINE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Humalog (vials may not be covered), Inuslin Lispro, or Lyumjev. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 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	
15901622	VANESSA AILEEN FRASSATI APN	ADVANCED PRACTICE NURSE	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	f33.3	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show that another drug called quetiapine OR olanzapine used with an antidepressant medication did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND 5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication.	
15907802	ASHLEY MARIE WESTRUM PA	PHYSICIAN ASSISTANT	GEMTESA	URINARY ANTISPASMODICS	N39.41 - Urge incontinence	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	

15927867	MARIA EZIAFA CHIEJINA MD	GASTROENTEROLOGY	LINZESS	GASTROINTESTINAL AGENTS - MISC.	K59.04	Criteria Not Met	Our prior authorization criteria for linaclotide (LINZESS) have not been met. From the records that we have received, Linzess was denied for these reasons: 1) Records did not show that another drug called plecanatide (Trulance) did not work for you. 2) Records did not show that another drug called lubiprostone (Amitiza) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for linaclotide (LINZESS) have not been met. From the information we have received, the member does not meet number(s) 3, 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
15929908	KRISTIN ELISA MONDY MD	INFECTIOUS DISEASES	CEFEPIME	CEPHALOSPORINS	bacteremia	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.
15942125	RABIN KHERADPOUR MD	INTERNAL MEDICINE	TOBRAMYCIN	AMINOGLYCOSIDES	pneumonia	Criteria Not Met	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, Tobramycin was denied for this reason: 1) The drug is not prescribed by a(n) Infectious Disease or Pulmonology Specialist. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our Restricted to Specialist prior authorization criteria have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The provider's specialty matches the Restricted Specialty requirements per the formulary for the medication requested. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15951382	VANESSA LYNN MADRID	ADVANCED PRACTICE NURSE	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F33.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show that another drug called quetiapine OR olanzapine used with an antidepressant medication did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND 5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent) when used with an antidepressant medication.
15953565	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	HULIO	TARGETED IMMUNOMODULATORS	L73.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are all covered adalimumab products (adalimumab-adaz (Hyrimoz equivalent), adalimumab-fkjp (Hulio equivalent), adalimumab-aaty (Yuflyma equivalent), Hadlima, Humira, Simlandi). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
15954443	DIANA NATHALIE ANDINO MD	NEUROLOGY	UBRELVY	MIGRAINE PRODUCTS	migraine	Criteria Not Met	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy was denied for these reasons: 1) Records did not show that TWO (2) triptan drugs (such as sumatriptan (TRIED), rizatriptan, or others) did not work for you. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Ubrelvy. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for a diagnosis of acute migraine treatment AND 2) Member had trials with TWO (2) triptan medications that were ineffective, not tolerated, or triptan trials are contraindicated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization
15958197	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	HUMIRA PEN	TARGETED IMMUNOMODULATORS	HS	Criteria Not Met	Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Humira was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes showing that this drug has caused you to have fewer lumps under your skin, or that the lumps under your skin have gotten smaller, have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Adalimumab Products have not been met. From the information we have received, the member does not meet number(s) 3 & 4 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of hidradenitis suppurativa (HS); AND 2) Prescribed by a Dermatologist; AND 3) Member has demonstrated a significant improvement in their condition; AND 4) Member has had improvement based on abscess/nodule size and/or number (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.

15968014	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	ADALIMUMAB-FKJP	TARGETED IMMUNOMODULATORS	L73.2	Criteria Not Met	Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, Adalimumab-fkjp was denied for these reasons: 1) Chart notes showing that this drug has caused you to have fewer lumps under your skin, or that the lumps under your skin have gotten smaller, have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Adalimumab Products have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Adalimumab-fkjp. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of hidradenitis suppurativa (HS); AND 2) Prescribed by a Dermatologist; AND 3) Member has demonstrated a significant improvement in their condition; AND 4) Member has had improvement based on abscess/nodule size and/or number (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.
