

Additional Therapeutic Classes with Clinical Criteria

Providers should provide supporting documentation (chart notes, lab work, medication history) to demonstrate criteria is satisfied

All requests must be in compliance with OAC 5160

Therapeutic Class	Drug Name	Clinical Criteria (Authorization is for 1 year unless otherwise stated)
Adrenocorticotrophic hormone (ACTH) analogue	H.P. Acthar® (≥ 2 years old)	<ul style="list-style-type: none"> • Must be prescribed by a specialist AND • Must have a diagnosis of multiple sclerosis (experiencing an acute exacerbation) AND • Must have failed corticosteroid therapy in the last 30 days or have a contraindication to corticosteroid therapy AND • Authorization will be granted for up to 28 days
Adrenocorticotrophic hormone (ACTH) analogue	H.P Acthar® (< 2 years old)	<ul style="list-style-type: none"> • Must be prescribed by a specialist AND • Must have a confirmed diagnosis of infantile spasms AND • Must not have or is suspected of having an untreated congenital infection AND • Authorization will be granted for up to 28 days
Agents for Homozygous familial hypercholesterolemia (HoFH) [non-PCKS9 Inhibitors]	Juxtapid® (lomitapide)	<ul style="list-style-type: none"> • Must be 18 years of age or older AND • Must have a diagnosis of Homozygous Familial Hypercholesterolemia AND • Must have a history of at least 90 days of high-dose statin therapy, ezetimibe and PCSK9 inhibitor in the past 180 days (or a clinical reason that these medications cannot be utilized) AND • Initial consultation with a lipid specialist • Initial authorization is for 6 months and re-authorization will be granted for 1 year
Agents to Promote Wakefulness	Provigil® (modafinil) Nuvigil® (armodafinil)	<ul style="list-style-type: none"> • Must not be pregnant or planning to become pregnant AND • Must not have a history of drug dependence or substance abuse AND • Must have a diagnosis of narcolepsy OR • Must have a diagnosis of Shift Work Disorder (SWD) OR • Must have a diagnosis of fatigue related to Multiple Sclerosis, cancer or Parkinson's OR • Must have a diagnosis of excessive sleepiness associated with obstructive sleepapnea AND • Authorization will be granted for 6 months

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Anabolic steroid	oxandrolone	<ul style="list-style-type: none"> • Must have a diagnosis of cachexia from extensive surgery, chronic infections or severe trauma • Must have a diagnosis of COPD with corticosteroid-induced protein catabolism or chronic non-healing wounds without impaired blood flow AND • Must have $\geq 10\%$ unintentional weight loss AND • Must be on a high protein diet • Authorization limited to 30 days with re-authorization granted with documentation of weight gain with therapy
Anabolic steroid for anemia	Anadrol®-50 (oxymetholone tablet)	<ul style="list-style-type: none"> • Must have a diagnosis of anemia AND • Must have a hematology consult AND • Prescriber must provide a monitoring plan AND • Authorization will be limited to 6 months only after a Medical Director review with re-authorization dependent upon documentation of patient improvement (lab test and RBC count) and documentation of lipid and liver enzyme monitoring
Antimycobacterial	Priftin® (rifapentine)	<ul style="list-style-type: none"> • Must have a recommendation or consult with an infectious disease specialist, tuberculosis clinic, CDC or state health department AND • Must have a diagnosis of tuberculosis AND • Must have a claim for another anti-TB drug AND • For an active infection must obtain molecular susceptibility testing prior to initiation of therapy
Benzothiazole for ALS	Rilutek® (riluzole)	<ul style="list-style-type: none"> • Must be prescribed by or in consultation with a neurologist AND • Must have a diagnosis of amyotrophic lateral sclerosis (ALS) without a tracheotomy
Central Nervous System Agents	Nuedexta® (dextromethorphan hydrobromide and quinidine sulfate)	<ul style="list-style-type: none"> • Has a diagnosis of PBA secondary to a neurologic condition AND • Has had treatment failure, contraindication, or allergy to a tricyclic antidepressant (TCA) or a selective serotonin reuptake inhibitor (SSRI) AND • Is ≥ 18 years old AND • Baseline Center for Neurologic Study-Lability Scale (CNS-LS) score >13 AND • Does not exceed 40mg dextromethorphan and 20mg quinidine (2 capsules per day) • Authorization will be granted for 12 weeks AND • For renewal, must respond positively to therapy as evidenced by a decrease in the CNS-LS score of ≥ 3 points from baseline