16052033	BRANDON SHAUN ALTILLO	INTERNAL MEDICINE	WEGOVY	ANTI-OBESITY/ANOREXIANTS	E66.01	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
16060518	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	HUMIRA PEN	TARGETED IMMUNOMODULATORS	L73.2	Criteria Not Met	Our prior authorization criteria for Adalimumab Products have not been met. From the records that we have received, HUMIRA was denied for these reasons: 1) The drug is not being used for hidradenitis suppurativa. This is a health issue of the skin where lumps form under the skin. 2) The drug is not prescribed by a doctor who specializes in your health issue. 3) Records did not show that this drug is working well for you. 4) Chart notes showing that this drug has caused you to have fewer lumps under your skin, or that the lumps under your skin have gotten smaller, have not been received. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Adalimumab Products have not been met. From the information we have received, the member does not meet number(s) 1, 2, 3 and 4 of our prior authorization criteria for HUMIRA. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of hidradenitis suppurativa (HS); AND 2) Prescribed by a Dermatologist; AND 3) Member has demonstrated a significant improvement in their condition; AND 4) Member has had improvement based on abscess/nodule size and/or number (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.
16065019	STEVEN KIRK FOSTER MD	GENERAL PRACTICE	DEXCOM G7 SENSOR	MEDICAL DEVICES	e 2 diabetes mellitus with hyperglycemia	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Dexcom G7 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.
16078322	ADITYA DESAI MD	INTERNAL MEDICINE	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.4	Criteria Not Met	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are hydrocortisone enema (CORTENEMA equivalent), Cortifoam, lidocaine/hydrocortisone cream (ANAMANTLE equivalent), Proctofoam HC foam, Proctosol HC cream (ANUSOL HC equivalent), and Analpram-E kit. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16101122	KAREN JENIFER ROMERO DO	FAMILY PRACTICE	FINASTERIDE	DERMATOLOGICALS	Acne, 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.
16101460	ASHLEY MARIE WESTRUM PA	PHYSICIAN ASSISTANT	GEMTESA	URINARY ANTISPASMODICS	N39.41 - Urge incontinence	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Myrbetriq, and 3 other drugs for your health issue, such as oxybutynin, trospium, tolterodine, darifenacin, solifenacin, fesoterodine extended release (ER) tablet (TOVIAZ equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16101592	JORDAN DAVID HARTMAN MD	FAMILY PRACTICE	NOVOLOG MIX 70/30 PREFILL	ANTIDIABETICS	betes mellitus with hyperglycemia (HCC)	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR Insulin Lispro (Humalog equivalent)/Humalog. . Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
16104753	JORDAN DAVID HARTMAN MD	FAMILY PRACTICE	NOVOLOG MIX 70/30 PREFILL	ANTIDIABETICS	e 2 diabetes mellitus with hyperglycemia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: Insulin lispro mix (Humalog equivalent) OR Humalog mix. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to 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
16111721	ALEXIS FUSELIER HOLDER	PHYSICIAN ASSISTANT	NOVOLOG	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR insulin lispro (Humalog equivalent) OR Humalog. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
16114194	SUSAN KATHLEEN DUBOIS MD	ENDOCRINOLOGY, DIABETES & M	DEXCOM G7 SENSOR	MEDICAL DEVICES	abetes mellitus wout complications(HHS)	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Dexcom G7 sensors (sample pack is not covered) and Freestyle Libre sensors. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16116578	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	ADALIMUMAB-AATY 1-PEN KIT	TARGETED IMMUNOMODULATORS	HS	Plan Limits Exceeded	The requested amount of adalimumab-aaty 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 adalimumab-aaty at 1 injection every 2 weeks for this use. The higher number of 3 injections in 28 days for a re-load is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
16126780	REBECCA LOIS NEKOLAICHUK	INTERNAL MEDICINE	INCONTROL ULTICARE MINI P	MEDICAL DEVICES	; with other diabetic kidney complication	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 needle and Novofine/Novotwist pen needle. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16184936	MICAH ELISE WILLIAMS PA-C	PHYSICIAN ASSISTANT	OTEZLA	TARGETED IMMUNOMODULATORS	PP	Criteria Not Met	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that your health issue is causing significant functional disability for you. More information is needed to show how your health issue is impacting your day-to-day life. 2) Records did not show that you have palmoplantar psoriasis. This is a health issue where skin cells build up and form itchy, dry patches and scales on your palms of the hands and the soles of the feet. 3) Records did not show at least one of the following treatments did not work for you: 15 sessions of light therapy, OR methotrexate 15mg per week, OR acitretin. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria for Otezla. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Plaque psoriasis (PsO) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) Minimum of 15 sessions of phototherapy; OR (B) methotrexate (minimum dose of 15 mg/week); OR (C) acitretin (SORIATANE); OR (D) ALL are contraindicated AND contraindication is specified. NOTE: A contraindication or intolerance to methotrexate does NOT cancel the requirement of a trial of acitretin; AND 4) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization	
16209546	AUDREY ANN BAUM WHNPBC	ADVANCED PRACTICE NURSE	GEMTESA	URINARY ANTISPASMODICS	N39.41	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 (Brand preferred) and 3 other drugs for your health issue, such as oxybutynin, trospium, tolterodine, darifenacin, solifenacin, fesoterodine extended release (ER) tablet (TOVIAZ equivalent). Records show some of these drugs may not be right for you, but more information about your health issues is needed. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16215604	ROBERT GLENN MORRISON MD	INTERNAL MEDICINE	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	Male erectile dysfunction, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for erectile dysfunction. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.	
16218615	JARROD PAUL HERTZLER NP	NURSE PRACTITIONER	LOKELMA	MISCELLANEOUS THERAPEUTIC CLASSES	N18.6	Criteria Not Met	Our prior authorization criteria for sodium zirconium cyclosilicate (LOKELMA) have not been met. From the records that we have received, Lokelma was denied for these reasons: 1) Records did not show your blood potassium level is higher than 5.3 mmol/L. 2) Records did not show your blood potassium level stayed high (above 5.3 mmol/L) even though you are on a low-potassium diet. 3) More information is needed to know if you cannot take a water pill (diuretic) to help lower your blood potassium level. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for sodium zirconium cyclosilicate (LOKELMA) 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 Lokelma. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Nephrologist, Cardiologist, or Endocrinologist; AND 2) Member is greater than or equal to 18 years of age; AND 3) Hyperkalemia (greater than 5.3 mmol/L) continues to persist despite dietary management; AND 4) Member meets ONE (1) of the following: (A) Hyperkalemia (greater than 5.3 mmol/L) continues to persist despite use of diuretics; OR (B) Use of diuretics is NOT appropriate. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.	Yes
16256611	DARSHAN NARENDRA SHAH MD	NEUROLOGY	NURTEC	MIGRAINE PRODUCTS	g43.111	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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, Aimovig, Emgality. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16260286	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	OZEMPIC	ANTIDIABETICS	e11.65	Plan Limits Exceeded	The requested amount of Ozempic 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 Ozempic at 1.5 milliliters per 28 days for this use. The higher number of 3 milliliters per 28 days is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.	

16310775	NATALIE ADRIANNE WILLIAMS MD	FAMILY PRACTICE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	E10.10	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin lispro kwikpen (Humalog equivalent) or Humalog Kwikpen or Lyumjev Kwikpen. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16333850	PATRICIA UADIALE OKHUOZAGBON NP	ADVANCED PRACTICE NURSE	ABILIFY MAINTENA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	current, severe with psychotic symptoms	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. ABILIFY MAINTENA 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.	