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Cortisol Receptor Blocker	Korlym® (mifepristone)	<ul style="list-style-type: none"> • Must have a recommendation or consultation from an endocrinologist AND • Must have a diagnosis of Cushing's Disease AND • Must have a history of at least 30 days of therapy with ketoconazole within the past 60 days (or a documented clinical reason the patient cannot use ketoconazole) AND • Must have documented hyperglycemia AND • Must not be pregnant AND • Authorization limited to less than or equal to 4 doses per day with an initial authorization for 60 days and subsequent authorization for 1 year
Diabetic Testing Supplies	Continuous Glucose Monitoring Systems (CGMS)	<p>INITIAL AUTHORIZATION</p> <ul style="list-style-type: none"> • Must be 2 years of age or older AND • Must have completed a comprehensive diabetes education program within the previous 12 months AND • Must be adherent to the insulin therapy recommended by an endocrinologist as demonstrated by monitoring logs and claims history maintained for at least 45 days AND • A letter or documentation indicating the patient regularly works with a certified diabetes educator AND • Insulin injections are required greater than or equal to 3 times a day or on an insulin pump AND • The patient meets one of the following: <ul style="list-style-type: none"> ○ History of recurrent hypoglycemia or hypoglycemic unawareness despite diligent adjustments to therapy ○ Pregnant with poorly controlled diabetes; poorly controlled is defined as hypoglycemic episodes, hypoglycemic unawareness, suspected post-prandial hyperglycemia, or recurrent diabetic ketoacidosis • Authorization will be provided for up to 6 months for sensors (1 year for renewal if compliant) and 1 year for transmitters with the following limits: 1 receiver per every 4 years; 1 transmitter every three months; 4 sensors per month. <p>REAUTHORIZATION</p> <p>Continuation of CGM use after one year or device replacement is considered medically necessary for the following:</p> <ul style="list-style-type: none"> • If for replacement, the device is malfunctioning and out of warranty • If for after one year, provider attestation or chart notes indicating that the member: <ul style="list-style-type: none"> ○ Is utilizing sensors at least 5 days per week (75% of the time) for at least 6 of the 8 weeks within 90 days of the submission of the Prior Authorization, unless hospitalized or other clinically valid reason. ○ Continued use of the device is recommended by an endocrinologist ○ Must be compliant with the CGM treatment plan (including regular sensor use) and clinical documentation indicates a continued benefit from CGM usage. • Authorization will be provided for up to 1 year for sensors and transmitters with the following limits: 1 receiver per every 4 years; 1 transmitter every three months; 4 sensors per month

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Diabetic Insulin Pump	Omnipod® V-Go®	<p>INITIAL AUTHORIZATION</p> <ul style="list-style-type: none"> • Requests for V-Go will be limited to a diagnosis of Type 2 Diabetes AND • Must have completed a comprehensive diabetes education program within the previous 12 months AND • Must be adherent to the insulin therapy recommended by an endocrinologist as demonstrated by monitoring logs and claims history maintained for at least 3 months AND • A letter or documentation indicating patient regularly works with a certified diabetes educator AND • Insulin injections are required greater than or equal to 3 times a day AND • Self-Home glucose monitoring is required greater than or equal to 4 times a day AND • Meets one of the following: <ul style="list-style-type: none"> • HgA1C>7% • History of recurrent hypoglycemia • Wide fluctuations in blood glucose before mealtime • A marked early morning increase in fasting blood sugar (dawn phenomenon-glucose level exceeds 200mg/dL) • History of ketoacidosis • A history of severe glycemic excursions AND • Must be capable of managing the pump and that the desired improvement in metabolic control can be achieved (or someone assisting the individual) <p>REAUTHORIZATION</p> <ul style="list-style-type: none"> • Prescriber must attest to the following <ul style="list-style-type: none"> • Must be able to manage the pump (or someone assisting the individual) • Objective documented evidence of improvement in control of diabetes (specific to baseline status of disease for individual patients)