16340088	MELANIE MARIE PICKETT MD	DERMATOLOGY	ZORYVE	DERMATOLOGICALS	L40.0	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for psoriasis. This is not an approved use. 2) When being used for an approved health issue, records must show all covered drugs used for your health issue did not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA); AND 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16352052	PAUL HIEN LE MD	ANESTHESIOLOGY	HYDROCODONE BITARTRATE/	ANALGESICS - OPIOID	G89.4	Plan Limits Exceeded	We have received a request for 90 tablets for a 30 day supply for hydrocodone/acetaminophen. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a 7 day supply for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. For members who do not show recent use of an opioid pain reliever, more than a 7 day supply for this first fill can be approved if records are sent in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care.	
16406205	PATRICIA UADIALE OKHUOZAGBON NP	ADVANCED PRACTICE NURSE	ABILIFY MAINTENA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.5	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Abilify Maintena 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.	
16413639	IKECHUKWU JOHN OBIH MD	NEUROLOGY	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	G43.009	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for migraines. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ibuprofen, naproxen, diclofenac tablets, rizatriptan (TRIED), sumatriptan, naratriptan, Reyvow, Ubrelvy, Zavzpret and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16424973	CLAIRE AMY MACPHERSON PA-C	PHYSICIAN ASSISTANT	QELBREE	ADHD/ANTI-NARCOLEPSY	t hyperactivity disorder, unspecified type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are atomoxetine (TRIED) and one long-acting stimulant drug (e.g., amphetamine/dextroamphetamine ER or lisdexamfetamine (Vyvanse equivalent)). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	Yes

16453500	RENU CHALASANI MD	OBSTETRICS & GYNECOLOGY	NOVOLOG FLEXPEN	ANTIDIABETICS	E10.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR insulin lispro (Humalog equivalent) OR Humalog. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
16456018	SUSAN NYAMBURA KINYANJUI CRNP	NURSE PRACTITIONER	DICLOFENAC POTASSIUM	ANALGESICS - ANTI-INFLAMMATORY	R52-Pain, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are all formulary nonsteroidal anti-inflammatory (NSAID) drugs (ibuprofen (TRIED), naproxen (TRIED), nabumetone (TRIED), etodolac (TRIED), sulindac, ketoprofen (TRIED), diclofenac (TRIED), indomethacin, salsalate, piroxicam). Please note, covered diclofenac products include: diclofenac potassium 50 mg (CATAFLAM equivalent)(TRIED) and diclofenac sodium 25 mg, 50 mg, and 75 mg (VOLTAREN equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
16458546	IKECHUKWU JOHN OBIH MD	NEUROLOGY	BUTALBITAL/ACETAMINOPHEN	ANALGESICS - NONNARCOTIC	G43.009	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for migraines. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ibuprofen, naproxen, diclofenac tablets, rizatriptan(TRIED), sumatriptan, naratriptan, Reyvow, Ubrelvy, Zavzpret and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16510412	JACK DAULTON BISSETT MD	INFECTIOUS DISEASES	FERROUS SULFATE	HEMATOPOIETIC AGENTS	9 - Folate deficiency anemia, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ferrex 150 forte. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16511337	RAYMONDA EL KHOURY MD	INTERNAL MEDICINE	SEVELAMER HYDROCHLORIDE	GASTROINTESTINAL AGENTS - MISC.	N18.6 - end stage renal disease	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are sevelamer (Renvela equivalent), lanthanum (Fosrenol equivalent), calcium acetate, Auryxia, Xphozah. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16511845	KAITLIN NICOLE SISSON PA-C	PHYSICIAN ASSISTANT	FEROSUL	HEMATOPOIETIC AGENTS	D50.9	Plan Exclusion	This request cannot be approved because this drug/product is in a class of drugs/products called 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.

16536955	DAMIAN G LARA MD	FAMILY PRACTICE	INSULIN DEGLUDEC FLEXTOUC	ANTIDIABETICS	E11.65	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are insulin glargine-yfgn OR Semglee, Levemir (TRIED), Toujeo, Tresiba. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16537146	JOSHUA THOMAS HAYWOOD DO	INTERNAL MEDICINE	DICLOFENAC SODIUM	DERMATOLOGICALS	M54.9	Plan Exclusion	This request cannot be approved because this drug can be purchased over the counter (OTC) without a prescription. Drugs or products available OTC 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.
16564941	PRAKASH SAMUEL EAPEN MD	INTERNAL MEDICINE	INSULIN ASPART FLEXPEN	ANTIDIABETICS	t2dm	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Lyumjev OR insulin lispro (Humalog equivalent) OR Humalog. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization
16611167	ENRIQUE GONZALES JR MD	PEDIATRICS	TRAMADOL HYDROCHLORIDE	ANALGESICS - OPIOID	m46.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are tramadol 50mg tablets, morphine sulfate immediate release (IR), oxycodone, oxycodone/acetaminophen, hydrocodone/acetaminophen, and hydromorphone. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16612306	BRYAN TODD IRVIN MD	FAMILY PRACTICE	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ANTICHOI	gerd	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole, pantoprazole (TRIED), rabeprazole, lansoprazole, and esomeprazole. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16621971	KRISTEN MICHELLE HAWTHORNE MD	OPHTHALMOLOGY	RESTASIS	OPHTHALMIC AGENTS	h16.223	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) Records did not show the generic version of this drug, called cyclosporine (Restasis 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 Xiidra, Miebo, and Tyrvaya. 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. Prior authorization and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior

16629554	BRYAN TODD IRVIN MD	FAMILY PRACTICE	LANSOPRAZOLE ODT	ULCER DRUGS/ANTISPASMODICS/ANTICHOI	r10.13	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lansoprazole capsules (Prevacid equivalent), esomeprazole, omeprazole, pantoprazole (TRIED), and rabeprazole. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16631275	BRYAN TODD IRVIN MD	FAMILY PRACTICE	LANSOPRAZOLE ODT	ULCER DRUGS/ANTISPASMODICS/ANTICHOI	R10.13	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused 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 capsule (Prevacid equivalent), esomeprazole. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16645648	AMY ROMINGER MASON MD	DERMATOLOGY	EUCRISA	DERMATOLOGICALS	L20.84	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 1 topical calcineurin inhibitor (such as tacrolimus, pimecrolimus), 1 high potency topical steroid (such as betamethasone, clobetasol, halobetasol and others), and Opzelura. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.
16654293	ALAA EDDIN TAYYEM MD	HOSPITALIST	VENCLEXTA	ANTINEOPLASTICS AND ADJUNCTIVE THERA	D46.9	Criteria Not Met	Our prior authorization criteria for venetoclax (VENCLEXTA) have not been met. From the records that we have received, Venclexta was denied for these reasons: 1) The drug is not being used for a type of blood cancer called Chronic Lymphocytic Leukemia (CLL), Small Lymphocytic Lymphoma (SLL), or Acute Myeloid Leukemia (AML). More information is needed if you have a covered health issue. Since the criteria have not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. Prior authorization and quantity limits may apply to covered drugs. Note: Please consider joining a clinical trial if possible and appropriate. You may also contact https://www.fda.gov/about-fda/oncology-center-excellence/project-facilitate for help in appealing to the drug maker for compassionate use. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for venetoclax (VENCLEXTA) have not been met. From the information we have received, the member does not meet numbers 1 and 2 of our Venclexta prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Lymphocytic Leukemia (CLL), Small Lymphocytic Lymphoma (SLL), or Acute Myeloid Leukemia (AML); AND 2) Additional criteria for a 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
16662381	CHRISTOPHER JAMES O'CONNOR PA	PHYSICIAN ASSISTANT	PREGABALIN	ANTICONVULSANTS	chronic pain syndrome	Plan Limits Exceeded	The requested amount of pregabalin (Lyrica 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 pregabalin (Lyrica equivalent) at 3 capsules per day for this use. The prescribed dose is 4 capsules per day. This drug comes in a 200mg capsule. The same dose can be reached by taking two (2) 200mg capsules per day. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.