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Diarylquinoline Antimycobacterial	Sirturo® (bedaquiline)	<ul style="list-style-type: none"> • Must be at least 5 years of age and weigh at least 15 kg AND • Must have a diagnosis of pulmonary multi-drug resistant tuberculosis as confirmed by an isolate showing resistance to both isoniazid and rifampin AND • Must be prescribed by an Infectious Disease specialist AND • ECG, liver enzymes and electrolytes must be obtained prior to administration AND • Must be used with at least three drugs to which MDR-TB isolate is susceptible in vitro (or, in the absence of in vitro testing, at least four other drugs to which isolate is likely to be susceptible) AND • Initial authorization for two weeks of therapy limited to 28 or 56 of the 100 mg tablets or 140 or 280 of the 20 mg tablets AND • For reauthorization, an ECG must have been obtained two weeks after starting the drug and another ECG about 10 weeks later. There must be documentation that the QT interval has been evaluated for continued drug therapy, recommended to be <500 milliseconds. The remaining 22 weeks of therapy limited to 66 or 132 of the 100 mg tablets or 330 or 660 of the 20 mg tablets
Dopamine Precursor	Lodosyn® (carbidopa)	<ul style="list-style-type: none"> • Approved for 1 year if being prescribed in combination with levodopa OR • Approved for 3 months if there is a history of levodopa-containing product in the past 45 days
Endocrine-Metabolic Analog	Sandostatin® (octreotide)	<ul style="list-style-type: none"> • Must be prescribed by an endocrinologist, or oncologist or prescriber in consultation with one of these specialists AND • Must have a diagnosis of acromegaly and be ≥ 18 years of age AND • Must have a documented baseline IGF-I (somatomedin C) level above normal range for age (level should be re-evaluated at 6-month intervals) AND • Did not have adequate response to surgery, radiation, bromocriptine mesylate OR surgical resection is not an option OR • Must have a diagnosis of carcinoid tumor with documented diarrhea and flushing associated with tumor OR • Must have a diagnosis of VIP-tumor (VIPoma) with documented profuse watery diarrhea associated with the VIP-secreting tumor AND • Authorization for up to 3 months with re-authorization requiring evidence of improvement in condition due to therapy

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Endocrine-Metabolic Analog	Octreotide, Long-Acting Formulation (Sandostatin LAR)	<ul style="list-style-type: none"> • Must be prescribed by an endocrinologist OR oncologist OR prescriber in consultation with one of these specialists AND • Must have previously treated with short-acting injection for at least 2 weeks with documented success AND • Initial authorization for up to 6 months with re-authorization requiring documentation of clinical benefit
Enzyme Replacement Therapy for disorder caused by mutations in the GBA gene, which results in a deficiency of the lysosomal enzyme beta-glucocerebrosidase	Cerezyme® (imiglucerase) Elelyso® (taliglucerase alfa) Vpriv® (velaglucerase alfa)	<ul style="list-style-type: none"> • Must have a confirmed diagnosis of Type 1 Gaucher disease and be of appropriate age (≥ 4 years old for Elelyso and Vpriv; ≥ 2 years old for Cerezyme) AND • Therapy must be initiated to manage any one of the following: anemia/thrombocytopenia/bone disease/ hepatomegaly/ splenomegaly [Cerezyme® Only] AND • Must not be already receiving another enzyme therapy (e.g. Zavesca, Cerdelga) AND • Must have baseline, and at least once annually, hemoglobin level, platelet count, spleen volume and liver volume tests/examination, dexta scan AND • Authorizations beyond the initial will require documentation demonstrating benefit from therapy (e.g. decreased liver and spleen volume, increased platelet count, increased hemoglobin concentration)
GH Receptor Antagonist	Somavert® (pegvisomant)	<ul style="list-style-type: none"> • Must have a diagnosis of acromegaly with inadequate response to surgery AND • Must have trialed other therapies and/or other therapies must not be appropriate for the patient with documented response and/or reasons to each provided
Glucocorticoid	Emflaza® (deflazacort)	<ul style="list-style-type: none"> • Must have a diagnosis of Duchenne Muscular Dystrophy AND • Is 2 years of age or older AND • Has a serum creatinine kinase activity at least 10 times the upper limit of normal prior to initiating treatment AND • Must have a trial and failure to 6 months use of prednisone OR • Must have an intolerance or contraindication to prednisone AND • Prescribed by or in consultation with a neurologist or specialist in Duchenne Muscular Dystrophy AND • Dose does not exceed 0.9mg/kg per day (Please provide patient weight on PA request)
Glutarimide Immunomodulatory Agent	Thalomid® (thalidomide)	<ul style="list-style-type: none"> • Must have a diagnosis of leprosy OR • Must have a diagnosis of cancer and medication must be prescribed by an oncologist AND • Initial authorization limited to 4 weeks AND • Re-authorization occurs automatically based upon claim history for Thalomid in the past 28 days

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H-2 Antagonist	Preferred: Cimetidine (generic of Tagamet®) Famotidine (generic of Pepcid®) Ranitidine (generic of Zantac®) Non-Preferred: nizatidine	<ul style="list-style-type: none"> • Non-preferred medications will be approved if there is at least a 30-day history of therapy with one preferred agent in the past 90 days written by the same prescriber OR • Allergy, contraindication, drug-drug interaction, or history of unacceptable/ toxic effects to the preferred drugs AND • Patient's condition is clinically unstable AND • Medication was initiated in hospital to treat a GI bleed or other serious acute condition AND • Ranitidine Syrup authorization limited to patient's less than 12 years of age unless any of the above applies
Hepatitis B Immune Globulin	Hepagam B® (hepatitis b immune globulin (human)) HyperHEP B® (hepatitis b immune globulin (human)) Nabi-HB® (human hepatitis b virus immune globulin)	<ul style="list-style-type: none"> • Less than or equal to 12 months of age authorization is limited to those exposed to others with hepatitis B and to 14 days OR • Must have a diagnosis requiring post-exposure prophylaxis and authorization will be limited to 2 months OR • Must have had a sexual encounter with a hepatitis B positive individual within the last two weeks and authorization will be limited to 14 days OR • Must have had a liver transplant and using Hepgam B® to prevent hepatitis B recurrence and authorization will be approved for 1 year
Human Chorionic Gonadotropin (HCG)	HCG (human chorionic gonadotropin) Novarel® (gonadotrophin, chorionic) Ovidrel® (choriogonadotropin alfa) Pregnyl® (choriogonadotropin alfa)	<ul style="list-style-type: none"> • Must have a diagnosis of hypogonadism OR • Must have a diagnosis of Prepubertal Cryptorchidism not due to anatomical obstruction
Human Recombinant Interleukin-2	Proleukin® (aldesleukin)	<ul style="list-style-type: none"> • Must have a diagnosis of metastatic renal cell carcinoma (metastatic RCC) or metastatic melanoma AND • Must have normal cardiac, pulmonary, hepatic and CNS function AND • Must have pulmonary function and thallium cardiac stress test with normal results AND • Patient must not have any organ allografts AND • Patient must have a serum creatinine $\leq 1.5\text{mg/dL}$

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Hydroxyphenyl-pyruvate dioxygenase inhibitor	Orfadin® (nitisinone)	<ul style="list-style-type: none"> • Patient must have a diagnosis of hereditary tyrosinemia type-1 (HT-) AND • Medication must be prescribed by an endocrinologist or pediatrician or consulting a specialist who has knowledge in treating patients with HT-1
Inhibitor of glucosylceramide synthase	Zavesca® (miglustat)	<ul style="list-style-type: none"> • Must have a diagnosis of mild to moderate Type 1 Gaucher disease AND • Must be unable to receive enzyme therapy due to an allergy, hypersensitivity, or poor venous access AND • Authorization limited to dose ≤ 300mg per day
Inhibitor of glucosylceramide synthase	Cerdelga™ (eliglustat)	<ul style="list-style-type: none"> • Must be ≥ 18 years of age AND • Must have a confirmed diagnosis of Type 1 Gaucher disease AND • Must have FDA-cleared test to evaluate cytochrome P450 enzyme (CYP)2D6 functionality AND • Must have baseline, and at least once annually, hemoglobin level, platelet count, spleen volume and liver volume tests/examination AND • Authorization will not be granted for any subsequent fill where the condition has not improved with treatment as measured relative to the baseline tests
Inhibitor of histone deacetylases	Zolinza® (vorinostat)	<ul style="list-style-type: none"> • Must have a diagnosis of progressive, persistent or recurrent cutaneous T-cell lymphoma AND • Initial authorization limited to 1 capsule per day and 6 months at a time
Insulin-like Growth Factors	Increlex® (mecasermin)	<ul style="list-style-type: none"> • Must be between the age of 2 to 17 years AND • Must have a diagnosis of primary IGF-1 Deficiency (height standard deviation score ≤ -3.0 AND normal or elevated GH) AND • Must have a diagnosis of growth hormone gene deletion with neutralizing antibodies to growth hormone AND • Must not have uncorrected thyroid or nutritional deficiencies AND • Prescriber must be familiar with treating patients with growth disorder AND • For re-authorization requests evidence must be provided of increase in height velocity
Isotretinoin (oral)	Absorica® (isotretinoin) Amnesteem® (isotretinoin) Claravis™ (isotretinoin) Myorisan™ (isotretinoin) Sotret® (isotretinoin) Zenatane™ (isotretinoin)	<ul style="list-style-type: none"> • Must have a diagnosis of Severe, Recalcitrant Nodular Acne AND • Must have tried at least 30 days of other anti-acne products within the past 90 days OR • Must have a diagnosis of keratinization disorder OR • Must have a diagnosis of Cutaneous T-cell Lymphoma, Leukoplakia, Neuroblastoma, Hidradenitis Suppurativa or tumor prevention during treatment of squamous cell carcinoma AND • Must be absent oral tretinoin in the past 60 days AND • Authorization provided for no more than 5 months at a time

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IV Lock Therapy	Ablysinol® (dehydrated alcohol)	<ul style="list-style-type: none"> • Has a history of catheter-related bloodstream infections caused by drug resistant pathogens for which there is not a suitable antibiotic lock agent (e.g. fungal) AND • Replacement of the catheter is not feasible AND • The patient is TPN dependent or on myelosuppressive chemotherapy AND • For approval, pharmacy must prepare prefilled syringes of Ablysinol diluted to 70% AND • For renewal, provide documentation of effectiveness (i.e. absence of recurrence of CRBSI or clearing of established infection)
Lipopeptide Antibacterials	Cubicin®(daptomycin)	<ul style="list-style-type: none"> • Must have a diagnosis of infection of the skin or skin structure caused by gram positive bacterial susceptible to the medication OR • Must have a diagnosis of right-sided Endocarditis OR • Must have a diagnosis of a MRSA bloodstream infection OR • Will be approved as a continuation of therapy if initiated in the hospital AND • Authorization limited to 28 days
Long-acting Benzodiazepine	Xanax XR® (alprazolam, extended release)	<ul style="list-style-type: none"> • Must have a diagnosis of panic disorder AND • Must have documented inadequate response to other benzodiazepines or is transitioning from other benzodiazepines to alprazolam ER AND • Initial authorization is for 6 months AND • Re- authorization is for 6 months if it is documented the patient's condition has improved with therapy
Melatonin receptor agonist	Hetlioz® (tasimelteon)	<ul style="list-style-type: none"> • Patient must be totally blind AND • Patient must have a diagnosis of Non-24-hour Sleep Wake Disorder AND • Authorization will be limited to 90 days
Miscellaneous Endocrine and Metabolic Agents	Carnitor® (levocarnitine)	<ul style="list-style-type: none"> • Automatically approved if there is a history of valproic acid drug use in the past 6 months OR • Must have a diagnosis of primary or secondary carnitine deficiency confirmed by testing to verify deficiency OR • Must have a diagnosis of mitochondrial disease
Miscellaneous Topical Combination Product	Tri-Luma® (fluocinolone, hydroquinone, and tretinoin)	<ul style="list-style-type: none"> • Must have a diagnosis of melisma of the face AND • Authorization limited to 6 months

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Monoclonal antibody for RSV	Synagis®(palivizumab)	<ul style="list-style-type: none"> Medication must be requested for use during the RSV season (November 1st to March 31st) AND Monthly doses must not exceed 15mg/kg per dose AND <p>Use not to exceed 5 doses per single RSV season or 1 dose per month; whichever is lower AND Patient must have a diagnosis of at least one of the following:</p> <ul style="list-style-type: none"> O Prematurity <ul style="list-style-type: none"> ▪Infants born before 29 weeks, 0 day's gestations who are < 12 months of age at the start of RSV season O Chronic Lung Disease <ul style="list-style-type: none"> ▪Infants gestation age < 32 weeks who are < 12 months of age and require >21% oxygen for at least the first 28 DAYS after birth OR ▪Infants born at < 32 weeks, 0 day's gestation who are ≥ 12 to < 24 months of age who required at least 28 days of >21% oxygen after birth and who continue to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV season O Congenital Heart Disease <ul style="list-style-type: none"> ▪Infants who are < 12 months of age with a diagnosis of hemodynamically significant heart disease who will most likely benefit from immunoprophylaxis: ▪Infants with acyanotic heart disease receiving drugs to control congestive heart failure with a history of at least 30 days of therapy with medications used to control congestive heart failure in the last 180 days and who will require surgery ▪Infants with moderate to severe pulmonary hypertension and history of at least 30 days of therapy with medications used to control pulmonary hypertension in the past 180 DAYS ▪Infants with a cyanotic heart defect who are prescribed therapy in consultation with a pediatric cardiologist O Congenital abnormalities of the airway or neuromuscular disease <ul style="list-style-type: none"> ▪Infants who are < 12 months of age with a diagnosis of a neuromuscular condition that compromises handling of respiratory secretions O Heart Transplant <ul style="list-style-type: none"> ▪Patients who are <24 months of age who have a heart transplant during RSV season O Immunocompromised <ul style="list-style-type: none"> ▪Patients who are <24 months of age who have a diagnosis that supports they are profoundly immunocompromised during the RSV season (e.g. chemotherapy)

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Monoclonal Antibody targeting CD20	Rituxan® (rituximab)	<ul style="list-style-type: none"> • Must have a living arrangement in a long-term care facility AND • Must have a diagnosis of CD20-positive B-cell Non- Hodgkin's Lymphoma (NHL) for an 8-week authorization OR • Must have a diagnosis of CD20-positive Chronic Lymphocytic Leukemia (CLL) also being treated with fludarabine and cyclophosphamide for a 4-week authorization OR • Must have a diagnosis of Wegner's Granulomatosis or Microscopic Polyangitis for a 4- week authorization OR • Must have a diagnosis of moderately to severely active rheumatoid arthritis with a history of methotrexate in the past 30 days and a history of a TNF inhibitor in the past year for a 30-day authorization
Monoclonal Antibody targeting TNFα	Remicade® (infliximab)	<p>Must not have moderate to severe heart failure (NYHA Class III/IV) AND</p> <ul style="list-style-type: none"> • Must have a diagnosis of Rheumatoid Arthritis AND • a history of oral methotrexate in the past 30 days OR • a diagnosis of Psoriatic Arthritis AND • Must have trialed at least two of the following medications in the past two years: Gold compounds (Mycophrysine, Ridaura), Hydroxychloroquine, Kineret, Leflunomide, Methotrexate (oral), NSAIDS, Penicillamine (Cuprimine, Depen), TNF Inhibitors (Remicade, Cimzia, Enbrel, Humira, Orencia, Simponi, etc) OR • Must have a diagnosis of Crohn's Disease AND • a history of at least 180 days of therapy with one of the following medications in the past year: oral corticosteroid+mesalamine (Asacol, Apriso, Canasa, Delzicol, Lialda, Pentasa, Rowasa), mercaptopurine, azathioprine OR • Must have a diagnosis of Ankylosing Spondylitis AND • a history of at least 180 days of therapy with a NSAID in the past year OR • Must have a diagnosis of Chronic, Severe Plaque Psoriasis AND • a trial of at least one of the following medications in the past year: acitretin (Soriatane), anthralin (Dritho-crème, Zithranol), calcipotriene (Dovonex), calcipotriene/betamethasone (Taclonex), cyclosporine, methoxsalen (8-MOP, Oxsooralen), TNF Inhibitors (Cimzia, Enbrel, Humira, Orencia, Simponi, etc), Tazarotene (Tazorac, Avage, Fabior), Topical steroids OR • Must have a diagnosis of Ulcerative Colitis AND • a history of at least one of the following medications in the past two years: azathioprine, balsalazide, Celestone Soluspan, cortisone (oral), cyclosporine, dexamethasone (oral), Dipentum, hydrocortisone (oral), mesalamine (Asacol, Apriso, Canasa, Delzicol, Lialda, Pentasa, Rowasa), methylprednisolone (oral), mercaptopurine, Paser, prednisone (oral), prednisolone (oral), sulfadiazine, sulfasalazine AND Authorization limited to a dose ≤ 5mg/kg

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Nasal synthetic vasopressin analogue	Stimate® (desmopressin acetate)	<ul style="list-style-type: none"> • Must have a diagnosis of mild hemophilia A (factor level 5% or greater) and a documented response to DDAVP OR • Must have a diagnosis of type 1 or 2 Von Willebrand Disease and a documented response to DDAVP OR • Females who are symptomatic carriers of hemophilia A and have a documented response to DDAVP OR • Must have a functional platelet disorder (such as storage pool disease) AND • Authorization limited to 30 days with re-authorization for 1 year for those with Documented adequate response to treatment
Oxazolidinone Antibacterial	Zyvox® (linezolid)	<ul style="list-style-type: none"> • Must have a diagnosis of MRSA or VRE OR • Medication must have been initiated in the hospital OR • Has a history of the linezolid injection in the past 28 days AND • Authorization limited to 28 days
Oxazolidinone Antibacterial	Sivextro® (tedizolid)	<ul style="list-style-type: none"> • Must have a diagnosis of an acute bacterial skin and skin structure infection caused by: MRSA, MSSA, S. pyogenes, S. agalactiae, S. anginosus Group (including S. anginosus, S. intermedius, and S. constellatus), E. faecalis, OR VRE OR • Medication must have been initiated in the hospital AND • Authorization limited to 6 days
Psoralens	8-MOP® (methoxsalen) Oxsoralen-Ultra® (methoxsalen)	<ul style="list-style-type: none"> • Prescriber must have proper training for use of the UVAR photopheresis system AND • Must not have a diagnosis of a light sensitive disease state OR • Must not have a diagnosis of melanoma or a history of melanoma or invasive squamous cell carcinoma
Retinoid X Receptor Activator	Targretin® (bexarotene)	<ul style="list-style-type: none"> • Must be confirmed to be not pregnant and not planning on becoming pregnant AND • Must have a diagnosis of cutaneous manifestations of T-cell lymphoma, non-small cell lung cancer AND • Must be prescribed by an oncologist
Somatostatin Analogue	Signifor® (pasireotide)	<ul style="list-style-type: none"> • Must have a diagnosis of Cushing's Disease AND • Must have a history of at least 30 days of therapy with ketoconazole or cabergoline within the past 60 days (or a documented clinical reason the patient cannot use ketoconazole or cabergoline) AND • Authorization limited to less than or equal to 2ml per day with an initial authorization for 60 days and subsequent authorization for 1 year

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Spinal Muscular Atrophy (SMA)	Evrysdi™ (risdiplam)	<ul style="list-style-type: none"> Member has a diagnosis of type 1, 2 or 3 Spinal Muscular Atrophy (SMA) with both of the following: <ol style="list-style-type: none"> Genetic testing quantifying the copy number of SMN2 gene ≤ 4. Member is symptomatic. Genetic testing confirms one of the following: <ol style="list-style-type: none"> Homozygous deletions of SMN1 gene Homozygous mutations in the SMN1 gene Compound heterozygous mutations in SMN1 gene Prescribed by, or in consultation with, a neurologist, AND Member is two months of age or older AND Dosing follows FDA approved dose for age and weight AND Not concomitantly prescribed other treatments for SMA such as Zolgensma or nusinersen AND If prior treatment with Zolgensma attempted, documentation of poor response (e.g. sustained decrease in CHOP-INTEND score over a 6-month period) <ul style="list-style-type: none"> Authorization will be provided for up to 1 year Renewal for continued use will be based on meeting the requirements of the prior authorization criteria and documentation of clinical efficacy
Streptogramin Antibacterial	Synercid® (quinupristin and dalfopristin)	<ul style="list-style-type: none"> Must have a diagnosis of serious and life-threatening vancomycin-resistant enterococcus (VR) infection AND Authorization limited to 30 days
Sublingual Allergen Extract	Grastek® (timothy grass pollen allergen extract) Ragwitek® (short ragweed pollen allergen extract)	<ul style="list-style-type: none"> Must not be a candidate to receive allergy shots AND Must be between the age 5 and 65 AND Must have a history of at least 90 days of therapy with two or more different anti- allergy classes in the past 6 months AND Must test positive to the appropriate allergen AND Must have symptoms present ≥ 120 DAYS during the last allergy season (January to June for Grastek; March to September for Ragwitek) AND Authorization will be limited 12 weeks prior to start of allergy season and continued for duration of allergy season (January to June for Grastek; March to September for Ragwitek) AND Authorization will be limited to 3 total years of treatment

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Tetracycline Antibacterial (IV Infusion)	Tygacil® (tigecycline)	<ul style="list-style-type: none"> • Must be ≥ 18 years of age AND • Must live in assisted living or receiving home healthcare with nursing services AND • Must have a diagnosis of a complicated skin and skin structure infection OR • Must have a diagnosis of drug-resistant complicated intra- abdominal infection AND • Must have documented trials and failed other anti- infectives
Tetracycline Antibacterials	demeclocycline	<ul style="list-style-type: none"> • Will be approved if doxycycline, minocycline or tetracycline are inappropriate to treat the current medical condition clinically AND • Authorization limited to 1 month
Thalidomide Analogue	Revlimid® (lenalidomide)	<ul style="list-style-type: none"> • Must have a diagnosis of multiple myeloma OR • Must have a diagnosis of transfusion-dependent anemia due to low- or intermediate-1- risk myelodysplastic syndromes (MDS) associated with a deletion 5q cytogenetic abnormality OR • Must have a diagnosis of mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib) AND • Patient and prescriber must be enrolled in the REM program
Topical agents for Actinic Keratosis	Aldara® (imiquimod)	<ul style="list-style-type: none"> • Must have a diagnosis of Actinic Keratosis AND • Authorization limited to 36 packets over 16 weeks in 1-year OR • Must have a diagnosis of Superficial Basal Cell Carcinoma AND • Authorization limited to 36 single-use packets over 6 weeks in 1-year OR • Must have a diagnosis of Genital or Perianal Warts AND • Authorization limited to 48 single-use packets over 16 weeks in 1 year
Topical agents for Actinic Keratosis	Picato® (ingenol mebutate)	<ul style="list-style-type: none"> • Must have a diagnosis of Actinic Keratosis AND • Must be 18 years of age or older AND • Authorization limited to one claim (MAX QTY of 3 tubes) of the 0.15% gel for treating the face every 180 days OR • Authorization limited to one claim of the 0.05% gel (MAX QTY of 2 tubes) for treating the trunk every 180 days
Topical agents for Actinic Keratosis	Zyclara® (imiquimod)	<ul style="list-style-type: none"> • Must have a diagnosis of Actinic Keratosis A AND • Authorization limited to 28 packs per year

Therapeutic Class	Drug Name	Clinical Criteria (Authorization is for 1 year unless otherwise stated)
Topical Agents: Treatment of Anal Fissure	Rectiv™ (nitroglycerin)	<ul style="list-style-type: none"> • Must have a diagnosis to treat moderate to severe pain associated with chronic anal fissure AND • Must have trialed laxatives, stool softeners and/or fiber in the past year AND • Must have trialed a topical steroid containing product in the past 60 days AND • Must have trialed a topical vasoconstrictor product containing phenylephrine in the past 60 days AND • Authorization limited to one fill of ≤ 30-gram tube every 6 months
Topical - astringents / protectants	Qbrexza™ (glycopyrronium)	<ul style="list-style-type: none"> • Must have a diagnosis of hyperhidrosis of the axillary AND • Must have a one-month trial and failure of either Drysol or Xerac-AC Solution OR • Has an intolerance or contraindication to the use of Drysol and Xerac-AC
Topical Retinoid	Panretin® (alitretinoin)	<ul style="list-style-type: none"> • Must have a diagnosis of cutaneous lesions in patients with AIDS-related Kaposi's Sarcoma (KS) AND • Must have less than 10 lesions in the past month AND • Must not have symptomatic lymphedema, symptomatic pulmonary KS or symptomatic visceral involvement
Vitamin B-12	Nascobal® (cyanocobalamin)	<ul style="list-style-type: none"> • Approved if member has a documented lack of muscle mass that prevents the use of cyanocobalamin injection
All Other Therapies Not Listed Here or on the Unified Preferred Drug List (UPDL)	All Other Therapies Not Listed Here or on the Unified Preferred Drug List (UPDL)	<ul style="list-style-type: none"> • Must be prescribed in accordance with its FDA approved labeling