16690969	AMY ROMINGER MASON MD	DERMATOLOGY	EUCRISA	DERMATOLOGICALS	L20.84	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 1 topical calcineurin inhibitor (such as tacrolimus, pimecrolimus), 1 high potency topical steroid (such as betamethasone, clobetasol, halobetasol and others), Opzelura. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.

16703403	REY XIMENES MD	ANESTHESIOLOGY	FENTANYL	ANALGESICS - OPIOID	G89.4	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent)-(TRIED), Xtampza ER, fentanyl patch (Duragesic equivalent) (25 mcg (TRIED), 50 mcg, 75 mcg, and 100 mcg are covered), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent)-(TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16719401	JOE THANH NGUYEN MD	FAMILY PRACTICE	FREESTYLE LIBRE 2/READER/	MEDICAL DEVICES	dm2	Criteria Not Met	Our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. Step Therapy means that you must be using insulin before the requested device will be covered. From the records that we have received, Freestyle Libre 2 was denied for these reasons: 1) Records did not show that you are using insulin. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitor (CGM) Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is currently using insulin. Since criteria have not been met, we are unable to approve coverage for this device at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply.	
16720339	RAYMONDA EL KHOURY MD	INTERNAL MEDICINE	LUPKYNIS	MISCELLANEOUS THERAPEUTIC CLASSES	LN	Criteria Not Met	Our prior authorization criteria for voclosporin (LUPKYNIS) have not been met. From the records that we have received, Lupkynis was denied for these reasons: 1) More information is needed to show this drug will not be used with Benlysta. 2) Records were not sent to us to show your health issue has gotten better while using 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 voclosporin (LUPKYNIS) have not been met. From the information we have received, the member does not meet number(s) 4 and 5 of our prior authorization criteria for Lupkynis for Continuing Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Rheumatologist or Nephrologist; AND 2) Member has a diagnosis of active lupus nephritis (LN); AND 3) Medication will be used in combination with a background immunosuppressive therapy regimen; AND 4) Medication will NOT be given in combination with belimumab (BENLYSTA); AND 5) Documentation of disease stabilization or improvement on voclosporin (LUPKYNIS) 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	Yes
16749997	REY XIMENES MD	ANESTHESIOLOGY	FENTANYL	ANALGESICS - OPIOID	G89.4 - chronic pain syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent)-(TRIED), Xtampza ER, fentanyl patch (Duragesic equivalent) (25 mcg (TRIED), 50 mcg, 75 mcg, and 100 mcg are covered), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent)-(TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	
16750023	NICOLE ANN TURGEON MD	SURGERY, GENERAL	SODIUM BICARBONATE	ANTACIDS	Z94.0 - Kidney transplant status	Plan Exclusion	This request cannot be approved because this drug can be purchased over the counter (OTC) without a prescription. Drugs or products available OTC 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.	
16773555	VEENA AJIT PATEL MD	RHEUMATOLOGY	HYRIMOZ	TARGETED IMMUNOMODULATORS	M05.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are all covered adalimumab products (adalimumab-adaz (Hyrimoz equivalent), adalimumab-fkjp (Hulio equivalent), adalimumab-aaty (Yuflyma equivalent), Hadlima, Simlandi, Humira), Enbrel, Orencia, Kevzara, Olumiant, a tocilizumab product (Actemra, Tyenne), Rinvoq, Xeljanz, Cimzia. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.	

16779158	AMY ROMINGER MASON MD	DERMATOLOGY	EUCRISA	DERMATOLOGICALS	Intrinsic (allergic) eczema	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are: 1 topical calcineurin inhibitor (such as tacrolimus, pimecrolimus), 1 high potency topical steroid (such as betamethasone, clobetasol, halobetasol and others), Opzelura. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment.