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Actimmune

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146461
Guideline Name	Actimmune
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Actimmune	
Diagnosis	Chronic Granulomatous Disease (CGD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTIMMUNE	INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML)	21700060702020	Brand

Approval Criteria

1 - Diagnosis of chronic granulomatous disease

Product Name: Actimmune	
Diagnosis	Osteopetrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTIMMUNE	INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML)	21700060702020	Brand

Approval Criteria

1 - Diagnosis of severe, malignant osteopetrosis

Product Name: Actimmune	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTIMMUNE	INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML)	21700060702020	Brand

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Mycosis fungoides (MF)
- Sézary syndrome (SS)

Product Name: Actimmune	
Diagnosis	Chronic Granulomatous Disease (CGD), Osteopetrosis, Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTIMMUNE	INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML)	21700060702020	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Actimmune

Product Name: Actimmune	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTIMMUNE	INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML)	21700060702020	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Actimmune	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTIMMUNE	INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML)	21700060702020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Actimmune therapy

Adalimumab

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155442
Guideline Name	Adalimumab
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand

HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand

HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand

HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand

ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand

CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

- Failure to a 3 month trial of ONE non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses confirmed by claims history or submission of medical records
- History of intolerance or contraindication to one non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) (please specify intolerance or contraindication)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

4.2.2 If the request is for a non-preferred adalimumab product, ONE of the following:

- Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Tyenne (tocilizumab-aazg) [please specify intolerance or contraindication]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand

IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand

HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand

YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand

ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

1.2 Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.3 Prescribed by or in consultation with a rheumatologist

AND

1.4 If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

AND

1.5 If the request is for a non-preferred adalimumab product, ONE of the following:

- Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Tyenne (tocilizumab-aazg) [please specify intolerance or contraindication]

OR

2 - ALL of the following:

2.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2.3 Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.4 Prescribed by or in consultation with a rheumatologist

AND

2.5 If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug cov erage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand

HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand

CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand

HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand

IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand

ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with one of the following:

- Rheumatologist
- Dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

4.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug cov erage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand

IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand

HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand

YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand

ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of moderate to severe chronic plaque psoriasis

AND

2 - Patient is not receiving adalimumab in combination with another targeted

immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 ALL of the following:

4.2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

4.2.1.2 ONE of the following:

4.2.1.2.1 Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

4.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

4.2.1.3 ONE of the following:

4.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

4.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use:

	CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand

AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand

HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand

ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand

ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Failure to two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

4.2.2 History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

4.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand

HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand

CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand

ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand

YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand

HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Failure to ONE of the following conventional drugs or classes at maximally indicated doses, as confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (generic Imuran)
- 6-mercaptopurine (generic Purinethol)

- Methotrexate

OR

4.2.2 History of intolerance or contraindication to ALL of the following conventional drugs or classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (generic Imuran)
- 6-mercaptopurine (generic Purinethol)
- Methotrexate

OR

4.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Stelara (ustekinumab)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand

ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand

HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand

SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand

CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) as confirmed by claims history or submitted medical records

OR

4.2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission medical records [e.g., Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib)]

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug cov erage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)

Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand

IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand

HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand

HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand

ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

4.2 ONE of the following:

4.2.1 Failure to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses, as confirmed by claims history or submission of medical records

OR

4.2.2 History of intolerance or contraindication to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) (please specify intolerance or contraindication)

AND

5 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug cov erage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	Uveitis (UV)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand

IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand

HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand

YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand

ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Diagnosis of non-infectious uveitis

AND

2 - Uveitis is classified as ONE of the following:

- Intermediate
- Posterior
- Panuveitis

AND

3 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Ophthalmologist

AND

5 - ONE of the following:

5.1 Patient is currently on Adalimumab therapy as confirmed by claims history or submission of medical records

OR

5.2 BOTH of the following:

5.2.1 ONE of the following:

5.2.1.1 Failure to at least ONE corticosteroid (e.g., prednisolone, prednisone) at maximally indicated dose, as confirmed by claims history or submission of medical records

OR

5.2.1.2 History of intolerance or contraindication to at least ONE corticosteroid (e.g., prednisolone, prednisone) (please specify intolerance or contraindication)

AND

5.2.2 ONE of the following:

5.2.2.1 Failure to at least ONE systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) at maximally indicated dose, as confirmed by claims history or submission of medical records

OR

5.2.2.2 History of intolerance or contraindication to at least ONE systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) (please specify intolerance or contraindication)

AND

6 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*

Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry, Adalimumab (all products)	
Diagnosis	RA, PJIA, PsA, Plaque Psoriasis, AS, CD, Ulcerative Colitis, HS, UV
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand

HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand

HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand

HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
ABRILADA	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand

HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
ADALIMUMAB-AATY 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand

CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ADALIMUMAB-AACF STARTER PACK/CD/UC/HS (6 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-AACF STARTER PACK/PSORIASIS/UVEITIS (4 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
HYRIMOZ PLAQUE PSORIASIS/UVEITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
ADALIMUMAB-AACF (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand

Approval Criteria

1 - Documentation of positive clinical response to Adalimumab therapy

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]^

AND

3 - If the request is for a non-preferred adalimumab product, the prescriber has given a clinical

reason or special circumstance why the patient is unable to use the preferred adalimumab products (please document reason/special circumstances)*	
Notes	*If approving a non-preferred adalimumab, please enter 1) The group authorization CSPREFADAL (for NY EPP and NY use: CSNYADAL) 2) An authorization for the non-preferred adalimumab at GPI-12 level For a list of preferred adalimumab products please reference drug coverage tools. ^ Examples of drug(s) may not be applicable based on the requested indication.

2 . Background

Benefit/Coverage/Program Information
PDL link NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
9/23/2024	Updated RA and PJIA to require step through of Tyenne for nonpreferred agents. Added additional targeted immunomodulator examples to reauth. Added PDL link

Adbry

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154616
Guideline Name	Adbry
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Adbry	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADBRY	TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN PREFILLED SYR 150 MG/ML	9027308045E520	Brand

Approval Criteria

1 - Diagnosis of moderate-to severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 Failure to TWO of the following therapeutic classes of topical therapies, confirmed by claims history or submission of medical records:

- One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.2 History of intolerance or contraindication to ALL of the following therapeutic classes of topical therapies (please specify intolerance or contraindication):

- One medium, high or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.3 Patient is currently on Adbry therapy as confirmed by claims history or submission of medical records

AND

3 - ONE of the following:

3.1 Failure to Dupixent confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to Dupixent (please specify intolerance or contraindication)

OR

3.3 Patient is currently on Adbry therapy as confirmed by claims history or submission of medical records

AND

4 - Patient is NOT receiving Adbry in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

5 - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Adbry	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ADBRY	TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN PREFILLED SYR 150 MG/ML	9027308045E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Adbry therapy

AND

2 - Patient is NOT receiving Adbry in combination with either of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab)]
- Janus kinas inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

3 - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information

Table 1. Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05

	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2

	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
9/9/2024	Updated step through to include Dupixient due to formulary change.

ADHD Products

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148172
Guideline Name	ADHD Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: (All) Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Adhansia XR, Adzenys XR-ODT, Brand Aptensio XR, generic methylphenidate ER cap, Azstarys, Brand Concerta, generic methylphenidate ER OSM (generic Concerta), Cotempla XR-ODT, Brand Daytrana, generic methylphenidate patch, Brand Desoxyn, generic methamphetamine, Brand Dexedrine, generic dextroamphetamine ER, Dyanavel XR, Brand Evekeo, generic amphetamine, Evekeo ODT, Brand Focalin, generic dexmethylphenidate, Brand Focalin XR, generic dexmethylphenidate ER, Brand Intuniv, generic guanfacine ER, Jornay PM, Brand Kapvay, generic clonidine ER, Brand Methylin, generic methylphenidate soln, generic methylphenidate chew tabs, Brand Metadate CD, generic methylphenidate ER (CD), generic methylphenidate ER tab, Brand Mydayis, generic amphetamine/dextroamphetamine ER (generic Mydayis), Brand Procentra, generic dextroamphetamine soln, Qelbree, Quillichew ER, Quillivant XR, Brand Relexxii, Brand Methylphenidate ER OSM, generic methylphenidate ER OSM (generic Relexxii), Brand Ritalin, generic methylphenidate tablet, Brand Ritalin LA, generic methylphenidate ER (LA), Brand Strattera, generic atomoxetine, Brand Vyvanse chewable tablets, generic lisdexamfetamine chewable tablets, Brand Vyvanse capsules, generic lisdexamfetamine capsules, Xelstrym, Brand Zenzedi, generic dextroamphetamine

Diagnosis	Members Less than the FDA Approved Minimum Age*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 5 MG	61109902100305	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 5 MG	61109902100305	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 7.5 MG	61109902100307	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 7.5 MG	61109902100307	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 10 MG	61109902100310	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 10 MG	61109902100310	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 12.5 MG	61109902100312	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 12.5 MG	61109902100312	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 15 MG	61109902100315	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 15 MG	61109902100315	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 20 MG	61109902100320	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 20 MG	61109902100320	Generic
ADDERALL	AMPHETAMINE-DEXTROAMPHETAMINE TAB 30 MG	61109902100330	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE TAB 30 MG	61109902100330	Generic

ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 5 MG	61109902107005	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 5 MG	61109902107005	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG	61109902107010	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG	61109902107010	Generic
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 10 MG	61109902107010	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 15 MG	61109902107015	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 15 MG	61109902107015	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG	61109902107020	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG	61109902107020	Generic
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 20 MG	61109902107020	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 25 MG	61109902107025	Brand
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 25 MG	61109902107025	Generic
ADDERALL XR	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Generic
AMPHETAMINE/DEXTROAMPHETAMINE	AMPHETAMINE-DEXTROAMPHETAMINE CAP ER 24HR 30 MG	61109902107030	Generic
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 3.1 MG	61100010000H410	Brand

ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 6.3 MG	6110001000H420	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 9.4 MG	6110001000H430	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 12.5 MG	6110001000H440	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 15.7 MG	6110001000H450	Brand
ADZENYS XR-ODT	AMPHETAMINE TAB EXTENDED RELEASE DISINTEGRATING 18.8 MG	6110001000H460	Brand
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (XR)	61400020107055	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 15 MG (XR)	61400020107060	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (XR)	61400020107065	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (XR)	61400020107070	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (XR)	61400020107075	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 50 MG (XR)	61400020107080	Generic
APTENSIO XR	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (XR)	61400020107085	Generic

AZSTARYS	SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 26.1-5.2 MG	61409802800120	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 39.2-7.8 MG	61409802800130	Brand
AZSTARYS	SERDEXMETHYLPHENIDATE-DEXMETHYLPHENIDATE CAP 52.3-10.4 MG	61409802800140	Brand
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Generic
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Generic
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Generic
CONCERTA	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Generic
COTEMPLA XR-ODT	METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 8.6 MG	6140002000H410	Brand
COTEMPLA XR-ODT	METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 17.3 MG	6140002000H420	Brand
COTEMPLA XR-ODT	METHYLPHENIDATE TAB EXTENDED RELEASE DISINTEGRATING 25.9 MG	6140002000H430	Brand
DAYTRANA	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Brand
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 10 MG/9HR	61400020005910	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Brand

METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 15 MG/9HR	61400020005915	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Brand
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 20 MG/9HR	61400020005920	Generic
DAYTRANA	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	Brand
METHYLPHENIDATE	METHYLPHENIDATE TD PATCH 30 MG/9HR	61400020005930	Generic
DESOXYN	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Brand
METHAMPHETAMINE HCL	METHAMPHETAMINE HCL TAB 5 MG	61100030100305	Generic
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Brand
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 10 MG	61100020107010	Generic
DYANAVEL XR	AMPHETAMINE EXTENDED RELEASE SUSP 2.5 MG/ML	6110001000G120	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 5 MG	61100010000410	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 10 MG	61100010000420	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 15 MG	61100010000430	Brand
DYANAVEL XR	AMPHETAMINE CHEW TAB EXTENDED RELEASE 20 MG	61100010000440	Brand
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Generic
EVEKEO	AMPHETAMINE SULFATE TAB 5 MG	61100010100310	Brand
AMPHETAMINE SULFATE	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	Generic
EVEKEO	AMPHETAMINE SULFATE TAB 10 MG	61100010100320	Brand
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Generic

INTUNIV	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 1 MG (BASE EQUIV)	61353030107520	Generic
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Generic
INTUNIV	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 2 MG (BASE EQUIV)	61353030107530	Generic
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Generic
INTUNIV	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 3 MG (BASE EQUIV)	61353030107540	Generic
GUANFACINE ER	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Generic
INTUNIV	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Brand
GUANFACINE HYDROCHLORIDE	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Generic
GUANFACINE HYDROCHLORIDE ER	GUANFACINE HCL TAB ER 24HR 4 MG (BASE EQUIV)	61353030107550	Generic
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 20 MG (PM)	61400020107067	Brand
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 40 MG (PM)	61400020107077	Brand
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 60 MG (PM)	61400020107087	Brand
JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 80 MG (PM)	61400020107090	Brand

JORNAY PM	METHYLPHENIDATE HCL CAP DELAYED ER 24HR 100 MG (PM)	61400020107094	Brand
CLONIDINE HCL ER	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Generic
CLONIDINE HYDROCHLORIDE	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Generic
CLONIDINE HYDROCHLORIDE ER	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Generic
METHYLIN	METHYLPHENIDATE HCL SOLN 5 MG/5ML	61400020102020	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Generic
METHYLIN	METHYLPHENIDATE HCL SOLN 10 MG/5ML	61400020102030	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL CHEW TAB 2.5 MG	61400020100510	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL CHEW TAB 5 MG	61400020100520	Generic
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL CHEW TAB 10 MG	61400020100530	Generic
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 10 MG (CD)	61400020100210	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 20 MG (CD)	61400020100220	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 30 MG (CD)	61400020100230	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 40 MG (CD)	61400020100240	Generic

METADATE CD	METHYLPHENIDATE HCL CAP ER 40 MG (CD)	61400020100240	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 50 MG (CD)	61400020100250	Brand
METHYLPHENIDATE HYDROCHLORIDE CD	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Generic
METADATE CD	METHYLPHENIDATE HCL CAP ER 60 MG (CD)	61400020100260	Brand
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG	61109902107060	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 12.5 MG	61109902107060	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG	61109902107065	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 25 MG	61109902107065	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG	61109902107070	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 37.5 MG	61109902107070	Generic
MYDAYIS	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG	61109902107075	Brand
AMPHETAMINE/DEXTROAMPHETAMINE ER	AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR 50 MG	61109902107075	Generic
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Generic
PROCENTRA	DEXTROAMPHETAMINE SULFATE ORAL SOLUTION 5 MG/5ML	61100020102020	Brand

QELBREE	VILOXAZINE HCL CAP ER 24HR 100 MG	61354080207020	Brand
QELBREE	VILOXAZINE HCL CAP ER 24HR 150 MG	61354080207030	Brand
QELBREE	VILOXAZINE HCL CAP ER 24HR 200 MG	61354080207040	Brand
QUILLICHEW ER	METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 20 MG	6140002010H220	Brand
QUILLICHEW ER	METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 30 MG	6140002010H230	Brand
QUILLICHEW ER	METHYLPHENIDATE HCL CHEW TAB EXTENDED RELEASE 40 MG	6140002010H240	Brand
QUILLIVANT XR	METHYLPHENIDATE HCL FOR ER SUSP 25 MG/5ML (5 MG/ML)	6140002010G220	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 18 MG	61400020100460	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 27 MG	61400020100465	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 36 MG	61400020100470	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG	61400020100475	Generic
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 54 MG	61400020100480	Brand
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG	61400020100485	Generic
RELEXXII	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Generic
RITALIN	METHYLPHENIDATE HCL TAB 5 MG	61400020100305	Brand
METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Generic
RITALIN	METHYLPHENIDATE HCL TAB 10 MG	61400020100310	Brand

METHYLPHENIDATE HYDROCHLORIDE	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	Generic
RITALIN	METHYLPHENIDATE HCL TAB 20 MG	61400020100315	Brand
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 10 MG (LA)	61400020107010	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 20 MG (LA)	61400020107020	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 30 MG (LA)	61400020107030	Generic
RITALIN LA	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL CAP ER 24HR 40 MG (LA)	61400020107040	Generic
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 10 MG (BASE EQUIV)	61354015100110	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 10 MG (BASE EQUIV)	61354015100110	Generic
STRATTERA	ATOMOXETINE HCL CAP 10 MG (BASE EQUIV)	61354015100110	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 18 MG (BASE EQUIV)	61354015100118	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 18 MG (BASE EQUIV)	61354015100118	Generic
STRATTERA	ATOMOXETINE HCL CAP 18 MG (BASE EQUIV)	61354015100118	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 25 MG (BASE EQUIV)	61354015100125	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 25 MG (BASE EQUIV)	61354015100125	Generic
STRATTERA	ATOMOXETINE HCL CAP 25 MG (BASE EQUIV)	61354015100125	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 40 MG (BASE EQUIV)	61354015100140	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 40 MG (BASE EQUIV)	61354015100140	Generic

STRATTERA	ATOMOXETINE HCL CAP 40 MG (BASE EQUIV)	61354015100140	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 60 MG (BASE EQUIV)	61354015100160	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 60 MG (BASE EQUIV)	61354015100160	Generic
STRATTERA	ATOMOXETINE HCL CAP 60 MG (BASE EQUIV)	61354015100160	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 80 MG (BASE EQUIV)	61354015100170	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 80 MG (BASE EQUIV)	61354015100170	Generic
STRATTERA	ATOMOXETINE HCL CAP 80 MG (BASE EQUIV)	61354015100170	Brand
ATOMOXETINE HYDROCHLORIDE	ATOMOXETINE HCL CAP 100 MG (BASE EQUIV)	61354015100180	Generic
ATOMOXETINE	ATOMOXETINE HCL CAP 100 MG (BASE EQUIV)	61354015100180	Generic
STRATTERA	ATOMOXETINE HCL CAP 100 MG (BASE EQUIV)	61354015100180	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 10 MG	61100025100110	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 10 MG	61100025100110	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 20 MG	61100025100120	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 20 MG	61100025100120	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 30 MG	61100025100130	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 30 MG	61100025100130	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 40 MG	61100025100140	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 40 MG	61100025100140	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 50 MG	61100025100150	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 50 MG	61100025100150	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 60 MG	61100025100160	Generic

VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 60 MG	61100025100160	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CAP 70 MG	61100025100170	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CAP 70 MG	61100025100170	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG	61100025100510	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 10 MG	61100025100510	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG	61100025100520	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 20 MG	61100025100520	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG	61100025100530	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 30 MG	61100025100530	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG	61100025100540	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 40 MG	61100025100540	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG	61100025100550	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 50 MG	61100025100550	Brand
LISDEXAMFETAMINE DIMESYLATE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG	61100025100560	Generic
VYVANSE	LISDEXAMFETAMINE DIMESYLATE CHEW TAB 60 MG	61100025100560	Brand
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 4.5 MG/9HR	61100020005910	Brand
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 9 MG/9HR	61100020005920	Brand
XELSTRYM	DEXTROAMPHETAMINE TD PATCH 13.5 MG/9HR	61100020005930	Brand

XELSTRYM	DEXTROAMPHETAMINE TD PATCH 18 MG/9HR	61100020005940	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 2.5 MG	61100020100303	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 2.5 MG	61100020100303	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 5 MG	61100020100305	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 5 MG	61100020100305	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 7.5 MG	61100020100308	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 7.5 MG	61100020100308	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 10 MG	61100020100310	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 10 MG	61100020100310	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 15 MG	61100020100315	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 20 MG	61100020100330	Brand
DEXTROAMPHETAMINE SULFATE	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Generic
ZENZEDI	DEXTROAMPHETAMINE SULFATE TAB 30 MG	61100020100350	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 45 MG	61400020100475	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 63 MG	61400020100485	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER OSMOTIC RELEASE (OSM) 72 MG	61400020100490	Generic
FOCALIN	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 2.5 MG	61400016100320	Generic

FOCALIN	DEXMETHYLPHENIDATE HCL TAB 5 MG	61400016100330	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 5 MG	61400016100330	Generic
DEXMETHYLPHENIDATE HCL	DEXMETHYLPHENIDATE HCL TAB 5 MG	61400016100330	Generic
FOCALIN	DEXMETHYLPHENIDATE HCL TAB 10 MG	61400016100340	Brand
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL TAB 10 MG	61400016100340	Generic
DEXMETHYLPHENIDATE HCL	DEXMETHYLPHENIDATE HCL TAB 10 MG	61400016100340	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 5 MG	61400016107020	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 10 MG	61400016107030	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 15 MG	61400016107035	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG	61400016107040	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG	61400016107040	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 20 MG	61400016107040	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Brand

DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 25 MG	61400016107045	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 30 MG	61400016107050	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 35 MG	61400016107055	Generic
DEXMETHYLPHENIDATE HYDROCHLORIDE ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Generic
FOCALIN XR	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Brand
DEXMETHYLPHENIDATE HCL ER	DEXMETHYLPHENIDATE HCL CAP ER 24 HR 40 MG	61400016107060	Generic
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Generic
DEXTROAMPHETAMINE SULFATE ER	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 5 MG	61100020107005	Generic
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 5 MG	61100010107210	Brand
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 10 MG	61100010107220	Brand
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 15 MG	61100010107230	Brand
EVEKEO ODT	AMPHETAMINE SULFATE ORALLY DISINTEGRATING TAB 20 MG	61100010107240	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 25 MG	61400020107068	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 35 MG	61400020107073	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 45 MG	61400020107078	Brand

ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 55 MG	61400020107083	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 70 MG	61400020107088	Brand
ADHANSIA XR	METHYLPHENIDATE HCL CAP ER 24HR 85 MG	61400020107091	Brand
DEXEDRINE	DEXTROAMPHETAMINE SULFATE CAP ER 24HR 15 MG	61100020107015	Brand
KAPVAY	CLONIDINE HCL TAB ER 12HR 0.1 MG	61353020107420	Brand
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 18 MG	61400020107518	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 27 MG	61400020107527	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 36 MG	61400020107536	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 24HR 54 MG	61400020107554	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 10 MG	61400020100403	Generic
METHYLPHENIDATE HYDROCHLORIDE ER	METHYLPHENIDATE HCL TAB ER 20 MG	61400020100405	Generic
METHYLPHENIDATE HYDROCHLORIDE ER (LA)	METHYLPHENIDATE HCL CAP ER 24HR 60 MG (LA)	61400020107048	Generic

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD)

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex

• Clinical Pharmacology • United States Pharmacopoeia-National Formulary (USP-NF) **AND** **2** - The child is unresponsive to, or has had an inadequate response to behavioral therapy **AND** **3** - The child is experiencing moderate-severe continuing disturbance in function despite behavioral therapy	
Notes	*See Table 1 in background section for FDA approved min ages.

2 . Background

Benefit/Coverage/Program Information

Table 1: FDA Approved Minimum Age Table

Product name	FDA Approved Minimum Age
All products NOT listed below	6 years of age
Adderall (amphetamine/dextroamphetamine salts)	3 years of age
Dexedrine (dextroamphetamine)	3 years of age
Evekeo ODT/Evekeo (amphetamine) tablet	3 years of age
Mydayis (mixed amphetamine salts) ER capsule	13 years of age
ProCentra (dextroamphetamine) solution	3 years of age
Zenzedi (dextroamphetamine) tablet	3 years of age

3 . Revision History

Date	Notes
6/12/2024	New program.

Aemcolo

Prior Authorization Guideline

Guideline ID	GL-146288
Guideline Name	Aemcolo
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Aemcolo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AEMCOLO	RIFAMYCIN SODIUM TAB DELAYED RELEASE 194 MG (BASE EQUIV)	16000048200620	Brand

Approval Criteria

1 - Diagnosis of travelers' diarrhea

AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

Afinitor

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155816
Guideline Name	Afinitor
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Neuroendocrine tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand

AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Neuroendocrine tumors of gastrointestinal origin
- Neuroendocrine tumors of lung origin
- Neuroendocrine tumors of thymic origin

AND

1.2 Disease is progressive

AND

1.3 ONE of the following:

- Disease is unresectable
- Disease is locally advanced
- Disease is metastatic

AND

1.4 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

OR

2 - ALL of the following:

2.1 Diagnosis of neuroendocrine tumors of pancreatic origin

AND

2.2 ONE of the following:

- Used for the management of recurrent, locoregional advanced disease and/or metastatic disease
- Used as preoperative therapy of locoregional insulinoma with or without diazoxide

AND

2.3 If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Neuroendocrine Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Renal cell cancer, Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of advanced renal cell cancer/kidney cancer

AND

2 - Disease is ONE of the following:

- Relapsed
- Stage IV disease

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Renal cell cancer, Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic

EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Tuberous Sclerosis Complex-Associated Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic

EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of tuberous sclerosis complex (TSC)-associated renal cell carcinoma

AND

2 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Tuberous Sclerosis Complex-Associated Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand

AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Subependymal Giant Cell Astrocytoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand

AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of subependymal giant cell astrocytoma (SEGA)

AND

2 - Used as adjuvant treatment

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records

- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Subependymal Giant Cell Astrocytoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Waldenströms Macroglobulinemia or Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of one of the following:

- Waldenströms macroglobulinemia
- Lymphoplasmacytic lymphoma

AND

2 - One of the following:

- Disease is non-responsive to primary treatment
- Disease is progressive
- Disease has relapsed

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Waldenströms Macroglobulinemia or Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand

AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand

AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - One of the following:

2.1 Disease is recurrent

OR

2.2 Disease is metastatic

AND

3 - Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)]

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - One of the following:

5.1 Patient is a postmenopausal woman

OR

5.2 BOTH of the following:

- Patient is a premenopausal woman
- Patient is being treated with ovarian ablation/suppression

OR

5.3 Patient is male

AND

6 - Used in combination with one of the following:

6.1 Exemestane if progressed within 12 months or on a non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)]

OR

6.2 Fulvestrant

OR

6.3 Tamoxifen

AND

7 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic

EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic

EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of classic Hodgkin lymphoma

AND

2 - Disease is refractory to at least 3 prior lines of therapy

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	PEComa (perivascular epitheliod cell tumor), recurrent angiomyolipoma, or lymphangioleiomyomatosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of one of the following soft tissue sarcoma subtypes:

1.1 Locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa)

OR

1.2 Recurrent angiomyolipoma

OR

1.3 Lymphangioleiomyomatosis

AND

2 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	PEComa (perivascular epitheliod cell tumor), recurrent angiomyolipoma, or lymphangioleiomyomatosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic

EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Thymic Carcinoma or Thymoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic

EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - One of the following:

- Diagnosis of thymic carcinoma
- Diagnosis of thymoma

AND

2 - ONE of the following:

2.1 First-line therapy as a single agent for those who cannot tolerate first-line combination regimens

OR

2.2 Second-line therapy as a single agent

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records

- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Thymic Carcinoma or Thymoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Follicular carcinoma, Oncocytic carcinoma, or papillary carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

2 - ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

3 - ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

4 - Disease is refractory to radioactive iodine treatment

AND

5 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

Diagnosis	Follicular carcinoma, Oncocytic carcinoma, or papillary carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO

Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of meningioma

AND

2 - Disease is recurrent or progressive

AND

3 - Surgery and/or radiation is not possible

AND

4 - One of the following:

- Used in combination with bevacizumab (Avastin, Mvasi, etc.)
- Used in combination with octreotide acetate LAR

AND

5 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand

AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand

AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of endometrial carcinoma

AND

2 - Used in combination with letrozole

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Tuberous Sclerosis Complex associated Partial-Onset Seizures
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of tuberous sclerosis complex associated partial-onset seizures

AND

2 - Used as adjunctive therapy

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Tuberous Sclerosis Complex associated Partial-Onset Seizures
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic

EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Osteosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic

EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of osteosarcoma

AND

2 - Disease is ONE of the following:

- Relapsed/Refractory
- Metastatic

AND

3 - Used as second-line therapy

AND

4 - Used in combination with Nexavar (sorafenib)

AND

5 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records

- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Osteosarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of ONE of the following

- Rosai-Dorfman Disease
- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease

AND

2 - Presence of phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation

AND

3 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand

AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand

AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Diagnosis of Gastrointestinal Stromal Tumor (GIST)

AND

2 - Disease is one of the following:

- Unresectable
- Progressive
- Metastatic
- Gross residual (R2 resection)
- Tumor rupture

AND

3 - Disease has progressed after single agent therapy with ALL of the following:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)

- Qinlock (ripretinib)

AND

4 - Used in combination with ONE of the following:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)

AND

5 - If the request is for Torpenz, ONE of the following:

- Failure to everolimus (generic Afinitor) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to everolimus (generic Afinitor) (please specify contraindication or intolerance)

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand

EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand

EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Afinitor, generic everolimus, Torpenz, Brand Afinitor Disperz, generic everolimus TBSO	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	Brand
AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	Brand
AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	Brand
AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Brand
AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Brand

AFINITOR DISPERZ	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Brand
EVEROLIMUS	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
EVEROLIMUS	EVEROLIMUS TAB 5 MG	21532530000320	Generic
EVEROLIMUS	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 2 MG	21532530007310	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 3 MG	21532530007320	Generic
EVEROLIMUS	EVEROLIMUS TAB FOR ORAL SUSP 5 MG	21532530007340	Generic
EVEROLIMUS	EVEROLIMUS TAB 10 MG	21532530000330	Generic
TORPENZ	EVEROLIMUS TAB 2.5 MG	21532530000310	Generic
TORPENZ	EVEROLIMUS TAB 5 MG	21532530000320	Generic
TORPENZ	EVEROLIMUS TAB 7.5 MG	21532530000325	Generic
TORPENZ	EVEROLIMUS TAB 10 MG	21532530000330	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
9/24/2024	Added step thru everolimus for Torpenz

Afrezza

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146289
Guideline Name	Afrezza
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Afrezza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 4 UNIT/CARTRIDGE	27104010002940	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 8 UNIT/CARTRIDGE	27104010002950	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 12 UNIT/CARTRIDGE	27104010002955	Brand

AFREZZA	INSULIN REGULAR (HUMAN) INHAL POWD 90 X 4 UNIT & 90 X 8 UNIT	27104010002978	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 90 X 8 UNIT & 90 X 12 UNIT	27104010002988	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 60X4 & 60X8 & 60X12 UT/CART	27104010002990	Brand

Approval Criteria

1 - One of the following:

1.1 Diagnosis of type 1 diabetes mellitus and used in combination with a basal insulin or continuous insulin pump

OR

1.2 Diagnosis of type 2 diabetes mellitus

AND

2 - Patient is unable to self-inject medications (e.g. Humalog, Lantus, Levemir) due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

3 - Forced Expiratory Volume (FEV1) within the last 60 days is greater than or equal to 70% of expected normal as determined by the physician

AND

4 - Afrezza will not be approved in patients with ONE of the following:

- Who smoke cigarettes
- Who recently quit smoking (within the past 6 months)
- With chronic lung disease (e.g. asthma, chronic obstructive pulmonary disease)

Product Name: Afrezza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 4 UNIT/CARTRIDGE	27104010002940	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 8 UNIT/CARTRIDGE	27104010002950	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHALATION POWDER 12 UNIT/CARTRIDGE	27104010002955	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INHAL POWD 90 X 4 UNIT & 90 X 8 UNIT	27104010002978	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 90 X 8 UNIT & 90 X 12 UNIT	27104010002988	Brand
AFREZZA	INSULIN REGULAR (HUMAN) INH POWD 60X4 & 60X8 & 60X12 UT/CART	27104010002990	Brand

Approval Criteria

1 - Repeat pulmonary function test confirms that patient has NOT experienced a decline of 20% or more in Forced Expiratory Volume (FEV1)

AND

2 - Patient continues to be unable to self-inject short-acting insulin due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy

- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

3 - Patient continues to not smoke cigarettes

Agamree

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155765
Guideline Name	Agamree
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Agamree			
Diagnosis	Duchenne Muscular Dystrophy		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
AGAMREE	VAMOROLONE ORAL SUSP 40 MG/ML	22100075001820	Brand

Approval Criteria

1 - Published clinical evidence shows Agamree is likely to produce equivalent therapeutic results as other available corticosteroids (e.g., prednisone); therefore, Agamree is not medically necessary for treatment of Duchenne muscular dystrophy

Notes	All requests for authorization will be denied by OptumRx and must be submitted through the appeals process to the UnitedHealthcare Community Plan Pharmacy Appeals team for consideration.

Akeega

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146465
Guideline Name	Akeega
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Akeega	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG	21409902120320	Brand
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG	21409902120330	Brand

Approval Criteria

1 - Diagnosis of metastatic castration-resistant prostate cancer (mCRPC)

AND

2 - Deleterious or suspected deleterious BRCA-mutated (BRCAm)

AND

3 - Used in combination with prednisone

Product Name: Akeega	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG	21409902120320	Brand
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG	21409902120330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Akeega therapy

Product Name: Akeega	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG	21409902120320	Brand
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG	21409902120330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Akeega	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 50-500 MG	21409902120320	Brand
AKEEGA	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE TAB 100-500 MG	21409902120330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Akeega therapy

Alecensa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151762
Guideline Name	Alecensa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Alecensa	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is anaplastic lymphoma kinase (ALK)-positive

AND

3 - One of the following:

3.1 Disease is one of the following:

- Recurrent
- Advanced
- Metastatic

OR

3.2 Used as adjuvant treatment following tumor resection

Product Name: Alecensa	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Diagnosis of symptomatic Erdheim-Chester Disease

AND

2 - Used as targeted therapy anaplastic lymphoma kinase (ALK)-fusion

AND

3 - Disease is ONE of the following:

- Relapsed
- Refractory

Product Name: Alecensa	
Diagnosis	T-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Diagnosis of anaplastic large cell lymphoma (ALCL)

AND

2 - Used as second-line or initial palliative intent therapy and subsequent therapy

AND

3 - Disease is ONE of the following:

- Relapsed
- Refractory

AND

4 - Anaplastic lymphoma kinase (ALK)-positive

Product Name: Alecensa	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Diagnosis of large B-Cell lymphoma

AND

2 - Disease is ONE of the following:

- Relapsed
- Refractory

AND

3 - Anaplastic lymphoma kinase (ALK)-positive

Product Name: Alecensa

Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Diagnosis of metastatic brain cancer from NSCLC

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

Product Name: Alecensa	
Diagnosis	Soft Tissue Sarcoma/Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Diagnosis of inflammatory myofibroblastic tumor (IMT)

AND

2 - Presence of anaplastic lymphoma kinase (ALK) translocation

Product Name: Alecensa	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Histiocytic Neoplasms, T-Cell Lymphomas, B-Cell Lymphomas, Central Nervous System (CNS) Cancers, Soft Tissue Sarcoma/Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Alecensa therapy

Product Name: Alecensa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Alecensa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALECENSA	ALECTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21530507100120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Alecensa therapy

2 . Revision History

Date	Notes
8/14/2024	Added criteria for adjuvant treatment following tumor resection of AL K-positive NSCLC per FDA label. Updated references.

Alfa Interferons

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146467
Guideline Name	Alfa Interferons
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Intron A, Pegasys	
Diagnosis	Chronic Hepatitis B
Approval Length	48 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand
PEGASYS	PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML	1235306005E540	Brand

PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/ML	12353060052020	Brand

Approval Criteria

1 - Diagnosis of chronic hepatitis B infection

AND

2 - Patient does not have decompensated liver disease (defined as Child-Pugh Class B or C)

Product Name: Intron A, Pegasys	
Diagnosis	Chronic Hepatitis C
Approval Length	48 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand
PEGASYS	PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML	1235306005E540	Brand
PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/ML	12353060052020	Brand

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - Patient does not have decompensated liver disease (defined as Child-Pugh Class B or C)

AND

3 - Will be used as part of a combination antiviral treatment regimen

Product Name: Intron A	
Diagnosis	Diagnoses Other Than Hepatitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Hairy cell leukemia
- Malignant melanoma
- Follicular lymphoma
- Condylomata acuminata (genital or perianal)
- AIDS (acquired immunodeficiency syndrome)-related Kaposi's sarcoma
- Giant cell tumors of the bone
- Mycosis fungoides/Sezary syndrome
- Primary cutaneous CD30+ T-cell lymphoproliferative disorders
- Adult T-cell leukemia/lymphoma

Product Name: Pegasys	
Diagnosis	Diagnoses Other Than Hepatitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PEGASYS	PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML	1235306005E540	Brand
PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/ML	12353060052020	Brand

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Chronic myeloid leukemia (CML)
- Hairy cell leukemia
- Erdheim-Chester disease (ECD)
- Myeloproliferative neoplasms (MPNs) such as essential thrombocythemia (ET), polycythemia vera (PV), or myelofibrosis (MF)
- Mycosis fungoides/Sezary syndrome
- Primary cutaneous CD30+ T-cell lymphoproliferative disorders
- Systemic mastocytosis
- Adult T-cell leukemia/lymphoma

Product Name: Intron A, Pegasys	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand
PEGASYS	PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML	1235306005E540	Brand
PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/ML	12353060052020	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Intron A, Pegasys	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INTRON A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 18000000 UNIT	21700060202135	Brand
INTRON A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	Brand
PEGASYS	PEGINTERFERON ALFA-2A SOLN PREFILLED SYR 180 MCG/0.5ML	1235306005E540	Brand
PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/ML	12353060052020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Intron A or Pegasys therapy

Alinia

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146290
Guideline Name	Alinia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic nitazoxanide, Brand Alinia	
Diagnosis	Diarrhea caused by Giardia lamblia
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NITAZOXANIDE	NITAZOXANIDE TAB 500 MG	16400060000330	Generic
ALINIA	NITAZOXANIDE TAB 500 MG	16400060000330	Brand
ALINIA	NITAZOXANIDE FOR SUSP 100 MG/5ML	16400060001920	Brand

Approval Criteria

1 - Diagnosis of giardiasis

AND

2 - ONE of the following:

2.1 Failure to metronidazole, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to metronidazole (please specify contraindication or intolerance)

Product Name: generic nitazoxanide, Brand Alinia	
Diagnosis	Diarrhea caused by Cryptosporidium parvum
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NITAZOXANIDE	NITAZOXANIDE TAB 500 MG	16400060000330	Generic
ALINIA	NITAZOXANIDE TAB 500 MG	16400060000330	Brand
ALINIA	NITAZOXANIDE FOR SUSP 100 MG/5ML	16400060001920	Brand

Approval Criteria

1 - Diagnosis of cryptosporidiosis

Alunbrig

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146468
Guideline Name	Alunbrig
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Alunbrig	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALUNBRIG	BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG	2153051000B720	Brand
ALUNBRIG	BRIGATINIB TAB 30 MG	21530510000330	Brand
ALUNBRIG	BRIGATINIB TAB 90 MG	21530510000350	Brand

ALUNBRIG	BRIGATINIB TAB 180 MG	21530510000365	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Recurrent
- Advanced

AND

3 - Tumor is anaplastic lymphoma kinase (ALK)-positive

Product Name: Alunbrig	
Diagnosis	Soft Tissue Sarcoma/Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALUNBRIG	BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG	2153051000B720	Brand
ALUNBRIG	BRIGATINIB TAB 30 MG	21530510000330	Brand
ALUNBRIG	BRIGATINIB TAB 90 MG	21530510000350	Brand
ALUNBRIG	BRIGATINIB TAB 180 MG	21530510000365	Brand

Approval Criteria

1 - Diagnosis of inflammatory myofibroblastic tumor (IMT)

AND

2 - Presence of ALK (anaplastic lymphoma kinase) translocation

Product Name: Alunbrig	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALUNBRIG	BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG	2153051000B720	Brand
ALUNBRIG	BRIGATINIB TAB 30 MG	21530510000330	Brand
ALUNBRIG	BRIGATINIB TAB 90 MG	21530510000350	Brand
ALUNBRIG	BRIGATINIB TAB 180 MG	21530510000365	Brand

Approval Criteria

1 - Diagnosis of symptomatic Erdheim-Chester Disease

AND

2 - Used as targeted therapy (anaplastic lymphoma kinase) ALK-fusion

AND

3 - Disease is ONE of the following:

- Relapsed
- Refractory

Product Name: Alunbrig	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALUNBRIG	BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG	2153051000B720	Brand
ALUNBRIG	BRIGATINIB TAB 30 MG	21530510000330	Brand
ALUNBRIG	BRIGATINIB TAB 90 MG	21530510000350	Brand
ALUNBRIG	BRIGATINIB TAB 180 MG	21530510000365	Brand

Approval Criteria

1 - Diagnosis of metastatic brain cancer from NSCLC

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

Product Name: Alunbrig	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Soft Tissue Sarcoma/Uterine Neoplasms, Histiocytic Neoplasms, Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALUNBRIG	BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG	2153051000B720	Brand
ALUNBRIG	BRIGATINIB TAB 30 MG	21530510000330	Brand
ALUNBRIG	BRIGATINIB TAB 90 MG	21530510000350	Brand

ALUNBRIG	BRIGATINIB TAB 180 MG	21530510000365	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Alunbrig therapy

Product Name: Alunbrig	
Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALUNBRIG	BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG	2153051000B720	Brand
ALUNBRIG	BRIGATINIB TAB 30 MG	21530510000330	Brand
ALUNBRIG	BRIGATINIB TAB 90 MG	21530510000350	Brand
ALUNBRIG	BRIGATINIB TAB 180 MG	21530510000365	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Alunbrig	
Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ALUNBRIG	BRIGATINIB TAB INITIATION THERAPY PACK 90 MG & 180 MG	2153051000B720	Brand
ALUNBRIG	BRIGATINIB TAB 30 MG	21530510000330	Brand
ALUNBRIG	BRIGATINIB TAB 90 MG	21530510000350	Brand
ALUNBRIG	BRIGATINIB TAB 180 MG	21530510000365	Brand

Approval Criteria

1 - Documentation of positive clinical response to Alunbrig therapy

Ampyra

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146469
Guideline Name	Ampyra
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Ampyra, generic dalfampridine ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AMPYRA	DALFAMPRIDINE TAB ER 12HR 10 MG	62406030007420	Brand
DALFAMPRIDINE ER	DALFAMPRIDINE TAB ER 12HR 10 MG	62406030007420	Generic

Approval Criteria

1 - Diagnosis of multiple sclerosis

Anthelmintics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155832
Guideline Name	Anthelmintics
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Generic albendazole, Emverm	
Diagnosis	Enterobius vermicularis (pinworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Enterobius vermicularis (pinworm)

AND

2 - ONE of the following:

2.1 Failure of over-the-counter pyrantel pamoate confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to over-the-counter pyrantel pamoate (please specify intolerance or contraindication)

Product Name: Generic albendazole	
Diagnosis	Taenia solium and Taenia saginata (Taeniasis or Cysticercosis/Neurocysticercosis)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Taeniasis or Cysticercosis/Neurocysticercosis

Product Name: Generic albendazole, Emverm	
Diagnosis	Echinococcosis (Tapeworm)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]

Product Name: Emverm	
Diagnosis	Ancylostoma/Necatoriasis (Hookworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

Product Name: Generic albendazole	
Diagnosis	Ancylostoma/Necatoriasis (Hookworm)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Ascariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Ascariasis (Roundworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Toxocariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Toxocariasis (Roundworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Trichinellosis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Trichinellosis

Product Name: Generic albendazole, Emverm	
Diagnosis	Trichuriasis (Whipworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Trichuriasis (Whipworm)

Product Name: Generic albendazole, Emverm	
Diagnosis	Capillariasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Capillariasis

Product Name: Generic albendazole, Emverm	
Diagnosis	Baylisascaris
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic
EMVERM	MEBENDAZOLE CHEW TAB 100 MG	15000010000505	Brand

Approval Criteria

1 - Diagnosis of Baylisascaris

Product Name: Generic albendazole	
Diagnosis	Clonorchiasis (Liver flukes)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Clonorchiasis (Liver flukes)

Product Name: Generic albendazole	
Diagnosis	Gnathostomiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Gnathostomiasis

Product Name: Generic albendazole	
Diagnosis	Strongyloidiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Strongyloidiasis

Product Name: Generic albendazole	
Diagnosis	Loiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Loiasis

Product Name: Generic albendazole	
Diagnosis	Opisthorchiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Opisthorchiasis

Product Name: Generic albendazole	
Diagnosis	Anisakiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria

1 - Diagnosis of Anisakiasis

Product Name: Generic albendazole	
Diagnosis	Microsporidiosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALBENDAZOLE	ALBENDAZOLE TAB 200 MG	15000002000320	Generic

Approval Criteria **1** - Diagnosis of Microsporidiosis not caused by Enterocytozoon bieneusi or Vittaforma corneae

2 . Revision History

Date	Notes
9/24/2024	Clarified spelling of Opisthorchiasis

Anticonvulsants

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146470
Guideline Name	Anticonvulsants
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Aptiom, Briviact tabs/oral soln, Xcopri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APTIOM	ESLICARBAZEPINE ACETATE TAB 200 MG	72600024100320	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 400 MG	72600024100330	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 600 MG	72600024100340	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 800 MG	72600024100360	Brand
BRIVIACT	BRIVARACETAM TAB 10 MG	72600015000310	Brand
BRIVIACT	BRIVARACETAM TAB 25 MG	72600015000320	Brand

BRIVIACT	BRIVARACETAM TAB 50 MG	72600015000330	Brand
BRIVIACT	BRIVARACETAM TAB 75 MG	72600015000340	Brand
BRIVIACT	BRIVARACETAM TAB 100 MG	72600015000350	Brand
BRIVIACT	BRIVARACETAM ORAL SOLN 10 MG/ML	72600015002020	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 12.5 MG & 14 X 25 MG	7212001000B720	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 50 MG & 14 X 100 MG	7212001000B725	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 150 MG & 14 X 200 MG	7212001000B730	Brand
XCOPRI	CENOBAMATE TAB PACK 100 MG & 150 MG TABS (250 MG DAILY DOSE)	7212001000B738	Brand
XCOPRI	CENOBAMATE TAB PACK 150 MG & 200 MG TABS (350 MG DAILY DOSE)	7212001000B740	Brand
XCOPRI	CENOBAMATE TAB 50 MG	72120010000320	Brand
XCOPRI	CENOBAMATE TAB 100 MG	72120010000325	Brand
XCOPRI	CENOBAMATE TAB 150 MG	72120010000330	Brand
XCOPRI	CENOBAMATE TAB 200 MG	72120010000335	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)

- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Fycompa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FYCOMPA	PERAMPANEL TAB 2 MG	72550060000310	Brand
FYCOMPA	PERAMPANEL TAB 4 MG	72550060000320	Brand
FYCOMPA	PERAMPANEL TAB 6 MG	72550060000330	Brand
FYCOMPA	PERAMPANEL TAB 8 MG	72550060000340	Brand
FYCOMPA	PERAMPANEL TAB 10 MG	72550060000350	Brand
FYCOMPA	PERAMPANEL TAB 12 MG	72550060000360	Brand
FYCOMPA	PERAMPANEL SUSP 0.5 MG/ML	72550060001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial-onset seizures with or without secondarily generalized seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: generic lacosamide tabs/oral soln, Brand Vimpat tabs/oral soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LACOSAMIDE	LACOSAMIDE TAB 50 MG	72600036000320	Generic
VIMPAT	LACOSAMIDE TAB 50 MG	72600036000320	Brand
LACOSAMIDE	LACOSAMIDE TAB 100 MG	72600036000330	Generic
VIMPAT	LACOSAMIDE TAB 100 MG	72600036000330	Brand
LACOSAMIDE	LACOSAMIDE TAB 150 MG	72600036000340	Generic
VIMPAT	LACOSAMIDE TAB 150 MG	72600036000340	Brand
LACOSAMIDE	LACOSAMIDE TAB 200 MG	72600036000350	Generic
VIMPAT	LACOSAMIDE TAB 200 MG	72600036000350	Brand

LACOSAMIDE	LACOSAMIDE ORAL SOLUTION 10 MG/ML	72600036002060	Generic
VIMPAT	LACOSAMIDE ORAL SOLUTION 10 MG/ML	72600036002060	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial onset seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

- Zonisamide (generic Zonegran

Product Name: Epidiolex	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPIDIOLEX	CANNABIDIOL SOLN 100 MG/ML	72600017002020	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of seizures associated with Dravet syndrome or tuberous sclerosis complex

OR

3 - ALL of the following:

3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

3.2 History of greater than or equal to 8 week trial of at least TWO generic anticonvulsants (e.g., divalproex, lamotrigine, topiramate, valproic acid)

Product Name: Brand Onfi, generic clobazam	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ONFI	CLOBAZAM TAB 10 MG	72100007000310	Brand
CLOBAZAM	CLOBAZAM TAB 10 MG	72100007000310	Generic
ONFI	CLOBAZAM TAB 20 MG	72100007000320	Brand
CLOBAZAM	CLOBAZAM TAB 20 MG	72100007000320	Generic
ONFI	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Brand
CLOBAZAM	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - BOTH of the following:

2.1 ONE of the following:

- Diagnosis of seizures associated with Lennox-Gastaut syndrome
- Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)
- Diagnosis of Dravet syndrome

AND

2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

Product Name: generic rufinamide, Brand Banzel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUFINAMIDE	RUFINAMIDE TAB 200 MG	72600065000320	Generic
BANZEL	RUFINAMIDE TAB 200 MG	72600065000320	Brand
RUFINAMIDE	RUFINAMIDE TAB 400 MG	72600065000330	Generic
BANZEL	RUFINAMIDE TAB 400 MG	72600065000330	Brand
RUFINAMIDE	RUFINAMIDE SUSP 40 MG/ML	72600065001820	Generic
BANZEL	RUFINAMIDE SUSP 40 MG/ML	72600065001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of seizures associated with Lennox-Gastaut syndrome

Product Name: generic tiagabine, Brand Gabitril	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 2 MG	72170070100302	Generic
GABITRIL	TIAGABINE HCL TAB 2 MG	72170070100302	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 4 MG	72170070100305	Generic
GABITRIL	TIAGABINE HCL TAB 4 MG	72170070100305	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 12 MG	72170070100315	Generic
GABITRIL	TIAGABINE HCL TAB 12 MG	72170070100315	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 16 MG	72170070100320	Generic
GABITRIL	TIAGABINE HCL TAB 16 MG	72170070100320	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Sympazan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYMPAZAN	CLOBAZAM ORAL FILM 5 MG	72100007008205	Brand
SYMPAZAN	CLOBAZAM ORAL FILM 10 MG	72100007008210	Brand
SYMPAZAN	CLOBAZAM ORAL FILM 20 MG	72100007008220	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)

AND

2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Felbamate (generic Felbatol)

- Rufinamide (generic Banzel)

AND

2.4 Prescriber provides a reason or special circumstance the patient cannot use clobazam (generic Onfi) tablets or suspension

OR

3 - ALL of the following:

3.1 Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)

AND

3.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

3.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

AND

3.4 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

4 - ALL of the following:

- Diagnosis of Dravet syndrome
- Patient is currently taking Diacomit
- Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

Product Name: Brand Sabril powd pack, Vigadrone powd pack, generic vigabatrin powd pack	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SABRIL	VIGABATRIN POWD PACK 500 MG	72170085003020	Brand
VIGADRONE	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic
VIGABATRIN	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of infantile spasms

OR

3 - ALL of the following:

3.1 Diagnosis of complex partial seizures

AND

3.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

3.3 Not used as primary treatment

AND

3.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Brand Sabril tablets, Vigadrone tablets, generic vigabatrin tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SABRIL	VIGABATRIN TAB 500 MG	72170085000320	Brand

VIGABATRIN	VIGABATRIN TAB 500 MG	72170085000320	Generic
VIGADRONE	VIGABATRIN TAB 500 MG	72170085000320	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of complex partial seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

- Zonisamide (generic Zonegran)

Product Name: Diacomit	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DIACOMIT	STIRIPENTOL CAP 250 MG	72600070000120	Brand
DIACOMIT	STIRIPENTOL CAP 500 MG	72600070000130	Brand
DIACOMIT	STIRIPENTOL PACKET 250 MG	72600070003020	Brand
DIACOMIT	STIRIPENTOL PACKET 500 MG	72600070003030	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of Dravet syndrome and currently taking clobazam

Product Name: Fintepla	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FINTEPLA	FENFLURAMINE HCL ORAL SOLN 2.2 MG/ML	72600028102020	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with Dravet syndrome

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Levetiracetam (e.g., generic Keppra)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

OR

3 - ALL of the following:

3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

3.2 ONE of the following:

3.2.1 Failure of a greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

OR

3.2.2 History of intolerance or contraindication to ALL of the following (any release formulation qualifies) (please specify intolerance or contraindication):

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

Product Name: Ztalmy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZTALMY	GANAXOLONE SUSP 50 MG/ML	72600033001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder confirmed with genetic testing

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)

- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Anticonvulsants

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146292
Guideline Name	Anticonvulsants
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Aptiom, Briviact tabs/oral soln, Xcopri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APTIOM	ESLICARBAZEPINE ACETATE TAB 200 MG	72600024100320	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 400 MG	72600024100330	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 600 MG	72600024100340	Brand
APTIOM	ESLICARBAZEPINE ACETATE TAB 800 MG	72600024100360	Brand
BRIVIACT	BRIVARACETAM TAB 10 MG	72600015000310	Brand
BRIVIACT	BRIVARACETAM TAB 25 MG	72600015000320	Brand

BRIVIACT	BRIVARACETAM TAB 50 MG	72600015000330	Brand
BRIVIACT	BRIVARACETAM TAB 75 MG	72600015000340	Brand
BRIVIACT	BRIVARACETAM TAB 100 MG	72600015000350	Brand
BRIVIACT	BRIVARACETAM ORAL SOLN 10 MG/ML	72600015002020	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 12.5 MG & 14 X 25 MG	7212001000B720	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 50 MG & 14 X 100 MG	7212001000B725	Brand
XCOPRI	CENOBAMATE TAB TITRATION PACK 14 X 150 MG & 14 X 200 MG	7212001000B730	Brand
XCOPRI	CENOBAMATE TAB PACK 100 MG & 150 MG TABS (250 MG DAILY DOSE)	7212001000B738	Brand
XCOPRI	CENOBAMATE TAB PACK 150 MG & 200 MG TABS (350 MG DAILY DOSE)	7212001000B740	Brand
XCOPRI	CENOBAMATE TAB 50 MG	72120010000320	Brand
XCOPRI	CENOBAMATE TAB 100 MG	72120010000325	Brand
XCOPRI	CENOBAMATE TAB 150 MG	72120010000330	Brand
XCOPRI	CENOBAMATE TAB 200 MG	72120010000335	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)

- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Fycompa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FYCOMPA	PERAMPANEL TAB 2 MG	72550060000310	Brand
FYCOMPA	PERAMPANEL TAB 4 MG	72550060000320	Brand
FYCOMPA	PERAMPANEL TAB 6 MG	72550060000330	Brand
FYCOMPA	PERAMPANEL TAB 8 MG	72550060000340	Brand
FYCOMPA	PERAMPANEL TAB 10 MG	72550060000350	Brand
FYCOMPA	PERAMPANEL TAB 12 MG	72550060000360	Brand
FYCOMPA	PERAMPANEL SUSP 0.5 MG/ML	72550060001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial-onset seizures with or without secondarily generalized seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: generic lacosamide tabs/oral soln, Brand Vimpat tabs/oral soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LACOSAMIDE	LACOSAMIDE TAB 50 MG	72600036000320	Generic
VIMPAT	LACOSAMIDE TAB 50 MG	72600036000320	Brand
LACOSAMIDE	LACOSAMIDE TAB 100 MG	72600036000330	Generic
VIMPAT	LACOSAMIDE TAB 100 MG	72600036000330	Brand
LACOSAMIDE	LACOSAMIDE TAB 150 MG	72600036000340	Generic
VIMPAT	LACOSAMIDE TAB 150 MG	72600036000340	Brand
LACOSAMIDE	LACOSAMIDE TAB 200 MG	72600036000350	Generic
VIMPAT	LACOSAMIDE TAB 200 MG	72600036000350	Brand

LACOSAMIDE	LACOSAMIDE ORAL SOLUTION 10 MG/ML	72600036002060	Generic
VIMPAT	LACOSAMIDE ORAL SOLUTION 10 MG/ML	72600036002060	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of partial onset seizures

OR

2.1.2 ALL of the following:

- Diagnosis of primary generalized tonic-clonic seizures
- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies) confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

- Zonisamide (generic Zonegran

Product Name: Epidiolex	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPIDIOLEX	CANNABIDIOL SOLN 100 MG/ML	72600017002020	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of seizures associated with Dravet syndrome or tuberous sclerosis complex

OR

3 - ALL of the following:

3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

3.2 History of greater than or equal to 8 week trial of at least TWO generic anticonvulsants (e.g., divalproex, lamotrigine, topiramate, valproic acid)

Product Name: Brand Onfi, generic clobazam	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ONFI	CLOBAZAM TAB 10 MG	72100007000310	Brand
CLOBAZAM	CLOBAZAM TAB 10 MG	72100007000310	Generic
ONFI	CLOBAZAM TAB 20 MG	72100007000320	Brand
CLOBAZAM	CLOBAZAM TAB 20 MG	72100007000320	Generic
ONFI	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Brand
CLOBAZAM	CLOBAZAM SUSPENSION 2.5 MG/ML	72100007001830	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - BOTH of the following:

2.1 ONE of the following:

- Diagnosis of seizures associated with Lennox-Gastaut syndrome
- Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)
- Diagnosis of Dravet syndrome

AND

2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

Product Name: generic rufinamide, Brand Banzel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUFINAMIDE	RUFINAMIDE TAB 200 MG	72600065000320	Generic
BANZEL	RUFINAMIDE TAB 200 MG	72600065000320	Brand
RUFINAMIDE	RUFINAMIDE TAB 400 MG	72600065000330	Generic
BANZEL	RUFINAMIDE TAB 400 MG	72600065000330	Brand
RUFINAMIDE	RUFINAMIDE SUSP 40 MG/ML	72600065001820	Generic
BANZEL	RUFINAMIDE SUSP 40 MG/ML	72600065001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of seizures associated with Lennox-Gastaut syndrome

Product Name: generic tiagabine, Brand Gabitril	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 2 MG	72170070100302	Generic
GABITRIL	TIAGABINE HCL TAB 2 MG	72170070100302	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 4 MG	72170070100305	Generic
GABITRIL	TIAGABINE HCL TAB 4 MG	72170070100305	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 12 MG	72170070100315	Generic
GABITRIL	TIAGABINE HCL TAB 12 MG	72170070100315	Brand
TIAGABINE HYDROCHLORIDE	TIAGABINE HCL TAB 16 MG	72170070100320	Generic
GABITRIL	TIAGABINE HCL TAB 16 MG	72170070100320	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of partial-onset seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Sympazan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYMPAZAN	CLOBAZAM ORAL FILM 5 MG	72100007008205	Brand
SYMPAZAN	CLOBAZAM ORAL FILM 10 MG	72100007008210	Brand
SYMPAZAN	CLOBAZAM ORAL FILM 20 MG	72100007008220	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)

AND

2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

2.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Felbamate (generic Felbatol)

- Rufinamide (generic Banzel)

AND

2.4 Prescriber provides a reason or special circumstance the patient cannot use clobazam (generic Onfi) tablets or suspension

OR

3 - ALL of the following:

3.1 Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)

AND

3.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)
- Not used as primary treatment

AND

3.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

AND

3.4 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

4 - ALL of the following:

- Diagnosis of Dravet syndrome
- Patient is currently taking Diacomit
- Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

Product Name: Brand Sabril powd pack, Vigadrone powd pack, generic vigabatrin powd pack	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SABRIL	VIGABATRIN POWD PACK 500 MG	72170085003020	Brand
VIGADRONE	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic
VIGABATRIN	VIGABATRIN POWD PACK 500 MG	72170085003020	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of infantile spasms

OR

3 - ALL of the following:

3.1 Diagnosis of complex partial seizures

AND

3.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

3.3 Not used as primary treatment

AND

3.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Product Name: Brand Sabril tablets, Vigadrone tablets, generic vigabatrin tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SABRIL	VIGABATRIN TAB 500 MG	72170085000320	Brand

VIGABATRIN	VIGABATRIN TAB 500 MG	72170085000320	Generic
VIGADRONE	VIGABATRIN TAB 500 MG	72170085000320	Generic

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of complex partial seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)
- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

- Zonisamide (generic Zonegran)

Product Name: Diacomit	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DIACOMIT	STIRIPENTOL CAP 250 MG	72600070000120	Brand
DIACOMIT	STIRIPENTOL CAP 500 MG	72600070000130	Brand
DIACOMIT	STIRIPENTOL PACKET 250 MG	72600070003020	Brand
DIACOMIT	STIRIPENTOL PACKET 500 MG	72600070003030	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - Diagnosis of Dravet syndrome and currently taking clobazam

Product Name: Fintepla	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FINTEPLA	FENFLURAMINE HCL ORAL SOLN 2.2 MG/ML	72600028102020	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with Dravet syndrome

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Levetiracetam (e.g., generic Keppra)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

OR

3 - ALL of the following:

3.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

3.2 ONE of the following:

3.2.1 Failure of a greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

OR

3.2.2 History of intolerance or contraindication to ALL of the following (any release formulation qualifies) (please specify intolerance or contraindication):

- Divalproex (e.g., generic Depakote)
- Lamotrigine (e.g., generic Lamictal)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)

Product Name: Ztalmy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZTALMY	GANAXOLONE SUSP 50 MG/ML	72600033001820	Brand

Approval Criteria

1 - For continuation of prior therapy for a seizure disorder

OR

2 - ALL of the following:

2.1 Diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder confirmed with genetic testing

AND

2.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies), confirmed by claims history or submitted medical records:

- Carbamazepine (e.g., generic Tegretol)
- Divalproex (e.g., generic Depakote)
- Gabapentin (e.g., generic Neurontin)
- Lamotrigine (e.g., generic Lamictal)
- Levetiracetam (e.g., generic Keppra)
- Oxcarbazepine (e.g., generic Trileptal)

- Phenytoin (e.g., generic Dilantin)
- Pregabalin (e.g., generic Lyrica)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

Antipsoriatic Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146293
Guideline Name	Antipsoriatic Agents
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic calcipotriene cream, generic calcipotriene ointment, generic calcitriol ointment	
Diagnosis	Psoriasis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALCIPOTRIENE	CALCIPOTRIENE CREAM 0.005%	90250025003710	Generic
CALCIPOTRIENE	CALCIPOTRIENE OINT 0.005%	90250025004210	Generic
CALCITRIOL	CALCITRIOL OINT 3 MCG/GM	90250028004220	Generic

Approval Criteria

1 - Diagnosis of psoriasis

AND

2 - ONE of the following:

2.1 Failure to TWO medium to high potency corticosteroid topical treatments (see Background) as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to TWO medium to high potency corticosteroid topical treatments (see Background) (please specify intolerance or contraindication)

2 . Background

Benefit/Coverage/Program Information

Table 1. Relative Potency of Selected Topical Corticosteroid Products

Drug	Dosage Form	Strength
Super-High Potency (group 1)		
Augmented betamethasone dipropionate (Diprolene)	Gel, Ointment, lotion	0.05%
Clobetasol propionate (Clobex, Olux, Temovate, Temovate E)	Cream, Ointment, Gel, Solution, Lotion, Shampoo, Spray Aerosol, Foam Aerosol	0.05%
Fluocinonide (Vanos)	Cream	0.1%
Flurandrenolide (Cordran)	Tape (roll)	4 mcg/cm^2
Halobetasol propionate (Ultravate, Lexette)	Lotion, Cream, Ointment, Foam	0.05%

High Potency (group 2)		
Amcinonide (Amcort)	Ointment	0.1%
Augmented betamethasone dipropionate (Diprolene, Diprolene AF)	Cream, Lotion, Ointment	0.05%
Betamethasone dipropionate	Lotion, Ointment	0.05%
Clobetasol propionate (Impoyz)	Cream	0.025%
Desoximetasone (Topicort)	Cream, Ointment, Spray	0.25%,
	Gel	0.05%
Diflorasone diacetate (Psorcon)	Cream, Ointment	0.05%
Fluocinonide (Lidex, Lidex E)	Cream, Gel, Ointment, Solution	0.05%
Halcinonide (Halog)	Cream, Ointment, Solution	0.1%
Halobetasol propionate (Bryhali)	Lotion	0.01%
High Potency (group 3)		
Amcinonide (Amcort)	Cream, Lotion	0.1%
Betamethasone valerate (Valisone)	Ointment	0.1%
Desoximetasone (Topicort)	Cream, ointment	0.05%
Diflorasone diacetate (Florone, Psorcon)	Cream	0.05%
Fluocinonide (Lidex-E)	Cream	0.05%
Fluticasone propionate (Cutivate)	Ointment	0.005%
Mometasone furoate (Elocon)	Ointment	0.1%
Triamcinolone acetonide (Aristocort HP, Kenalog, Triderm)	Cream, ointment	0.5%

Medium Potency (group 4)		
Betamethasone dipropionate (sernivo)	Spray	0.05%
Clocortolone pivalate (Cloderm)	Cream	0.1%
Fluocinolone acetonide (Synalar)	Cream, Ointment	0.025%
Flurandrenolide (Cordran)	Ointment	0.05%
Fluticasone propionate (Cutivate)	Cream, Lotion	0.05%
Hydrocortisone valerate (Westcort)	Ointment	0.2%
Mometasone furoate (Elocon)	Cream, lotion, Solution	0.1%
Triamcinolone acetonide (Aristocort, Kenalog)	Cream, Lotion Ointment	0.1%
	Ointment	0.05%

Antipsychotics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148167
Guideline Name	Antipsychotics
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: aripiprazole ODT, aripiprazole oral soln, Abilify Maintena, Abilify MyCite, Brand Abilify, generic aripiprazole tabs, Abilify Asimtufii, Aristada, Aristada Initio, Caplyta, Brand Clozaril, generic clozapine tabs, clozapine ODT, Fanapt, Fanapt Titration Pack, Brand Geodon caps, generic ziprasidone caps, Brand Invega, generic paliperidone ER, Invega Sustenna, Invega Trinza, Invega Hafyera, Brand Latuda, generic lurasidone, Lybalvi, molindone, Perseris, Rexulti, Brand Risperdal, generic risperidone tabs/oral soln, risperidone ODT, Brand Risperdal Consta, generic risperidone ER inj, Rykindo, Brand Saphris, generic asenapine, Secuado, Brand Seroquel, generic quetiapine, Brand Seroquel XR, generic quetiapine ER, Uzedy, Versacloz, Vraylar, Brand Zyprexa tabs, generic olanzapine tabs, Brand Zyprexa Zydis, generic olanzapine ODT	
Diagnosis	Atypical Antipsychotics: Prior Authorization for Minimum Age Edit*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

CAPLYTA	LUMATEPERONE TOSYLATE CAP 10.5 MG	59400022400110	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 21 MG	59400022400115	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 42 MG	59400022400120	Brand
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 10 MG	59250015007220	Generic
ARIPIPRAZOLE ODT	ARIPIPRAZOLE ORALLY DISINTEGRATING TAB 15 MG	59250015007230	Generic
ARIPIPRAZOLE	ARIPIPRAZOLE ORAL SOLUTION 1 MG/ML	59250015002020	Generic
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 300 MG	5925001500E430	Brand
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR ER SUSP PREFILLED SYRINGE 400 MG	5925001500E440	Brand
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR EXTENDED RELEASE SUSP 300 MG	5925001500G230	Brand
ABILIFY MAINTENA	ARIPIPRAZOLE IM FOR EXTENDED RELEASE SUSP 400 MG	5925001500G240	Brand
ABILIFY	ARIPIPRAZOLE TAB 2 MG	59250015000305	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 2 MG	59250015000305	Generic
ABILIFY	ARIPIPRAZOLE TAB 5 MG	59250015000310	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 5 MG	59250015000310	Generic
ABILIFY	ARIPIPRAZOLE TAB 10 MG	59250015000320	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 10 MG	59250015000320	Generic
ABILIFY	ARIPIPRAZOLE TAB 15 MG	59250015000330	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 15 MG	59250015000330	Generic
ABILIFY	ARIPIPRAZOLE TAB 20 MG	59250015000340	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 20 MG	59250015000340	Generic
ABILIFY	ARIPIPRAZOLE TAB 30 MG	59250015000350	Brand
ARIPIPRAZOLE	ARIPIPRAZOLE TAB 30 MG	59250015000350	Generic
ABILIFY ASIMTUFII	ARIPIPRAZOLE IM ER SUSP PREFILLED SYRINGE 720 MG/2.4ML	5925001500E455	Brand
ABILIFY ASIMTUFII	ARIPIPRAZOLE IM ER SUSP PREFILLED SYRINGE 960 MG/3.2ML	5925001500E465	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 441 MG/1.6ML	5925001520E420	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 662 MG/2.4ML	5925001520E430	Brand
ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 882 MG/3.2ML	5925001520E440	Brand

ARISTADA	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 1064 MG/3.9ML	5925001520E450	Brand
ARISTADA INITIO	ARIPIPRAZOLE LAUROXIL IM ER SUSP PREFILLED SYR 675 MG/2.4ML	5925001520E435	Brand
CLOZAPINE	CLOZAPINE TAB 25 MG	59152020000320	Generic
CLOZARIL	CLOZAPINE TAB 25 MG	59152020000320	Brand
CLOZAPINE	CLOZAPINE TAB 50 MG	59152020000325	Generic
CLOZARIL	CLOZAPINE TAB 50 MG	59152020000325	Brand
CLOZAPINE	CLOZAPINE TAB 100 MG	59152020000330	Generic
CLOZARIL	CLOZAPINE TAB 100 MG	59152020000330	Brand
CLOZAPINE	CLOZAPINE TAB 200 MG	59152020000340	Generic
CLOZARIL	CLOZAPINE TAB 200 MG	59152020000340	Brand
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 12.5 MG	59152020007210	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 25 MG	59152020007220	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 100 MG	59152020007230	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 150 MG	59152020007240	Generic
CLOZAPINE ODT	CLOZAPINE ORALLY DISINTEGRATING TAB 200 MG	59152020007250	Generic
FANAPT	ILOPERIDONE TAB 1 MG	59070035000310	Brand
FANAPT	ILOPERIDONE TAB 2 MG	59070035000320	Brand
FANAPT	ILOPERIDONE TAB 4 MG	59070035000340	Brand
FANAPT	ILOPERIDONE TAB 6 MG	59070035000360	Brand
FANAPT	ILOPERIDONE TAB 8 MG	59070035000380	Brand
FANAPT	ILOPERIDONE TAB 10 MG	59070035000385	Brand
FANAPT	ILOPERIDONE TAB 12 MG	59070035000390	Brand
FANAPT TITRATION PACK	ILOPERIDONE TAB 1 MG & 2 MG & 4 MG & 6 MG TITRATION PAK	59070035006320	Brand
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
GEODON	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 20 MG	59400085100120	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
GEODON	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Brand

ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 40 MG	59400085100130	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
GEODON	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 60 MG	59400085100140	Generic
ZIPRASIDONE HYDROCHLORIDE	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
GEODON	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Brand
ZIPRASIDONE HCL	ZIPRASIDONE HCL CAP 80 MG	59400085100150	Generic
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 3 MG	59070050007510	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 3 MG	59070050007510	Brand
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 6 MG	59070050007520	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 6 MG	59070050007520	Brand
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 9 MG	59070050007530	Generic
INVEGA	PALIPERIDONE TAB ER 24HR 9 MG	59070050007530	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 39 MG/0.25ML	5907005010E626	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 78 MG/0.5ML	5907005010E629	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 117 MG/0.75ML	5907005010E632	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 156 MG/ML	5907005010E635	Brand
INVEGA SUSTENNA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 234 MG/1.5ML	5907005010E638	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 273 MG/0.88ML	5907005010E643	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 410 MG/1.32ML	5907005010E647	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 546 MG/1.75ML	5907005010E651	Brand
INVEGA TRINZA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 819 MG/2.63ML	5907005010E655	Brand
INVEGA HAFYERA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 1,092 MG/3.5ML	5907005010E670	Brand
INVEGA HAFYERA	PALIPERIDONE PALMITATE ER SUSP PREF SYR 1,560 MG/5ML	5907005010E675	Brand

LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 20 MG	59400023100310	Generic
LATUDA	LURASIDONE HCL TAB 20 MG	59400023100310	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 40 MG	59400023100320	Generic
LATUDA	LURASIDONE HCL TAB 40 MG	59400023100320	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 60 MG	59400023100330	Generic
LATUDA	LURASIDONE HCL TAB 60 MG	59400023100330	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 80 MG	59400023100340	Generic
LATUDA	LURASIDONE HCL TAB 80 MG	59400023100340	Brand
LURASIDONE HYDROCHLORIDE	LURASIDONE HCL TAB 120 MG	59400023100350	Generic
LATUDA	LURASIDONE HCL TAB 120 MG	59400023100350	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 5-10 MG	62994802500310	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 10-10 MG	62994802500320	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 15-10 MG	62994802500330	Brand
LYBALVI	OLANZAPINE-SAMIDORPHAN L-MALATE TAB 20-10 MG	62994802500340	Brand
MOLINDONE HYDROCHLORIDE	MOLINDONE HCL TAB 5 MG	59160050100305	Generic
MOLINDONE HYDROCHLORIDE	MOLINDONE HCL TAB 10 MG	59160050100310	Generic
MOLINDONE HYDROCHLORIDE	MOLINDONE HCL TAB 25 MG	59160050100315	Generic
PERSERIS	RISPERIDONE SUBCUTANEOUS FOR ER SUSP PREFILLED SYR 90 MG	5907007000E420	Brand
PERSERIS	RISPERIDONE SUBCUTANEOUS FOR ER SUSP PREFILLED SYR 120 MG	5907007000E430	Brand
REXULTI	BREXPIPRAZOLE TAB 0.25 MG	59250020000310	Brand
REXULTI	BREXPIPRAZOLE TAB 0.5 MG	59250020000320	Brand
REXULTI	BREXPIPRAZOLE TAB 1 MG	59250020000330	Brand
REXULTI	BREXPIPRAZOLE TAB 2 MG	59250020000340	Brand
REXULTI	BREXPIPRAZOLE TAB 3 MG	59250020000350	Brand
REXULTI	BREXPIPRAZOLE TAB 4 MG	59250020000360	Brand
RISPERIDONE	RISPERIDONE TAB 0.5 MG	59070070000306	Generic

RISPERDAL	RISPERIDONE TAB 0.5 MG	59070070000306	Brand
RISPERIDONE	RISPERIDONE TAB 1 MG	59070070000310	Generic
RISPERDAL	RISPERIDONE TAB 1 MG	59070070000310	Brand
RISPERIDONE	RISPERIDONE TAB 2 MG	59070070000320	Generic
RISPERDAL	RISPERIDONE TAB 2 MG	59070070000320	Brand
RISPERIDONE	RISPERIDONE TAB 3 MG	59070070000330	Generic
RISPERDAL	RISPERIDONE TAB 3 MG	59070070000330	Brand
RISPERIDONE	RISPERIDONE TAB 4 MG	59070070000340	Generic
RISPERDAL	RISPERIDONE TAB 4 MG	59070070000340	Brand
RISPERIDONE	RISPERIDONE SOLN 1 MG/ML	59070070002010	Generic
RISPERDAL	RISPERIDONE SOLN 1 MG/ML	59070070002010	Brand
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 0.25 MG	59070070007210	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 0.5 MG	59070070007220	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 1 MG	59070070007230	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 2 MG	59070070007240	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 3 MG	59070070007250	Generic
RISPERIDONE ODT	RISPERIDONE ORALLY DISINTEGRATING TAB 4 MG	59070070007260	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 12.5 MG	5907007010G210	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 25 MG	5907007010G220	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 37.5 MG	5907007010G230	Generic
RISPERDAL CONSTA	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Brand
RISPERIDONE ER	RISPERIDONE MICROSPHERES FOR IM EXTENDED REL SUSP 50 MG	5907007010G240	Generic
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 25 MG	5907007000G220	Brand

RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 37.5 MG	5907007000G230	Brand
RYKINDO	RISPERIDONE FOR IM EXTENDED RELEASE SUSPENSION 50 MG	5907007000G240	Brand
SAPHRIS	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Brand
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 2.5 MG (BASE EQUIV)	59155015100710	Generic
SAPHRIS	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Brand
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 5 MG (BASE EQUIV)	59155015100720	Generic
SAPHRIS	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	Brand
ASENAPINE MALEATE SL	ASENAPINE MALEATE SL TAB 10 MG (BASE EQUIV)	59155015100730	Generic
SECUADO	ASENAPINE TD PATCH 24 HR 3.8 MG/24HR	59155015008520	Brand
SECUADO	ASENAPINE TD PATCH 24 HR 5.7 MG/24HR	59155015008530	Brand
SECUADO	ASENAPINE TD PATCH 24 HR 7.6 MG/24HR	59155015008540	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 25 MG	59153070100310	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 25 MG	59153070100310	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 50 MG	59153070100314	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 50 MG	59153070100314	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 100 MG	59153070100320	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 100 MG	59153070100320	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 200 MG	59153070100330	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 200 MG	59153070100330	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 300 MG	59153070100340	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 300 MG	59153070100340	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 400 MG	59153070100350	Generic
SEROQUEL	QUETIAPINE FUMARATE TAB 400 MG	59153070100350	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 50 MG/0.14ML	5907007000E610	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 75 MG/0.21ML	5907007000E618	Brand

UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 100 MG/0.28ML	5907007000E626	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 125 MG/0.35ML	5907007000E634	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 150 MG/0.42ML	5907007000E642	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 200 MG/0.56ML	5907007000E658	Brand
UZEDY	RISPERIDONE SUBCUTANEOUS ER SUSP PREF SYR 250 MG/0.7ML	5907007000E674	Brand
VRAYLAR	CARIPRAZINE HCL CAP 1.5 MG (BASE EQUIVALENT)	59400018100120	Brand
VRAYLAR	CARIPRAZINE HCL CAP 3 MG (BASE EQUIVALENT)	59400018100130	Brand
VRAYLAR	CARIPRAZINE HCL CAP 4.5 MG (BASE EQUIVALENT)	59400018100140	Brand
VRAYLAR	CARIPRAZINE HCL CAP 6 MG (BASE EQUIVALENT)	59400018100150	Brand
ZYPREXA	OLANZAPINE TAB 2.5 MG	59157060000305	Brand
OLANZAPINE	OLANZAPINE TAB 2.5 MG	59157060000305	Generic
ZYPREXA	OLANZAPINE TAB 5 MG	59157060000310	Brand
OLANZAPINE	OLANZAPINE TAB 5 MG	59157060000310	Generic
ZYPREXA	OLANZAPINE TAB 7.5 MG	59157060000315	Brand
OLANZAPINE	OLANZAPINE TAB 7.5 MG	59157060000315	Generic
ZYPREXA	OLANZAPINE TAB 10 MG	59157060000320	Brand
OLANZAPINE	OLANZAPINE TAB 10 MG	59157060000320	Generic
ZYPREXA	OLANZAPINE TAB 15 MG	59157060000330	Brand
OLANZAPINE	OLANZAPINE TAB 15 MG	59157060000330	Generic
ZYPREXA	OLANZAPINE TAB 20 MG	59157060000340	Brand
OLANZAPINE	OLANZAPINE TAB 20 MG	59157060000340	Generic
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 5 MG	59157060007210	Generic
ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 5 MG	59157060007210	Brand
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 10 MG	59157060007220	Generic
ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 10 MG	59157060007220	Brand
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 15 MG	59157060007230	Generic

ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 15 MG	59157060007230	Brand
OLANZAPINE ODT	OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG	59157060007240	Generic
ZYPREXA ZYDIS	OLANZAPINE ORALLY DISINTEGRATING TAB 20 MG	59157060007240	Brand
VERSACLOZ	CLOZAPINE SUSP 50 MG/ML	59152020001820	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 2 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B705	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 2 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B706	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 5 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B710	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 5 MG WITH SENSOR&STRIPS (FOR POD) MAINT PAK	5925001503B711	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 10 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B720	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 10 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B721	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 15 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B730	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 15 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B731	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 20 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B740	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 20 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B741	Brand
ABILIFY MYCITE STARTER KIT	ARIPIPRAZOLE TAB 30 MG WITH SENSOR, STRIPS & POD STARTER PAK	5925001503B750	Brand
ABILIFY MYCITE MAINTENANCE KIT	ARIPIPRAZOLE TAB 30 MG WITH SENSOR&STRIPS(FOR POD) MAINT PAK	5925001503B751	Brand
RISPERIDONE	RISPERIDONE TAB 0.25 MG	59070070000303	Generic
PALIPERIDONE ER	PALIPERIDONE TAB ER 24HR 1.5 MG	59070050007505	Generic
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 50 MG	59153070107505	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 50 MG	59153070107505	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 150 MG	59153070107515	Generic

SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 150 MG	59153070107515	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 200 MG	59153070107520	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 200 MG	59153070107520	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 300 MG	59153070107530	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 300 MG	59153070107530	Brand
QUETIAPINE FUMARATE ER	QUETIAPINE FUMARATE TAB ER 24HR 400 MG	59153070107540	Generic
SEROQUEL XR	QUETIAPINE FUMARATE TAB ER 24HR 400 MG	59153070107540	Brand
QUETIAPINE FUMARATE	QUETIAPINE FUMARATE TAB 150 MG	59153070100325	Generic

Approval Criteria

1 - ALL of the following:

1.1 The patient is unresponsive to other treatment modalities, unless contraindication (i.e., other medications or behavioral modification attempted)

AND

1.2 The patient has tried and failed all available preferred** atypical antipsychotics that are Food and Drug Administration (FDA) approved for the patient's age

AND

1.3 ONE of the following:

1.3.1 Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Autism
- Bipolar disorder

OR

1.3.2 Patient displays symptoms of aggression as a symptom of developmental delay, Tourette's syndrome or chronic tics, oppositional defiant disorder, or conduct disorder

Notes	*See Table 1 in the Background section for UHC C&S Plan Minimum Age Edits **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Caplyta	
Diagnosis	Caplyta Requests Exceeding Quantity Limit
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
CAPLYTA	LUMATEPERONE TOSYLATE CAP 10.5 MG	59400022400110	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 21 MG	59400022400115	Brand
CAPLYTA	LUMATEPERONE TOSYLATE CAP 42 MG	59400022400120	Brand

Approval Criteria

1 - ONE of the following:

1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical Pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - ONE of the following:

2.1 The drug is being prescribed within the manufacturer's published dosing guidelines

OR

2.2 The requested dose falls within dosing guidelines found in ONE of the following compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical Pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

5 - Physician has provided rationale for needing to exceed the quantity limit of one capsule per day, at a maximum dose of 42 mg (NOTE: The treatment effect of Caplyta at doses higher than 42 mg daily versus placebo was NOT statistically significant in clinical trials)

2 . Background

Benefit/Coverage/Program Information
Table 1: UHC C&S Plan Minimum Age Edits: Based on FDA-approved uses, prior authorization is required for antipsychotic medications for members less than the following ages: • Abilify Discmelt, Abilify oral solution – 6 years of age • Abilify Maintena – 18 years of age • Abilify MyCite – 18 years of age • Abilify oral tablets – 6 years of age • Abilify Asimtufii – 18 years of age • Aristada – 18 years of age • Caplyta – 18 years of age • Clozaril – 18 years of age • Fanapt – 18 years of age • Geodon – 18 years of age • Invega – 12 years of age • Invega Sustenna – 18 years of age • Invega Trinza – 18 years of age • Invega Hafyera – 18 years of age • Latuda – 10 years of age • Lybalvi – 18 years of age • Molindone – 12 years of age • Perseris – 18 years of age • Rexulti – 18 years of age • Risperdal – 5 years of age • Risperdal Consta – 18 years of age • Rykindo – 18 years of age • Saphris – 10 years of age • Secuado – 18 years of age • Seroquel, Seroquel XR – 10 years of age • Uzedy – 18 years of age • Vraylar – 18 years of age • Zyprexa – 13 years of age • Zyprexa Zydis – 6 years of age

3 . Revision History

Date	Notes
6/7/2024	New program.

Apokyn

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146471
Guideline Name	Apokyn
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Apokyn, generic apomorphine hcl	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APOKYN	APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Brand
APOMORPHINE HYDROCHLORIDE	APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Generic

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Apokyn will be used as intermittent treatment for OFF episodes

AND

3 - Prescribed by or in consultation with a neurologist or specialist in the treatment of Parkinson's disease

AND

4 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

5 - Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa/levodopa therapy including BOTH of the following:

- Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet
- Dose and dosing interval optimization

AND

6 - ONE of the following:

6.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes) confirmed by claims history or submitted medical records:

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

OR

6.2 History of contraindication or intolerance to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (contraindication/intolerance must be from two different classes; please specify intolerance or contraindication):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

Product Name: Brand Apokyn, generic apomorphine hcl	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APOKYN	APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Brand
APOMORPHINE HYDROCHLORIDE	APOMORPHINE HCL SOLN CARTRIDGE 30 MG/3ML	7320301010E220	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Arcalyst

Prior Authorization Guideline

Guideline ID	GL-146472
Guideline Name	Arcalyst
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ARCALYST	RILONACEPT FOR INJ 220 MG	66450060002120	Brand

Approval Criteria

1 - Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)

Product Name: Arcalyst	
Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ARCALYST	RILONACEPT FOR INJ 220 MG	66450060002120	Brand

Approval Criteria

1 - Diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

AND

2 - Disease is in remission (e.g., diary score of less than 0.5 [reflecting no fever, skin rash and bone pain], acute phase reactants [less than 0.5 mg/dL CRP (milligrams per deciliter C-Reactive protein)], absence of objective skin rash, no radiological evidence of active bone lesions)

Product Name: Arcalyst	
Diagnosis	Pericarditis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ARCALYST	RILONACEPT FOR INJ 220 MG	66450060002120	Brand

Approval Criteria

1 - Diagnosis of recurrent pericarditis (RP)

Product Name: Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS), Deficiency of Interleukin-1 Receptor Antagonist (DIRA), Pericarditis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ARCALYST	RILONACEPT FOR INJ 220 MG	66450060002120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Arcalyst therapy

Arikayce

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146473
Guideline Name	Arikayce
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ARIKAYCE	AMIKACIN SULFATE LIPOSOME INHAL SUSP 590 MG/8.4ML (BASE EQ)	07000010121830	Brand

Approval Criteria

1 - Diagnosis of refractory Mycobacterium avium complex (MAC) lung disease

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting respiratory cultures positive for MAC within the previous 6 months

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) or prescription claims history documenting the patient has been receiving a multidrug background regimen containing at least TWO of the following agents for a minimum of 6 consecutive months within the past 12 months:

- Macrolide antibiotic (e.g., azithromycin, clarithromycin)
- Ethambutol
- Rifamycin antibiotic (e.g., rifampin, rifabutin)

AND

4 - Patient will continue to receive a multidrug background regimen

AND

5 - Documentation that the patient has not achieved negative sputum cultures after receipt of a multidrug background regimen for a minimum of 6 consecutive months

AND

6 - In vitro susceptibility testing of recent (within 6 months) positive culture documents that the MAC isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than or equal to 64 micrograms per milliliter (mcg/mL)

AND

7 - Prescribed by or in consultation with one of the following:

- Infectious disease specialist
- Pulmonologist

Product Name: Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ARIKAYCE	AMIKACIN SULFATE LIPOSOME INHAL SUSP 590 MG/8.4ML (BASE EQ)	07000010121830	Brand

Approval Criteria

1 - ONE of the following:

1.1 Documentation that the patient has achieved negative respiratory cultures

OR

1.2 ALL of the following:

1.2.1 Patient has not achieved negative respiratory cultures while on Arikayce

AND

1.2.2 Physician attestation that patient has demonstrated clinical benefit while on Arikayce

AND

1.2.3 In vitro susceptibility testing of most recent (within 6 months) positive culture with available susceptibility testing documents that the Mycobacterium avium complex (MAC)

isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than 64 micrograms per milliliter (mcg/mL)

AND

1.2.4 Patient has NOT received greater than 12 months of Arikayce therapy with continued positive respiratory cultures

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) or prescription claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents:

- Macrolide antibiotic (e.g., azithromycin, clarithromycin)
- Ethambutol
- Rifamycin antibiotic (e.g., rifampin, rifabutin)

AND

3 - Prescribed by or in consultation with one of the following:

- Infectious disease specialist
- Pulmonologist

Augtyro

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155867
Guideline Name	Augtyro
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Augtyro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUGTYRO	REPOTRECTINIB CAP 40 MG	21533865000120	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Advanced
- Metastatic

AND

3 - Disease is ROS1-positive

Product Name: Augtyro	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUGTYRO	REPOTRECTINIB CAP 40 MG	21533865000120	Brand

Approval Criteria

1 - Presence of solid tumor(s)

AND

3 - Disease is positive for neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

2 - Disease is ONE of the following:

- Locally advanced
- Metastatic
- Unresectable

Product Name: Augtyro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUGTYRO	REPOTRECTINIB CAP 40 MG	21533865000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Augtyro therapy

Product Name: Augtyro	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUGTYRO	REPOTRECTINIB CAP 40 MG	21533865000120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Augtyro	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUGTYRO	REPOTRECTINIB CAP 40 MG	21533865000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Augtyro therapy

2 . Revision History

Date	Notes
9/24/2024	Added criteria for Solid Tumors.

Austedo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146475
Guideline Name	Austedo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Austedo	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUSTEDO PATIENT TITRATION KIT	DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG	6238003000B720	Brand
AUSTEDO	DEUTETRABENAZINE TAB 6 MG	62380030000310	Brand

AUSTEDO	DEUTETRABENAZINE TAB 9 MG	62380030000320	Brand
AUSTEDO	DEUTETRABENAZINE TAB 12 MG	62380030000330	Brand

Approval Criteria

1 - Diagnosis of moderate to severe tardive dyskinesia

AND

2 - ONE of the following:

2.1 Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

OR

2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

AND

3 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Psychiatrist

Product Name: Austedo	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

AUSTEDO PATIENT TITRATION KIT	DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG	6238003000B720	Brand
AUSTEDO	DEUTETRABENAZINE TAB 6 MG	62380030000310	Brand
AUSTEDO	DEUTETRABENAZINE TAB 9 MG	62380030000320	Brand
AUSTEDO	DEUTETRABENAZINE TAB 12 MG	62380030000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Austedo therapy

Product Name: Austedo	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUSTEDO PATIENT TITRATION KIT	DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG	6238003000B720	Brand
AUSTEDO	DEUTETRABENAZINE TAB 6 MG	62380030000310	Brand
AUSTEDO	DEUTETRABENAZINE TAB 9 MG	62380030000320	Brand
AUSTEDO	DEUTETRABENAZINE TAB 12 MG	62380030000330	Brand

Approval Criteria

1 - Diagnosis of chorea associated with Huntington's Disease

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - ONE of the following:

3.1 Failure to tetrabenazine as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to tetrabenazine (please specify intolerance or contraindication)

Product Name: Austedo	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUSTEDO PATIENT TITRATION KIT	DEUTETRABENAZINE TAB TITRATION PACK 6 MG & 9 MG & 12 MG	6238003000B720	Brand
AUSTEDO	DEUTETRABENAZINE TAB 6 MG	62380030000310	Brand
AUSTEDO	DEUTETRABENAZINE TAB 9 MG	62380030000320	Brand
AUSTEDO	DEUTETRABENAZINE TAB 12 MG	62380030000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Austedo therapy

Ayvakit

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154695
Guideline Name	Ayvakit
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Ayvakit	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AYVAKIT	AVAPRITINIB TAB 25 MG	21490009000310	Brand
AYVAKIT	AVAPRITINIB TAB 50 MG	21490009000315	Brand
AYVAKIT	AVAPRITINIB TAB 100 MG	21490009000320	Brand
AYVAKIT	AVAPRITINIB TAB 200 MG	21490009000330	Brand

AYVAKIT	AVAPRITINIB TAB 300 MG	21490009000340	Brand

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST)

AND

2 - ONE of the following:

2.1 Submission of medical records or claims history confirming patient has unresectable, recurrent, or metastatic disease after failure on approved therapies (e.g., imatinib, sunitinib, dasatinib, regorafenib, ripretinib)

OR

2.2 BOTH of the following:

2.2.1 Disease is ONE of the following:

- Unresectable
- Resectable with significant morbidity
- Metastatic
- Recurrent
- Limited progression
- Gross residual disease (R2 resection)
- Residual disease with significant morbidity

AND

2.2.2 Presence of a platelet-derived growth factor receptor alpha (PDGFRA) exon mutation, including 18 D842V mutation

Product Name: Ayvakit	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AYVAKIT	AVAPRITINIB TAB 25 MG	21490009000310	Brand
AYVAKIT	AVAPRITINIB TAB 50 MG	21490009000315	Brand
AYVAKIT	AVAPRITINIB TAB 100 MG	21490009000320	Brand
AYVAKIT	AVAPRITINIB TAB 200 MG	21490009000330	Brand
AYVAKIT	AVAPRITINIB TAB 300 MG	21490009000340	Brand

Approval Criteria

1 - Diagnosis of myeloid/lymphoid neoplasms with eosinophilia

AND

2 - Presence of a FIP1L1-PDGFRA (platelet-derived growth factor receptor alpha) rearrangement

AND

3 - Presence of a PDGFRA D842V mutation

Product Name: Ayvakit	
Diagnosis	Systemic Mastocytosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AYVAKIT	AVAPRITINIB TAB 25 MG	21490009000310	Brand
AYVAKIT	AVAPRITINIB TAB 50 MG	21490009000315	Brand
AYVAKIT	AVAPRITINIB TAB 100 MG	21490009000320	Brand

AYVAKIT	AVAPRITINIB TAB 200 MG	21490009000330	Brand
AYVAKIT	AVAPRITINIB TAB 300 MG	21490009000340	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Advanced systemic mastocytosis
- Aggressive systemic mastocytosis
- Systemic mastocytosis with an associated hematological neoplasm
- Mast cell leukemia
- Indolent systemic mastocytosis

AND

2 - Platelet count is greater than or equal to 50 x 10^9/liter

Product Name: Ayvakit	
Diagnosis	Gastrointestinal Stromal Tumor (GIST), Myeloid/Lymphoid Neoplasms, Systemic Mastocytosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AYVAKIT	AVAPRITINIB TAB 25 MG	21490009000310	Brand
AYVAKIT	AVAPRITINIB TAB 50 MG	21490009000315	Brand
AYVAKIT	AVAPRITINIB TAB 100 MG	21490009000320	Brand
AYVAKIT	AVAPRITINIB TAB 200 MG	21490009000330	Brand
AYVAKIT	AVAPRITINIB TAB 300 MG	21490009000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Ayvakit therapy

Product Name: Ayvakit	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AYVAKIT	AVAPRITINIB TAB 25 MG	21490009000310	Brand
AYVAKIT	AVAPRITINIB TAB 50 MG	21490009000315	Brand
AYVAKIT	AVAPRITINIB TAB 100 MG	21490009000320	Brand
AYVAKIT	AVAPRITINIB TAB 200 MG	21490009000330	Brand
AYVAKIT	AVAPRITINIB TAB 300 MG	21490009000340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Ayvakit	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AYVAKIT	AVAPRITINIB TAB 25 MG	21490009000310	Brand
AYVAKIT	AVAPRITINIB TAB 50 MG	21490009000315	Brand
AYVAKIT	AVAPRITINIB TAB 100 MG	21490009000320	Brand
AYVAKIT	AVAPRITINIB TAB 200 MG	21490009000330	Brand
AYVAKIT	AVAPRITINIB TAB 300 MG	21490009000340	Brand

Approval Criteria **1** - Documentation of positive clinical response to Ayvakit therapy

2 . Revision History

Date	Notes
9/10/2024	Updated wording of systemic mastocytosis criteria per NCCN without change to clinical intent.

Azole Antifungals

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147444
Guideline Name	Azole Antifungals
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Blastomycosis
- Histoplasmosis
- Aspergillosis

OR

2 - BOTH of the following:

2.1 Diagnosis of coccidioidomycosis

AND

2.2 ONE of the following:

2.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

2.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Diagnosis of fingernail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Three months have elapsed since completion of initial therapy for fingernail onychomycosis

AND

2 - Documentation of positive clinical response to therapy

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Diagnosis of toenail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand

Approval Criteria

1 - Nine months have elapsed since completion of initial therapy for toenail onychomycosis

AND

2 - Documentation of positive clinical response to therapy

Product Name: Brand Sporanox oral solution, generic itraconazole oral solution

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Generic
SPORANOX	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Oropharyngeal candidiasis
- Esophageal candidiasis

Product Name: Brand Vfend tablets, generic voriconazole tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VORICONAZOLE	VORICONAZOLE TAB 50 MG	11407080000320	Generic
VFEND	VORICONAZOLE TAB 50 MG	11407080000320	Brand
VORICONAZOLE	VORICONAZOLE TAB 200 MG	11407080000340	Generic
VFEND	VORICONAZOLE TAB 200 MG	11407080000340	Brand

Approval Criteria

1 - Diagnosis of invasive aspergillosis including Aspergillus fumigatus

OR

2 - ALL of the following:

2.1 Diagnosis of candidemia

AND

2.2 Patient is non-neutropenic

AND

2.3 ONE of the following:

2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

3 - BOTH of the following:

3.1 ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

AND

3.2 ONE of the following:

3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

4 - Diagnosis of Scedosporium apiospermum infection (asexual form of Pseudallescheria boydii)

OR

5 - Diagnosis of Fusarium spp. infection including Fusarium solani

OR

6 - Diagnosis of Exserohilum species infection

Product Name: Brand Vfend susp, generic voriconazole susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VFEND	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Brand
VORICONAZOLE	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Generic

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of invasive aspergillosis including Aspergillus fumigatus

OR

1.2 ALL of the following:

1.2.1 Diagnosis of Candidemia

AND

1.2.2 Patient is non-neutropenic

AND

1.2.3 ONE of the following:

1.2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

1.3 BOTH of the following:

1.3.1 ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

AND

1.3.2 ONE of the following:

1.3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

1.4 Diagnosis of Scedosporium apiospermum infection (asexual form of Pseudallescheria boydii)

OR

1.5 Diagnosis of Fusarium spp. infection including Fusarium solani

OR

1.6 Diagnosis of Exserohilum species infection

AND

2 - Physician has provided rationale for the patient needing to use voriconazole oral suspension instead of voriconazole tablets

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NOXAFIL	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Brand
POSACONAZOLE DR	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic

Approval Criteria

1 - Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

2.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

2.1.1 Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Treatment of Invasive Aspergillosis
Approval Length	84 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NOXAFIL	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Brand
POSACONAZOLE DR	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic

Approval Criteria

1 - Diagnosis of invasive aspergillosis

AND

2 - ONE of the following:

2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

Product Name: Brand Noxafil suspension, generic posaconazole suspension, Noxafil delayed release suspension packets	
Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOXAFIL	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Brand
NOXAFIL	POSACONAZOLE FOR DELAYED RELEASE SUSP PACKET 300 MG	11407060003020	Brand
POSACONAZOLE	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Generic

Approval Criteria

1 - Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

2.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

2.1.1 Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

Product Name: Brand Noxafil suspension, generic posaconazole suspension	
Diagnosis	Oropharyngeal Candidiasis (OPC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOXAFIL	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Brand
POSACONAZOLE	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Generic

Approval Criteria

1 - Diagnosis of oropharyngeal candidiasis (OPC)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

OR

2.2 History of contraindication, intolerance, or resistance to BOTH of the following (please specify intolerance, contraindication, or resistance):

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

Product Name: Cresemba	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 186 MG (ISAVUCONAZOLE 100 MG)	11407030100120	Brand
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 74.5 MG (ISAVUCONAZOLE 40 MG)	11407030100105	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of invasive aspergillosis

AND

1.2 ONE of the following:

1.2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

OR

1.2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

OR

2 - Diagnosis of invasive mucormycosis

Product Name: Tolsura	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOLSURA	ITRACONAZOLE CAP 65 MG	11407035000113	Brand

Approval Criteria

1 - Diagnosis of ONE of the following fungal infections:

- Blastomycosis
- Histoplasmosis
- Aspergillosis

AND

2 - ONE of the following:

2.1 Failure to itraconazole capsules (generic Sporanox) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to itraconazole capsules (generic Sporanox) (please specify intolerance or contraindication)

Product Name: Brand Sporanox capsules, generic itraconazole capsules, Brand Sporanox oral solution, generic itraconazole oral solution, Brand Vfend tablets, generic voriconazole tablets, Brand Vfend suspension, generic voriconazole suspension, Brand Noxafil tablets, generic posaconazole tablets, Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil delayed release suspension packets, Cresemba, Tolsura	
Diagnosis	Infectious Diseases Society of America (IDSA) Recommended Regimens
Approval Length	Based on provider and IDSA recommended treatment durations, up to 12 months
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ITRACONAZOLE	ITRACONAZOLE CAP 100 MG	11407035000120	Generic
SPORANOX	ITRACONAZOLE CAP 100 MG	11407035000120	Brand
ITRACONAZOLE	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Generic
SPORANOX	ITRACONAZOLE ORAL SOLN 10 MG/ML	11407035002020	Brand
VORICONAZOLE	VORICONAZOLE TAB 50 MG	11407080000320	Generic
VFEND	VORICONAZOLE TAB 50 MG	11407080000320	Brand
VORICONAZOLE	VORICONAZOLE TAB 200 MG	11407080000340	Generic
VFEND	VORICONAZOLE TAB 200 MG	11407080000340	Brand
VORICONAZOLE	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Generic
VFEND	VORICONAZOLE FOR SUSP 40 MG/ML	11407080001920	Brand
NOXAFIL	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Brand
POSACONAZOLE DR	POSACONAZOLE TAB DELAYED RELEASE 100 MG	11407060000620	Generic
NOXAFIL	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Brand
NOXAFIL	POSACONAZOLE FOR DELAYED RELEASE SUSP PACKET 300 MG	11407060003020	Brand
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 186 MG (ISAVUCONAZOLE 100 MG)	11407030100120	Brand

TOLSURA	ITRACONAZOLE CAP 65 MG	11407035000113	Brand
POSACONAZOLE	POSACONAZOLE SUSP 40 MG/ML	11407060001820	Generic
CRESEMBA	ISAVUCONAZONIUM SULFATE CAP 74.5 MG (ISAVUCONAZOLE 40 MG)	11407030100105	Brand

Approval Criteria

1 - Use is recognized for treatment of the diagnosis by the Infectious Diseases Society of America (IDSA)

2 . Revision History

Date	Notes
5/16/2024	Updated GPIs (removed obsolete posaconazole tab; added new Cre semba 74.5mg)

Balversa

Prior Authorization Guideline

Guideline ID	GL-150796
Guideline Name	Balversa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/2/2024

1 . Criteria

Product Name: Balversa	
Diagnosis	Urothelial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BALVERSA	ERDAFITINIB TAB 3 MG	21532225000320	Brand
BALVERSA	ERDAFITINIB TAB 4 MG	21532225000325	Brand
BALVERSA	ERDAFITINIB TAB 5 MG	21532225000330	Brand

Approval Criteria

1 - Diagnosis of urothelial carcinoma

AND

2 - ONE of the following:

- Locally advanced
- Metastatic

AND

3 - Presence of FGFR3 genetic alterations

AND

4 - Disease has progressed on or after at least one line of prior systemic therapy [e.g., platinum-based chemotherapy (e.g., cisplatin, carboplatin), immune checkpoint inhibitor (e.g., pembrolizumab, nivolumab, avelumab)]

AND

5 - One of the following:

5.1 Patient has received prior systemic therapy containing an immune checkpoint inhibitor (e.g., pembrolizumab, nivolumab, avelumab)

OR

5.2 Patient is not eligible for immune checkpoint inhibitor therapy (e.g., pembrolizumab, nivolumab, avelumab)

Product Name: Balversa

Diagnosis	Urothelial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BALVERSA	ERDAFITINIB TAB 3 MG	21532225000320	Brand
BALVERSA	ERDAFITINIB TAB 4 MG	21532225000325	Brand
BALVERSA	ERDAFITINIB TAB 5 MG	21532225000330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Balversa therapy

Product Name: Balversa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BALVERSA	ERDAFITINIB TAB 3 MG	21532225000320	Brand
BALVERSA	ERDAFITINIB TAB 4 MG	21532225000325	Brand
BALVERSA	ERDAFITINIB TAB 5 MG	21532225000330	Brand

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Balversa	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BALVERSA	ERDAFITINIB TAB 3 MG	21532225000320	Brand
BALVERSA	ERDAFITINIB TAB 4 MG	21532225000325	Brand
BALVERSA	ERDAFITINIB TAB 5 MG	21532225000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Balversa therapy

2 . Revision History

Date	Notes
8/1/2024	Copy of core

Baxdela

Prior Authorization Guideline

Guideline ID	GL-146295
Guideline Name	Baxdela
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Baxdela	
Diagnosis	Community-Acquired Bacterial Pneumonia
Approval Length	10 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BAXDELA	DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV)	05000025100320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

3.3 One of the following:

3.3.1 Failure to three of the following antibiotics or antibiotic regimens as confirmed by claims history or submission of medical records:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

3.3.2 History of intolerance or contraindication to all of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication)

- Amoxicillin

- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name: Baxdela	
Diagnosis	Acute Bacterial Skin and Skin Structure Infections
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BAXDELA	DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV)	05000025100320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 One of the following diagnoses:

3.1.1 Both of the following

3.1.1.1 Acute bacterial skin and skin structure infections

AND

3.1.1.2 Infection caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

3.1.2 Both of the following:

3.1.2.1 Empirical treatment of patients with acute bacterial skin and skin structure infections

AND

3.1.2.2 Presence of MRSA infection is likely

AND

3.2 ONE of the following:

3.2.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

3.2.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

3.3 One of the following:

3.3.1 Failure to one of the following antibiotics as confirmed by claims history or submitted medical records:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

3.3.2 History of intolerance or contraindication to all of the following (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

4 - All of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infections

AND

4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

4.3 One of the following:

4.3.1 Failure to three of the following antibiotics as confirmed by claims history or submitted medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

OR

4.3.2 History of intolerance or contraindication to all of the following antibiotics (please specify intolerance or contraindication):

- A penicillin

- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

Product Name: Baxdela	
Diagnosis	Off-Label Uses
Approval Length	Based on provider and IDSA recommended treatment durations, up to 6 months.
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BAXDELA	DELAFLOXACIN MEGLUMINE TAB 450 MG (BASE EQUIV)	05000025100320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Belbuca_Butrans

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146296
Guideline Name	Belbuca_Butrans
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	DUR: Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand

BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Patient meets ONE of the following:

- Cancer diagnosis
- End of life care, including hospice care
- Palliative care
- Sickle cell anemia

OR

2 - Prescriber attests that the patient has received an opioid within the past 60 days

Notes	*Approval length for cancer, end of life, palliative care, or sickle cell pa in will be issued for 12 months. All other approvals will be issued for th e requested duration, not to exceed one month.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life related pain
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - The patient is being treated for cancer, hospice, sickle cell anemia, or end of life related pain

AND

2 - If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches

Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic buprenorphine patches, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 12-month authorization should be entered for generic buprenorphine patches.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia pain/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand

BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 The patient has a history of failure to a trial of tramadol IR (immediate release) as confirmed by claims history or submission of medical records

OR

4.2 The patient has a contraindication or intolerance to tramadol IR (please specify contraindication or intolerance)

OR

4.3 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on Belbuca or Butrans for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), BOTH of the following:

5.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

5.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication)

AND

6 - If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches

Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic buprenorphine patches, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for generic buprenorphine patches.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia pain/Non-end of life care pain
Approval Length	6 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Documented rationale for not tapering and discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - If the request is for Belbuca or Brand Butrans, the prescriber provides a reason or special circumstance the patient cannot use generic buprenorphine patches

Notes	If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic buprenorphine patches, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for generic buprenorphine patches.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND

2 - The requested dose is within the FDA (Food and Drug Administration) maximum dose per day, where an FDA maximum dose per day exists

Notes	Approval durations: 12 months for cancer pain/hospice/sickle cell anemia related pain/end of life related pain. 6 months for non-cancer pain/non-hospice/non-sickle cell anemia related pain/non-end of life related pain.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Cancer/Hospice/End of Life Related Pain/Sickle Cell Anemia Related Pain
Approval Length	12 month(s)
Guideline Type	Morphine Milligram Equivalents (MME)

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand

BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Patient has cancer pain, hospice pain, an end of life diagnosis, or sickle cell anemia related pain

Notes	The authorization should be entered for an MME of 9999 so as to prev ent future disruptions in therapy if the patient's dose is increased.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer/Non-hospice/Non-End of Life Related Pain/Non-Sickle Cell Anemia Related Pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME)

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic

BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Opioid medication doses of less than 90 MME (Morphine Milligram Equivalents) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

OR

4.2 Patient is new to plan and currently established on the requested MME for at least the past 30 days

Notes	Authorization will be issued for 6 months for non-cancer/non-hospice/ non-sickle cell anemia related pain/non-end of life related pain up to th e current requested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization c riteria requirements, a denial should be issued and a maximum 60-da y authorization may be authorized one time for the requested MME do se.

Product Name: Belbuca, generic buprenorphine patches, Brand Butrans	
Diagnosis	Non-cancer/Non-hospice/Non-End of Life Related Pain/Non-Sickle Cell Anemia Related Pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalents (MME)

Product Name	Generic Name	GPI	Brand/Generic
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 75 MCG (BASE EQUIVALENT)	65200010108210	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 150 MCG (BASE EQUIVALENT)	65200010108220	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 300 MCG (BASE EQUIVALENT)	65200010108230	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 450 MCG (BASE EQUIVALENT)	65200010108240	Brand

BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 600 MCG (BASE EQUIVALENT)	65200010108250	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 750 MCG (BASE EQUIVALENT)	65200010108260	Brand
BELBUCA	BUPRENORPHINE HCL BUCCAL FILM 900 MCG (BASE EQUIVALENT)	65200010108270	Brand
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR	65200010008820	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 7.5 MCG/HR	65200010008825	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 10 MCG/HR	65200010008830	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 15 MCG/HR	65200010008835	Generic
BUTRANS	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Brand
BUPRENORPHINE	BUPRENORPHINE TD PATCH WEEKLY 20 MCG/HR	65200010008840	Generic

Approval Criteria

1 - Prescriber attests that the patient has been screened for substance abuse/opioid dependence

AND

2 - Documented rationale for not tapering and discontinuing opioid if treatment goals are not being met

AND

3 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

Notes	Authorization will be issued for 6 months for non-cancer/non-hospice/ non-sickle cell anemia related pain/non-end of life related pain up to th e current requested MME plus 90 MME If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization c riteria requirements, a denial should be issued and a maximum 60-da y authorization may be authorized one time for the requested MME do se.

Benefit Determination Mifeprex

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146297
Guideline Name	Benefit Determination Mifeprex
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Mifeprex, generic mifepristone	
Approval Length	1 month(s)
Guideline Type	Benefit Determination

Product Name	Generic Name	GPI	Brand/Generic
MIFEPREX	MIFEPRISTONE TAB 200 MG	30502060000320	Brand
MIFEPRISTONE	MIFEPRISTONE TAB 200 MG	30502060000320	Generic

Approval Criteria

1 - Provider attests patient requires treatment for purposes identified in the Hyde amendment and any applicable state laws and regulations.

Benlysta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146478
Guideline Name	Benlysta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Benlysta SQ	
Diagnosis	Systemic Lupus Erythematosus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BENLYSTA	BELIMUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	9942201500D520	Brand
BENLYSTA	BELIMUMAB SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	9942201500E520	Brand

Approval Criteria

1 - Diagnosis of systemic lupus erythematosus

AND

2 - Patient is currently receiving standard immunosuppressive therapy [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

3 - Patient does NOT have severe active central nervous system lupus

AND

4 - Patient is NOT receiving Benlysta in combination with any of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

Product Name: Benlysta SQ	
Diagnosis	Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BENLYSTA	BELIMUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	9942201500D520	Brand
BENLYSTA	BELIMUMAB SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	9942201500E520	Brand

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - Patient is currently receiving standard immunosuppressive therapy for systemic lupus erythematosus [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

3 - Patient does NOT have severe active central nervous system lupus

AND

4 - Patient is NOT receiving Benlysta in combination with any of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

Product Name: Benlysta SQ	
Diagnosis	Systemic Lupus Erythematosus, Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BENLYSTA	BELIMUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	9942201500D520	Brand
BENLYSTA	BELIMUMAB SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	9942201500E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Benlysta therapy

AND

2 - Patient is NOT receiving Benlysta in combination with any of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

Benznidazole

Prior Authorization Guideline

Guideline ID	GL-146298
Guideline Name	Benznidazole
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Benznidazole	
Approval Length	60 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BENZNIDAZOLE	BENZNIDAZOLE TAB 12.5 MG	15000003000320	Brand
BENZNIDAZOLE	BENZNIDAZOLE TAB 100 MG	15000003000340	Brand

Approval Criteria

1 - Diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi

Berinert

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147728
Guideline Name	Berinert
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Berinert	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BERINERT	C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ KIT 500 UNIT	85802022006420	Brand

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - Prescribed for the acute treatment of HAE attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Firazyr, Ruconest)

AND

4 - ONE of the following:

4.1 Failure of Ruconest as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Ruconest (please specific intolerance or contraindication)

OR

4.3 Patient is currently on Berinert therapy as confirmed by claims history or submission of medical records

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name: Berinert	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BERINERT	C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ KIT 500 UNIT	85802022006420	Brand

Approval Criteria

1 - Documentation of positive clinical response to Berinert therapy

AND

2 - Prescribed for the acute treatment of HAE (hereditary angioedema) attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Firazyr, Ruconest)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
5/23/2024	Update to types of genetic variant(s) and diagnostic criteria with nor mal C1 inhibitor levels in initial auth section and minor update in reau th section.

Biktarvy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146806
Guideline Name	Biktarvy
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Biktarvy	
Diagnosis	Human Immunodeficiency Virus (HIV)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 30-120-15 MG	12109903240320	Brand
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 50-200-25 MG	12109903240330	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)

Product Name: Biktarvy	
Diagnosis	Post-Exposure Prophylaxis
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 30-120-15 MG	12109903240320	Brand
BIKTARVY	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR AF TAB 50-200-25 MG	12109903240330	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis

2 . Revision History

Date	Notes
4/30/2024	Removed "-New York" from guideline name

Biltricide

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146300
Guideline Name	Biltricide
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Biltricide, generic praziquantel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BILTRICIDE	PRAZIQUANTEL TAB 600 MG	15000050000305	Brand
PRAZIQUANTEL	PRAZIQUANTEL TAB 600 MG	15000050000305	Generic

Approval Criteria

1 - ONE of the following:

1.1 Infections due to schistosoma

OR

1.2 Infections due to the liver trematodes (flukes), Clonorchis sinensis/Opisthorchis viverrini (i.e., clonorchiasis or opisthorchiasis)

Bimzelx

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152443
Guideline Name	Bimzelx
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Bimzelx	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BIMZELX	BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN AUTO-INJECTOR 160 MG/ML	9025051800D520	Brand
BIMZELX	BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN PREFILLED SYR 160 MG/ML	9025051800E520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderate to severe plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

1.2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure of ONE of the following topical therapy classes confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.2.1.3 ONE of the following:

- Failure of a 3 month trial of methotrexate, at the maximally indicated doses, confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Otezla (apremilast)]

AND

1.3 Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

1.4 ONE of the following:

1.4.1 Failure of TWO of the following preferred biologic products confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

OR

1.4.2 History of intolerance or contraindication to ALL of the following preferred biologic products (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

AND

1.5 ONE of the following:

1.5.1 Failure to a 6 month trial of Cosentyx (secukinumab) with moderate clinical response yet residual disease activity confirmed by claims history or submitted medical records

OR

1.5.2 BOTH of the following:

1.5.2.1 History of intolerance or adverse event to Cosentyx (please specify intolerance or contraindication)

AND

1.5.2.2 Physician attests that in their clinical opinion the same intolerance or adverse event would not be expected to occur with Bimzelx

AND

1.6 Prescribed by or in consultation with a dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Bimzelx therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderate to severe plaque psoriasis

AND

2.3 Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a dermatologist

Notes	*For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Bimzelx	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BIMZELX	BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN AUTO-INJECTOR 160 MG/ML	9025051800D520	Brand
BIMZELX	BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN PREFILLED SYR 160 MG/ML	9025051800E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Bimzelx therapy

AND **2** - Patient is not receiving Bimzelx in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

2 . Revision History

Date	Notes
8/20/2024	Copy core

Bonjesta and Diclegis

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146301
Guideline Name	Bonjesta and Diclegis
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic doxylamine/pyridoxine, Brand Diclegis, Bonjesta	
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOXYLAMINE SUCCINATE/PYRIDOXINE HYDROCHLORIDE	DOXYLAMINE-PYRIDOXINE TAB DELAYED RELEASE 10-10 MG	50309902100620	Generic
DICLEGIS	DOXYLAMINE-PYRIDOXINE TAB DELAYED RELEASE 10-10 MG	50309902100620	Brand
BONJESTA	DOXYLAMINE-PYRIDOXINE TAB ER 20-20 MG	50309902100430	Brand

Approval Criteria

1 - Diagnosis of nausea and vomiting associated with pregnancy

AND

2 - Documented failure or contraindication to lifestyle modifications (e.g., diet, avoidance of triggers)

AND

3 - ONE of the following:

3.1 Failure to a five day trial of over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly), as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly) (please specify contraindication or intolerance)

Bosulif

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146480
Guideline Name	Bosulif
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Bosulif	
Diagnosis	Chronic Myelogenuous/Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BOSULIF	BOSUTINIB TAB 100 MG	21531812000320	Brand
BOSULIF	BOSUTINIB TAB 400 MG	21531812000327	Brand
BOSULIF	BOSUTINIB TAB 500 MG	21531812000340	Brand
BOSULIF	BOSUTINIB CAP 50 MG	21531812000120	Brand

BOSULIF	BOSUTINIB CAP 100 MG	21531812000130	Brand

Approval Criteria

1 - Patient must have a diagnosis of chronic myeloid leukemia

AND

2 - One of the following:

2.1 Patient is not a candidate for imatinib as attested by physician

OR

2.2 Patient is currently on Bosulif therapy

Product Name: Bosulif	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BOSULIF	BOSUTINIB TAB 100 MG	21531812000320	Brand
BOSULIF	BOSUTINIB TAB 400 MG	21531812000327	Brand
BOSULIF	BOSUTINIB TAB 500 MG	21531812000340	Brand
BOSULIF	BOSUTINIB CAP 50 MG	21531812000120	Brand
BOSULIF	BOSUTINIB CAP 100 MG	21531812000130	Brand

Approval Criteria

1 - Patient must have a diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia

Product Name: Bosulif	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BOSULIF	BOSUTINIB TAB 100 MG	21531812000320	Brand
BOSULIF	BOSUTINIB TAB 400 MG	21531812000327	Brand
BOSULIF	BOSUTINIB TAB 500 MG	21531812000340	Brand
BOSULIF	BOSUTINIB CAP 50 MG	21531812000120	Brand
BOSULIF	BOSUTINIB CAP 100 MG	21531812000130	Brand

Approval Criteria

1 - Patient must have a diagnosis of myeloid/lymphoid neoplasms with eosinophilia

AND

2 - Presence of ABL1 (gene) rearrangement

Product Name: Bosulif	
Diagnosis	Chronic Myelogenuous/Myeloid Leukemia, Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia, Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BOSULIF	BOSUTINIB TAB 100 MG	21531812000320	Brand

BOSULIF	BOSUTINIB TAB 400 MG	21531812000327	Brand
BOSULIF	BOSUTINIB TAB 500 MG	21531812000340	Brand
BOSULIF	BOSUTINIB CAP 50 MG	21531812000120	Brand
BOSULIF	BOSUTINIB CAP 100 MG	21531812000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Bosulif therapy

Product Name: Bosulif	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BOSULIF	BOSUTINIB TAB 100 MG	21531812000320	Brand
BOSULIF	BOSUTINIB TAB 400 MG	21531812000327	Brand
BOSULIF	BOSUTINIB TAB 500 MG	21531812000340	Brand
BOSULIF	BOSUTINIB CAP 50 MG	21531812000120	Brand
BOSULIF	BOSUTINIB CAP 100 MG	21531812000130	Brand

Approval Criteria

1 - Bosulif will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Bosulif	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BOSULIF	BOSUTINIB TAB 100 MG	21531812000320	Brand
BOSULIF	BOSUTINIB TAB 400 MG	21531812000327	Brand
BOSULIF	BOSUTINIB TAB 500 MG	21531812000340	Brand
BOSULIF	BOSUTINIB CAP 50 MG	21531812000120	Brand
BOSULIF	BOSUTINIB CAP 100 MG	21531812000130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Bosulif therapy

Braftovi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156254
Guideline Name	Braftovi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Braftovi	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Diagnosis of melanoma

AND

2 - Presence of BRAF V600E mutation

AND

3 - Disease is one of the following:

- Unresectable
- Metastatic

AND

4 - Used in combination with Mektovi (binimetinib)

AND

5 - ONE of the following:

5.1 Patient has a contraindication or history of intolerance to ONE of the following regimens (please specify contraindication or intolerance)

- Tafinlar (dabrafenib) plus Mekinist (trametinib)
- Zelboraf (vemurafenib) plus Cotellic (cobimetinib)

OR

5.2 Provider attests that the patient is not an appropriate candidate for either of the following regimens

- Tafinlar (dabrafenib) plus Mekinist (trametinib)
- Zelboraf (vemurafenib) plus Cotellic (cobimetinib)

OR

5.3 For continuation of prior Braftovi therapy

Product Name: Braftovi	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Braftovi therapy

AND

2 - Used in combination with Mektovi (binimetinib)

Product Name: Braftovi	
Diagnosis	Colon Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Diagnosis of colon cancer

AND

2 - Presence of BRAF V600E mutation

AND

3 - Disease is one of the following:

- Advanced
- Metastatic

AND

4 - Patient has received prior therapy

AND

5 - Used in combination with ONE of the following:

- Erbitux (cetuximab)
- Vectibix (panitumumab)

Product Name: Braftovi	
Diagnosis	Colon Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Braftovi therapy

AND

2 - Used in combination with ONE of the following:

- Erbitux (cetuximab)
- Vectibix (panitumumab)

Product Name: Braftovi	
Diagnosis	Rectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Diagnosis of rectal cancer

AND

2 - Presence of BRAF V600E mutation

AND

3 - Disease is one of the following:

- Advanced
- Metastatic

AND

4 - Patient has received prior therapy

AND

5 - Used in combination with ONE of the following:

- Erbitux (cetuximab)
- Vectibix (panitumumab)

Product Name: Braftovi	
Diagnosis	Rectal Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Braftovi therapy

AND

2 - Used in combination with ONE of the following:

- Erbitux (cetuximab)

- Vectibix (panitumumab)

Product Name: Braftovi	
Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Presence of BRAF V600E mutation

AND

3 - Disease is one of the following:

- Advanced
- Recurrent
- Metastatic

AND

4 - Used in combination with Mektovi (binimetinib)

AND

5 - ONE of the following:

5.1 Patient has a contraindication or history of intolerance to the following regimen (please specify contraindication or intolerance):

- Tafinlar (dabrafenib) plus Mekinist (trametinib)

OR

5.2 Provider attests that the patient is not an appropriate candidate for the following regimen:

- Tafinlar (dabrafenib) plus Mekinist (trametinib)

OR

5.3 For continuation of prior Braftovi therapy

Product Name: Braftovi	
Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Braftovi therapy

AND

2 - Used in combination with Mektovi (binimetinib)

Product Name: Braftovi	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Braftovi	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRAFTOVI	ENCORAFENIB CAP 75 MG	21532040000130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Braftovi therapy

2 . Revision History

Date	Notes
9/25/2024	Add step thru section for melanoma and NSCLC

Brexafemme

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146302
Guideline Name	Brexafemme
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brexafemme	
Diagnosis	Vulvovaginal candidiasis
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREXAFEMME	IBREXAFUNGERP CITRATE TAB 150 MG	11507040100320	Brand

Approval Criteria

1 - Diagnosis of vulvovaginal candidiasis (VVC)

AND

2 - ONE of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 BOTH of the following:

2.2.1 Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

AND

2.2.2 Failure of a 7-day course of oral fluconazole therapy defined as 100 mg (milligrams), 150 mg, or 200 mg taken orally every third day for a total of 3 doses (days 1,4, and 7), confirmed by claims history or submission of medical records, for the current episode of VVC

AND

3 - Prescribed by or in consultation with ONE of the following:

- Infectious disease physician
- Obstetrician/Gynecologist

Product Name: Brexafemme	
Diagnosis	Recurrent vulvovaginal candidiasis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREXAFEMME	IBREXAFUNGERP CITRATE TAB 150 MG	11507040100320	Brand

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis (RVVC)

AND

2 - ONE of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 BOTH of the following:

2.2.1 Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

AND

2.2.2 Failure of a maintenance course of oral fluconazole confirmed by claims history or submission of medical records defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months

AND

3 - Prescribed by or in consultation with ONE of the following:

- Infectious disease physician
- Obstetrician/Gynecologist

Brilinta and Effient

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146303
Guideline Name	Brilinta and Effient
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brilinta	
Diagnosis	Acute coronary syndrome (ACS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRILINTA	TICAGRELOR TAB 60 MG	85158470000315	Brand
BRILINTA	TICAGRELOR TAB 90 MG	85158470000320	Brand

Approval Criteria

1 - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]

OR

2 - The medication is being used to reduce the risk of a first myocardial infarction (MI) or stroke in a patient with coronary artery disease (CAD) at high risk for such events [e.g., type 2 diabetes mellitus, hypertension, dyslipidemia, multi-vessel CAD, obesity, heart failure, current smoker or chronic kidney disease]

OR

3 - The medication is being used to reduce the risk of stroke in patients with acute ischemic stroke (NIH Stroke Scale score less than or equal to 5) or high-risk transient ischemic attack (TIA)

Product Name: Brand Effient, generic prasugrel	
Diagnosis	Acute coronary syndrome (ACS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EFFIENT	PRASUGREL HCL TAB 5 MG (BASE EQUIV)	85158060100320	Brand
PRASUGREL	PRASUGREL HCL TAB 5 MG (BASE EQUIV)	85158060100320	Generic
EFFIENT	PRASUGREL HCL TAB 10 MG (BASE EQUIV)	85158060100330	Brand
PRASUGREL	PRASUGREL HCL TAB 10 MG (BASE EQUIV)	85158060100330	Generic

Approval Criteria

1 - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]

AND

2 - The patient must be managed with percutaneous coronary intervention (PCI)

Bronchitol

Prior Authorization Guideline

Guideline ID	GL-146304
Guideline Name	Bronchitol
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Bronchitol	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRONCHITOL TOLERANCE TEST	MANNITOL INHAL CAP 40 MG	45307060000140	Brand
BRONCHITOL	MANNITOL INHAL CAP 40 MG	45307060000140	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Used in conjunction with standard CF therapies [e.g., chest physiotherapy, bronchodilators, antibiotics, anti-inflammatory therapy (e.g., ibuprofen, oral/inhaled corticosteroids)]

AND

3 - Patient has passed the Bronchitol Tolerance Test

Product Name: Bronchitol	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRONCHITOL TOLERANCE TEST	MANNITOL INHAL CAP 40 MG	45307060000140	Brand
BRONCHITOL	MANNITOL INHAL CAP 40 MG	45307060000140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Bronchitol therapy

Brukinsa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154623
Guideline Name	Brukinsa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Brukinsa	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - ALL of the following:

- Diagnosis of follicular lymphoma (FL)
- Disease is relapsed or refractory
- Patient has received at least two or more lines of systemic therapy
- Brukinsa will be used in combination with obinutuzumab

OR

2 - ALL of the following:

2.1 Diagnosis of ONE of the following:

- Extranodal marginal zone lymphoma (EMZL) of the stomach
- Extranodal marginal zone lymphoma of nongastric sites (noncutaneous)
- Nodal marginal zone lymphoma

AND

2.2 Disease is relapsed, refractory, or progressive

AND

2.3 Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab)

OR

3 - ALL of the following:

3.1 Diagnosis of splenic marginal zone lymphoma

AND

3.2 Disease is relapsed or refractory

AND

3.3 Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab)

OR

4 - Diagnosis of mantle cell lymphoma (MCL)

Product Name: Brukinsa	
Diagnosis	Waldenström's Macroglobulinemia (WM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - Diagnosis of Waldenström's macroglobulinemia (WM)

Product Name: Brukinsa	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)

Product Name: Brukinsa	
Diagnosis	B-Cell Lymphomas, Waldenström's Macroglobulinemia (WM), Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Brukinsa therapy

Product Name: Brukinsa	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - Diagnosis of hairy cell leukemia

AND

2 - Disease is relapsed, refractory, or progressive

Product Name: Brukinsa	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Brukinsa therapy

Product Name: Brukinsa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brukinsa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BRUKINSA	ZANUBRUTINIB CAP 80 MG	21532195000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Brukinsa therapy

2 . Revision History

Date	Notes
9/9/2024	Annual review. Clinical coverage criteria added for follicular lymphoma and hairy cell leukemia. Updated B-cell lymphoma formatting. Updated background and reference.

Buphenyl

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146483
Guideline Name	Buphenyl
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Buphenyl oral powder, generic sodium phenylbutyrate oral powder	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUPHENYL	SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL	30908060002950	Brand
SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE ORAL POWDER 3 GM/TEASPOONFUL	30908060002950	Generic

Approval Criteria

1 - Diagnosis of urea cycle disorders (UCDs)

Product Name: Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUPHENYL	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Brand
SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Generic

Approval Criteria

1 - Diagnosis of urea cycle disorders (UCDs)

AND

2 - Prescriber provides a reason or special circumstance the patient cannot use sodium phenylbutyrate (generic Buphenyl) powder for oral solution

Product Name: Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUPHENYL	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Brand
SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE TAB 500 MG	30908060000320	Generic

Approval Criteria

1 - Documentation of positive clinical response to Buphenyl (sodium phenylbutyrate) tablets

Buprenorphine for Opioid Dependence

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146305
Guideline Name	Buprenorphine for Opioid Dependence
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic buprenorphine/naloxone SL film, buprenorphine/naloxone SL tabs, buprenorphine SL tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Generic

BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic

Approval Criteria

1 - The patient has a DSM-V-TR (diagnostic and statistical manual, fifth edition, text revision) diagnosis of opioid use disorder

Notes	*Up to 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized.

Product Name: Brand Suboxone, Zubsolv, Bunavail	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand

SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - The patient has a DSM-V-TR (diagnostic and statistical manual, fifth edition, text revision) diagnosis of opioid use disorder

AND

2 - The patient must have a reason or special circumstance that they cannot use BOTH of the following (please specify reason or special circumstance):

- Buprenorphine/naloxone sublingual film (generic Suboxone sublingual film)
- Buprenorphine/naloxone sublingual tablet

Notes	*Up to 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized.

Product Name: Brand Suboxone, Zubsolv, Bunavail	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - The patient has been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy

AND

2 - The patient must have a reason or special circumstance that they cannot use BOTH of the following (please specify reason or special circumstance):

- Buprenorphine/naloxone sublingual film (generic Suboxone sublingual film)
- Buprenorphine/naloxone sublingual tablet

Notes	*Up to 24 mg per day of buprenorphine, or equivalent dosing of an alt ernative medication, will be authorized.

Product Name: generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs, Bunavail	
Diagnosis	Exceeding 24 mg of buprenorphine or Equivalent
Approval Length	Authorization length will be issued for requested duration of therapy, not to exceed 12 months
Guideline Type	Drug Utilization Review

Product Name	Generic Name	GPI	Brand/Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic

ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - Physician has provided rationale for needing to exceed the 24 mg (milligrams) buprenorphine daily limit

Product Name: generic buprenorphine/naloxone SL film, Brand Suboxone, buprenorphine/naloxone SL tabs, Zubsolv, buprenorphine SL tabs, Bunavail	
Approval Length	Authorization length will be issued for requested duration of therapy, not to exceed 12 months
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 2-0.5 MG (BASE EQUIV)	65200010208220	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 8-2 MG (BASE EQUIV)	65200010208240	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 4-1 MG (BASE EQUIV)	65200010208230	Brand
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Generic
SUBOXONE	BUPRENORPHINE HCL-NALOXONE HCL SL FILM 12-3 MG (BASE EQUIV)	65200010208250	Brand
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2-0.5 MG (BASE EQUIV)	65200010200720	Generic
BUPRENORPHINE HCL/NALOXONE HCL	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
BUPRENORPHINE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8-2 MG (BASE EQUIV)	65200010200740	Generic
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 0.7-0.18 MG (BASE EQ)	65200010200710	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 1.4-0.36 MG (BASE EQ)	65200010200715	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 2.9-0.71 MG (BASE EQ)	65200010200725	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 5.7-1.4 MG (BASE EQ)	65200010200732	Brand

ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 8.6-2.1 MG (BASE EQ)	65200010200745	Brand
ZUBSOLV	BUPRENORPHINE HCL-NALOXONE HCL SL TAB 11.4-2.9 MG (BASE EQ)	65200010200760	Brand
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 2 MG (BASE EQUIV)	65200010100760	Generic
BUPRENORPHINE HYDROCHLORIDE	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUPRENORPHINE HCL	BUPRENORPHINE HCL SL TAB 8 MG (BASE EQUIV)	65200010100780	Generic
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 4.2-0.7 MG (BASE EQUIV)	65200010208270	Brand
BUNAVAIL	BUPRENORPHINE-NALOXONE BUCCAL FILM 6.3-1 MG (BASE EQUIV)	65200010208280	Brand

Approval Criteria

1 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

OR

2 - Physician has provided rationale for requiring the specific quantity requested

Bylvay

Prior Authorization Guideline

Guideline ID	GL-156302
Guideline Name	Bylvay
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BYLVAY	ODEVIXIBAT CAP 400 MCG	52350060000120	Brand
BYLVAY	ODEVIXIBAT CAP 1200 MCG	52350060000140	Brand
BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG	52350060006810	Brand

BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG	52350060006830	Brand

Approval Criteria

1 - Confirmed molecular diagnosis of progressive familial intrahepatic cholestasis (PFIC)

AND

2 - Patient does not have a ABCB11 variant resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3)

AND

3 - Patient is experiencing moderate to severe pruritus associated with PFIC

AND

4 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory

AND

5 - Patient has had an inadequate response to at least TWO other conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, sertraline)

AND

6 - Prescribed by a gastroenterologist or hepatologist

Product Name: Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BYLVAY	ODEVIXIBAT CAP 400 MCG	52350060000120	Brand
BYLVAY	ODEVIXIBAT CAP 1200 MCG	52350060000140	Brand
BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG	52350060006810	Brand
BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG	52350060006830	Brand

Approval Criteria

1 - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritis, and less sleep disturbance)

AND

2 - Prescribed by a gastroenterologist or hepatologist

Product Name: Bylvay	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BYLVAY	ODEVIXIBAT CAP 400 MCG	52350060000120	Brand
BYLVAY	ODEVIXIBAT CAP 1200 MCG	52350060000140	Brand
BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG	52350060006810	Brand
BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG	52350060006830	Brand

Approval Criteria

1 - Diagnosis Alagille syndrome (ALGS)

AND

2 - Confirmation of diagnosis by presence of the JAG1 or Notch2 gene mutation

AND

3 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory

AND

4 - Patient is experiencing moderate to severe pruritis associated with ALGS

AND

5 - Patient has had an inadequate response to at least TWO other conventional treatments for the symptomatic relief of pruritus (e.g., ursodeoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, sertraline).

AND

6 - Prescribed by a gastroenterologist or hepatologist

Product Name: Bylvay	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

BYLVAY	ODEVIXIBAT CAP 400 MCG	52350060000120	Brand
BYLVAY	ODEVIXIBAT CAP 1200 MCG	52350060000140	Brand
BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 200 MCG	52350060006810	Brand
BYLVAY (PELLETS)	ODEVIXIBAT PELLETS CAP SPRINKLE 600 MCG	52350060006830	Brand

Approval Criteria

1 - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritis)

AND

2 - Prescribed by a gastroenterologist or hepatologist

2 . Revision History

Date	Notes
9/25/2024	Updated examples of conventional treatment and initial authorization durations

Cablivi

Prior Authorization Guideline

Guideline ID	GL-146485
Guideline Name	Cablivi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABLIVI	CAPLACIZUMAB-YHDP FOR INJ KIT 11 MG	85151020806420	Brand

Approval Criteria

1 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)

AND

2 - Cablivi was initiated as a bolus intravenous injection administered by a healthcare provider in combination with plasma exchange therapy

AND

3 - Cablivi will be used in combination with immunosuppressive therapy (e.g., corticosteroids)

AND

4 - Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange

Product Name: Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABLIVI	CAPLACIZUMAB-YHDP FOR INJ KIT 11 MG	85151020806420	Brand

Approval Criteria

1 - Request is for a new (different) episode requiring the re-initiation of plasma exchange for the treatment of acquired thrombotic thrombocytopenic purpura (aTTP) (Documentation of date of prior episode and documentation date of new episode required)

Cabometyx

Prior Authorization Guideline

Guideline ID	GL-146486
Guideline Name	Cabometyx
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cabometyx	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of advanced renal cell carcinoma

Product Name: Cabometyx	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Positive for RET gene rearrangements

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

Product Name: Cabometyx	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of hepatocellular carcinoma

AND

2 - ONE of the following:

2.1 Failure to Nexavar (sorafenib), as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to Nexavar (sorafenib) (please specify contraindication or intolerance)

OR

2.3 BOTH of the following:

2.3.1 Disease is Child-Pugh class A

AND

2.3.2 Patient has unresectable disease and is not a transplant candidate

OR

2.4 BOTH of the following:

2.4.1 Disease is Child-Pugh class A

AND

2.4.2 Patient has metastatic disease or extensive liver tumor burden

OR

2.5 BOTH of the following:

2.5.1 Disease is Child-Pugh class A

AND

2.5.2 Patient has liver-confined disease and it is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease

Product Name: Cabometyx	
Diagnosis	Osteosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of osteosarcoma

AND

2 - Patient's disease has progressed on prior treatment

AND

3 - ONE of the following:

3.1 Patient has relapsed/refractory disease

OR

3.2 Patient has metastatic disease

Product Name: Cabometyx	
Diagnosis	Ewing Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand

CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of Ewing sarcoma (including mesenchymal chondrosarcoma)

AND

2 - Patient has relapsed, progressive, or metastatic disease

Product Name: Cabometyx	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumors (GIST)

AND

2 - Patient has ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Recurrent/metastatic disease

AND

3 - Disease has progressed on ALL of the following:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Standard dose Qinlock (ripretinib)

Product Name: Cabometyx	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of kidney cancer

AND

2 - ONE of the following:

2.1 Patient has relapsed disease

OR

2.2 Patient has metastatic disease

Product Name: Cabometyx	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of endometrial carcinoma

AND

2 - Disease is recurrent, high-risk, or metastatic

AND

3 - Used as second-line treatment

Product Name: Cabometyx

Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Diagnosis of differentiated thyroid cancer (DTC)

AND

2 - Disease is locally advanced or metastatic

AND

3 - Disease has progressed following prior VEGFR-targeted therapy

AND

4 - Disease is radioactive iodine-refractory or ineligible

Product Name: Cabometyx	
Diagnosis	Renal Cell Carcinoma (RCC), Non-Small Cell Lung Cancer (NSCLC), Hepatocellular Carcinoma, Osteosarcoma, Ewing Sarcoma, Gastrointestinal Stromal Tumors (GIST), Kidney Cancer, Endometrial Carcinoma, Thyroid Cancer
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Cabometyx therapy

Product Name: Cabometyx	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Cabometyx	
Diagnosis	NCCN Recommended Regimen

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CABOMETYX	CABOZANTINIB S-MALATE TAB 20 MG (BASE EQUIVALENT)	21533010100320	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 40 MG (BASE EQUIVALENT)	21533010100330	Brand
CABOMETYX	CABOZANTINIB S-MALATE TAB 60 MG (BASE EQUIVALENT)	21533010100340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cabometyx therapy

Calquence

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146487
Guideline Name	Calquence
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Calquence	
Diagnosis	Mantle cell lymphoma (MCL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALQUENCE	ACALABRUTINIB CAP 100 MG	21532103000120	Brand
CALQUENCE	ACALABRUTINIB MALEATE TAB 100 MG	21532103500320	Brand

Approval Criteria

1 - Diagnosis of mantle cell lymphoma (MCL)

AND

2 - Patient has received at least one prior therapy for MCL [e.g., Rituxan (rituximab)]

Product Name: Calquence	
Diagnosis	Chronic lymphocytic leukemia/small lymphocytic lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALQUENCE	ACALABRUTINIB CAP 100 MG	21532103000120	Brand
CALQUENCE	ACALABRUTINIB MALEATE TAB 100 MG	21532103500320	Brand

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma

Product Name: Calquence	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALQUENCE	ACALABRUTINIB CAP 100 MG	21532103000120	Brand
CALQUENCE	ACALABRUTINIB MALEATE TAB 100 MG	21532103500320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Nodal Marginal Zone Lymphoma
- Extranodal Marginal Zone Lymphoma (EMZL) of the stomach
- Splenic Marginal Zone Lymphoma
- Extranodal Marginal Zone Lymphoma of Nongastric Sites (Non-cutaneous)

AND

2 - Disease is recurrent, relapsed, refractory, or progressive

Product Name: Calquence	
Diagnosis	Waldenström Macroglobulinemia/ Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALQUENCE	ACALABRUTINIB CAP 100 MG	21532103000120	Brand
CALQUENCE	ACALABRUTINIB MALEATE TAB 100 MG	21532103500320	Brand

Approval Criteria

1 - Diagnosis of Waldenström Macroglobulinemia/ Lymphoplasmacytic Lymphoma

AND

2 - ONE of the following:

- Patient did not respond to primary therapy
- Disease is relapsed or progressive

Product Name: Calquence	
Diagnosis	Mantle cell lymphoma (MCL), Chronic lymphocytic leukemia/small lymphocytic lymphoma, B-Cell Lymphomas, Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALQUENCE	ACALABRUTINIB CAP 100 MG	21532103000120	Brand
CALQUENCE	ACALABRUTINIB MALEATE TAB 100 MG	21532103500320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Calquence therapy

Product Name: Calquence	
Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALQUENCE	ACALABRUTINIB CAP 100 MG	21532103000120	Brand
CALQUENCE	ACALABRUTINIB MALEATE TAB 100 MG	21532103500320	Brand

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Calquence	
Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CALQUENCE	ACALABRUTINIB CAP 100 MG	21532103000120	Brand
CALQUENCE	ACALABRUTINIB MALEATE TAB 100 MG	21532103500320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Calquence therapy

Camzyos

Prior Authorization Guideline

Guideline ID	GL-146488
Guideline Name	Camzyos
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Camzyos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CAMZYOS	MAVACAMTEN CAP 2.5 MG	40190050000110	Brand
CAMZYOS	MAVACAMTEN CAP 5 MG	40190050000120	Brand
CAMZYOS	MAVACAMTEN CAP 10 MG	40190050000130	Brand
CAMZYOS	MAVACAMTEN CAP 15 MG	40190050000140	Brand

Approval Criteria

1 - Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

AND

2 - Heart failure is classified as ONE of the following:

- New York Heart Association (NYHA) class II heart failure
- NYHA class III heart failure

AND

3 - Patient has a left ventricular ejection fraction of greater than or equal to 55%

AND

4 - Patient has a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

AND

5 - One of the following:

5.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)
- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)
- Disopyramide

OR

5.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)
- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)
- Disopyramide

AND

6 - Camzyos is prescribed by, or in consultation with, a cardiologist

Product Name: Camzyos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CAMZYOS	MAVACAMTEN CAP 2.5 MG	40190050000110	Brand
CAMZYOS	MAVACAMTEN CAP 5 MG	40190050000120	Brand
CAMZYOS	MAVACAMTEN CAP 10 MG	40190050000130	Brand
CAMZYOS	MAVACAMTEN CAP 15 MG	40190050000140	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy as supported by ONE of the following:

- Reduction in NYHA (New York Heart Association) class
- No worsening in NYHA class

AND

2 - Patient has a left ventricular ejection fraction of greater than or equal to 50%

AND

3 - Camzyos is prescribed by, or in consultation with, a cardiologist

Caprelsa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146489
Guideline Name	Caprelsa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Caprelsa	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CAPRELSA	VANDETANIB TAB 100 MG	21533085000320	Brand
CAPRELSA	VANDETANIB TAB 300 MG	21533085000340	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of medullary thyroid cancer (MTC)

AND

1.2 ONE of the following:

- Unresectable locally advanced disease
- Metastatic disease

AND

1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

OR

2 - ALL of the following:

2.1 ONE of the following diagnoses:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

2.2 ONE of the following:

- Unresectable recurrent disease
- Persistent locoregional disease
- Metastatic disease

AND

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

2.4 Disease is refractory to radioactive iodine treatment

Product Name: Caprelsa	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CAPRELSA	VANDETANIB TAB 100 MG	21533085000320	Brand
CAPRELSA	VANDETANIB TAB 300 MG	21533085000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Caprelsa therapy

Product Name: Caprelsa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CAPRELSA	VANDETANIB TAB 100 MG	21533085000320	Brand
CAPRELSA	VANDETANIB TAB 300 MG	21533085000340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Caprelsa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CAPRELSA	VANDETANIB TAB 100 MG	21533085000320	Brand
CAPRELSA	VANDETANIB TAB 300 MG	21533085000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Caprelsa therapy

Carbaglu

Prior Authorization Guideline

Guideline ID	GL-146490
Guideline Name	Carbaglu
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Carbaglu, generic carglumic acid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CARBAGLU	CARGLUMIC ACID SOLUBLE TAB 200 MG	30908230007320	Brand
CARGLUMIC ACID	CARGLUMIC ACID SOLUBLE TAB 200 MG	30908230007320	Generic

Approval Criteria

1 - Diagnosis of hyperammonemia due to ONE of the following:

- N-acetylglutamate synthase (NAGS) deficiency
- Propionic acidemia (PA)
- Methylmalonic acidemia (MMA)

Product Name: Brand Carbaglu, generic carglumic acid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CARBAGLU	CARGLUMIC ACID SOLUBLE TAB 200 MG	30908230007320	Brand
CARGLUMIC ACID	CARGLUMIC ACID SOLUBLE TAB 200 MG	30908230007320	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Cayston

Prior Authorization Guideline

Guideline ID	GL-146491
Guideline Name	Cayston
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cayston	
Diagnosis	Cystic Fibrosis (CF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CAYSTON	AZTREONAM LYSINE FOR INHAL SOLN 75 MG (BASE EQUIVALENT)	16140010402120	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - ONE of the following:

2.1 Failure to tobramycin solution for inhalation (generic Bethkis) confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to tobramycin solution for inhalation (generic Bethkis) (please specify intolerance or contraindication)

Cerdelga and Zavesca

Prior Authorization Guideline

Guideline ID	GL-146492
Guideline Name	Cerdelga and Zavesca
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cerdelga	
Diagnosis	Gaucher Disease Type 1
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CERDELGA	ELIGLUSTAT TARTRATE CAP 84 MG (BASE EQUIVALENT)	82700040600120	Brand

Approval Criteria

1 - Diagnosis of Gaucher disease type 1

AND

2 - Patient is ONE of the following as detected by a Food and Drug Administration (FDA)-cleared test:

- CYP2D6 extensive metabolizer
- CYP2D6 intermediate metabolizer
- CYP2D6 poor metabolizer

Product Name: Cerdelga	
Diagnosis	Gaucher Disease Type 1
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CERDELGA	ELIGLUSTAT TARTRATE CAP 84 MG (BASE EQUIVALENT)	82700040600120	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Brand Zavesca, generic miglustat, Yargesa	
Diagnosis	Mild to Moderate Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MIGLUSTAT	MIGLUSTAT CAP 100 MG	82700070000120	Generic

ZAVESCA	MIGLUSTAT CAP 100 MG	82700070000120	Brand
YARGESA	MIGLUSTAT CAP 100 MG	82700070000120	Generic

Approval Criteria

1 - Diagnosis of mild to moderate type 1 Gaucher disease

AND

2 - Patient is unable to receive enzyme replacement therapy due to ONE of the following conditions:

2.1 Allergy or hypersensitivity to enzyme replacement therapy

OR

2.2 Poor venous access

OR

2.3 Unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV)

Product Name: Brand Zavesca, generic miglustat, Yargesa	
Diagnosis	Mild to Moderate Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MIGLUSTAT	MIGLUSTAT CAP 100 MG	82700070000120	Generic
ZAVESCA	MIGLUSTAT CAP 100 MG	82700070000120	Brand
YARGESA	MIGLUSTAT CAP 100 MG	82700070000120	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

CGRP

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147271
Guideline Name	CGRP
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ajovy, Emgality 120mg	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN AUTO-INJ 225 MG/1.5ML	6770203020D520	Brand
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN PREF SYR 225 MG/1.5ML	6770203020E520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML	6770203530D520	Brand

EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML	6770203530E520	Brand

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 4 to 7 migraine days per month and at least ONE of the following:

- Less than 15 headache days per month
- Provider attests this is the patient's predominant headache diagnosis (i.e., primary driver of headaches is not a different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - ONE of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

OR

3.2 History of intolerance or contraindication to ALL of the following prophylactic therapies or classes (please specify intolerance or contraindication):

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

AND

4 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Aimovig, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti (eptinezumab-jjmr)]

Notes	*Timolol and candesartan are non-preferred and should not be include d in denial to provider. **OnabotulinumtoxinA (generic Botox) might not be covered on your p harmacy prescription drug benefit. Coverage might be available on yo ur medical benefit.

Product Name: Aimovig	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 70 MG/ML	6770202010D520	Brand
AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	6770202010D540	Brand

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 4 to 7 migraine days per month and at least ONE of the following:

- Less than 15 headache days per month
- Provider attests this is the patient's predominant headache diagnosis (i.e., primary driver of headaches is not a different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - ONE of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

OR

3.2 History of intolerance or contraindication to ALL of the following prophylactic therapies or classes (please specify intolerance or contraindication):

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan (generic Atacand)*
- Divalproex sodium [generic Depakote/Depakote ER (extended-release)]
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)

- Venlafaxine [generic Effexor/Effexor XR (extended-release)]

AND

4 - ONE of the following:

4.1 Failure (after a trial of at least three months), to BOTH of the following as documented by claims history or submission of medical records:

- Ajovy
- Emgality [120 mg (milligram) strength]

OR

4.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Ajovy
- Emgality (120 mg strength)

AND

5 - Medication will not be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Ajovy, Emgality, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

Notes	*Timolol and candesartan are non-preferred and should not be include d in denial to provider. **OnabotulinumtoxinA (generic Botox) might not be covered on your p harmacy prescription drug benefit. Coverage might be available on yo ur medical benefit.

Product Name: Aimovig, Ajovy, Emgality 120mg	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 70 MG/ML	6770202010D520	Brand
AIMOVIG	ERENUMAB-AOOE SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	6770202010D540	Brand
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN AUTO-INJ 225 MG/1.5ML	6770203020D520	Brand
AJOVY	FREMANEZUMAB-VFRM SUBCUTANEOUS SOLN PREF SYR 225 MG/1.5ML	6770203020E520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN AUTO-INJECTOR 120 MG/ML	6770203530D520	Brand
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 120 MG/ML	6770203530E520	Brand

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

Product Name: Emgality 100mg	
Diagnosis	Episodic Cluster Headache
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML	6770203530E515	Brand

Approval Criteria

1 - Diagnosis of episodic cluster headache

AND

2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months

AND

3 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Aimovig, Ajovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

Product Name: Emgality 100mg	
Diagnosis	Episodic Cluster Headache
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMGALITY	GALCANEZUMAB-GNLM SUBCUTANEOUS SOLN PREFILLED SYR 100 MG/ML	6770203530E515	Brand

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Medication will NOT be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines [e.g., Aimovig, Ajovy, Nurtec ODT (orally disintegrating tablet), Qulipta, Vyepti]

2 . Revision History

Date	Notes
5/13/2024	Updated note regarding medical coverage of generic Botox. Added e pisodic to header of cluster headaches section.

Cholbam

Prior Authorization Guideline

Guideline ID	GL-146493
Guideline Name	Cholbam
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cholbam	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CHOLBAM	CHOLIC ACID CAP 50 MG	52700025000120	Brand
CHOLBAM	CHOLIC ACID CAP 250 MG	52700025000140	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of a bile acid synthesis disorder

AND

1.2 Bile acid synthesis disorder is due to single enzyme defects (SEDs)

OR

2 - ALL of the following:

2.1 Diagnosis of a peroxisomal disorder including Zellweger spectrum disorders

AND

2.2 Patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption

AND

2.3 Cholbam is being used as adjunctive treatment

Product Name: Cholbam	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CHOLBAM	CHOLIC ACID CAP 50 MG	52700025000120	Brand
CHOLBAM	CHOLIC ACID CAP 250 MG	52700025000140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cholbam therapy as evidenced by BOTH of the following:

1.1 Improvement in liver function (e.g., aspartate aminotransferase [AST], alanine aminotransferase [ALT])

AND

1.2 Absence of complete biliary obstruction

Cialis and Chewtadzy for BPH

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156306
Guideline Name	Cialis and Chewtadzy for BPH
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Chewtadzy 5mg, Brand Cialis 5 mg, generic tadalafil 5 mg	
Diagnosis	Benign prostatic hyperplasia (BPH)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIALIS	TADALAFIL TAB 5 MG	40304080000305	Brand
TADALAFIL	TADALAFIL TAB 5 MG	40304080000305	Generic
CHEWTADZY			

Approval Criteria

1 - The patient has a diagnosis of benign prostatic hyperplasia (BPH)

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Alpha Blockers: (e.g., tamsulosin, alfuzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Alpha Blockers: (e.g., tamsulosin, alfuzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

AND

3 - Dose does not exceed 5 mg (milligrams) once daily

AND

4 - If the request is for Chewtadzy, ONE of the following:

- Failure to tadalafil 5 mg (generic Cialis 5 mg) confirmed by claims history or submission of medical records
- History of intolerance or contraindication to tadalafil 5 mg (generic Cialis 5 mg) (please specify intolerance or contraindication)

2 . Revision History

Date	Notes
9/26/2024	Added Chewtadzy

Cibinqo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147335
Guideline Name	Cibinqo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cibinqo	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIBINQO	ABROCITINIB TAB 50 MG	90272005000320	Brand
CIBINQO	ABROCITINIB TAB 100 MG	90272005000325	Brand
CIBINQO	ABROCITINIB TAB 200 MG	90272005000330	Brand

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to TWO of the following therapeutic classes of topical therapies as confirmed by claims history or submission of medical records:

- One medium, high, or very-high potency topical corticosteroid* [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.1.1.2 History of intolerance or contraindication to ALL of the following therapeutic classes of topical therapies (please specify intolerance or contraindication):

- One medium, high, or very-high potency topical corticosteroid* [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

AND

2.1.2 ONE of the following:

2.1.2.1 BOTH of the following:

2.1.2.1.1 Submission of medical records (e.g., chart notes, laboratory values) documenting a 3 month trial of a systemic drug product for the treatment of atopic dermatitis [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.]

AND

2.1.2.1.2 Physician attests that the patient was not adequately controlled with the documented systemic drug product

OR

2.1.2.2 Physician attests that systemic treatment with BOTH of the following FDA (Food and Drug Administration)-approved chronic atopic dermatitis therapies is inadvisable (document drug and contraindication rationale):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure [refer to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-V-TR) 300.29 for specific phobia diagnostic criteria]

OR

2.2 Patient is currently on Cibinqo therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Cibinqo in combination with any of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]

- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Notes	*See list of "Relative Potencies of Topical Corticosteroids" in Table 1 of the Background.

Product Name: Cibinqo	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIBINQO	ABROCITINIB TAB 50 MG	90272005000320	Brand
CIBINQO	ABROCITINIB TAB 100 MG	90272005000325	Brand
CIBINQO	ABROCITINIB TAB 200 MG	90272005000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cibinqo therapy

AND

2 - Patient is NOT receiving Cibinqo in combination with any of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]

- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

3 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05

	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
5/13/2024	Copy NY

Cimzia

Prior Authorization Guideline

Guideline ID	GL-146495
Guideline Name	Cimzia
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cimzia	
Diagnosis	Crohn’s Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	52505020 10F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	52505020 10F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active Crohn's disease

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (Imuran)
- 6-mercaptopurine (Purinethol)
- Methotrexate (Rheumatrex, Trexall)

OR

1.2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (Imuran)
- 6-mercaptopurine (Purinethol)
- Methotrexate (Rheumatrex, Trexall)

OR

1.2.3 Patient has been previously treated with a biologic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., adalimumab, Stelara (ustekinumab)]

AND

1.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with a gastroenterologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active Crohn's disease

AND

2.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a gastroenterologist

Product Name: Cimzia	
Diagnosis	Rheumatoid Arthritis (RA)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	5250502010F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine], at the maximally indicated doses, confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to ONE non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name: Cimzia	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	5250502010F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate, at the maximally indicated dose, confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-

approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast)]]

AND

1.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Cimzia	
Diagnosis	Ankylosing Spondylitis or Non-Radiographic Axial Spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	5250502010F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis

AND

1.2 ONE of the following:

1.2.1 Failure of TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to TWO NSAIDs (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis

AND

2.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name: Cimzia	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	5250502010F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	5250502010F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderate to severe plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

1.2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure to ONE of the following topical therapies, confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.2.1.3 ONE of the following:

1.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose, confirmed by claims history or submitted medical records

OR

1.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

AND

1.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with a dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Cimzia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderate to severe plaque psoriasis

AND

2.3 Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a dermatologist

Product Name: Cimzia	
Diagnosis	Crohn's Disease, Rheumatoid Arthritis (RA), Psoriatic Arthritis, Ankylosing Spondylitis or Non-Radiographic Axial Spondyloarthritis, Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIMZIA	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 2 X 200 MG/ML	52505020 10F840	Brand
CIMZIA STARTER KIT	CERTOLIZUMAB PEGOL PREFILLED SYRINGE KIT 6 X 200 MG/ML	52505020 10F840	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cimzia therapy

AND

2 - Patient is NOT receiving Cimzia in combination with any of the following:

- Biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Enbrel (etanercept), adalimumab, Orencia (abatacept), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Cinryze

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147161
Guideline Name	Cinryze
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cinryze	
Diagnosis	Hereditary angioedema (HAE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CINRYZE	C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ 500 UNIT	85802022002120	Brand

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by one of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - Prescribed for the prophylaxis of HAE attacks

AND

3 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Haegarda, Orladeyo, Takhzyro)

AND

4 - Prescriber attests that the patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Cinryze

AND

5 - One of the following:

5.1 Failure to Haegarda confirmed by claims history or submitted medical records

OR

5.2 History of intolerance or contraindication to Haegarda (please specify intolerance or contraindication)

OR

5.3 Patient is currently on Cinryze therapy confirmed by claims history or submitted medical records

AND

6 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name: Cinryze	
Diagnosis	Hereditary angioedema (HAE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CINRYZE	C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ 500 UNIT	85802022002120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cinryze therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Cinryze therapy

AND

3 - Prescribed for the prophylaxis of HAE attacks

AND

4 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Haegarda, Orladeyo, Takhzyro)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
5/8/2024	Update to diagnostic criteria for HAE with normal C1 inhibitor levels. Simplified reauthorization criteria.

Ciprodex

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146308
Guideline Name	Ciprodex
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Ciprodex, generic ciprofloxacin/dexamethasone	
Approval Length	1 Month
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CIPRODEX	CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1%	87991002361820	Brand
CIPROFLOXACIN/DEXAMETHASONE	CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1%	87991002361820	Generic

Approval Criteria

1 - ONE of the following:

1.1 The patient has a perforated tympanic membrane or tympanostomy tubes

OR

1.2 The patient has had an inadequate response, intolerance or contraindication to ONE preferred alternative confirmed by claims history or submission of medical records (please specify intolerance or contraindication if applicable).

Colony Stimulating Factors

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146497
Guideline Name	Colony Stimulating Factors
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Leukine, Zarxio	
Diagnosis	Bone Marrow/Stem Cell Transplant
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LEUKINE	SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG	82402050002120	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152060E530	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152060E540	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient has non-myeloid malignancies and is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)

OR

1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

OR

1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Releuko	
Diagnosis	Bone Marrow/Stem Cell Transplant
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	Brand
NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152000E545	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML)	8240152000E550	Brand

NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152010E520	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152010E530	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 300 MCG/ML	82401520102020	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML)	82401520102030	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152015E520	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152015E530	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 300 MCG/ML	82401520152020	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML)	82401520152030	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient has non-myeloid malignancies and is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)

OR

1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

OR

1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, or Nivestym, or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of contraindication, intolerance or adverse event to Zarxio (please specify contraindication, intolerance, or adverse event)

Product Name: Leukine, Zarxio	
Diagnosis	AML Induction or Consolidation Therapy
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LEUKINE	SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG	82402050002120	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152060E530	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152060E540	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - ONE of the following:

2.1 Patient achieved complete remission after induction therapy

OR

2.2 Patient is receiving consolidation chemotherapy

OR

2.3 Patient is receiving fludarabine, cytarabine with or without idarubicin for relapsed or refractory disease

OR

2.4 Patient is receiving cladribine, cytarabine with or without mitoxantrone or idarubicin for relapsed or refractory disease

AND

3 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Releuko	
Diagnosis	AML Induction or Consolidation Therapy
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	Brand
NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	Brand

NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152000E545	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML)	8240152000E550	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152010E520	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152010E530	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 300 MCG/ML	82401520102020	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML)	82401520102030	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152015E520	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152015E530	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 300 MCG/ML	82401520152020	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML)	82401520152030	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - One of the following:

2.1 Patient achieved complete remission after induction therapy

OR

2.2 Patient is receiving consolidation chemotherapy

OR

2.3 Patient is receiving fludarabine, cytarabine with or without idarubicin for relapsed or refractory disease

OR

2.4 Patient is receiving cladribine, cytarabine with or without mitoxantrone or idarubicin for relapsed or refractory disease

AND

3 - Prescribed by or in consultation with a hematologist or oncologist

AND

4 - ONE of the following:

4.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

4.2 Both of the following:

4.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, or Nivestym, or Releuko than experienced with Zarxio

AND

4.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of contraindication, intolerance or adverse effect to Zarxio (please specify contraindication, intolerance, or adverse effect)

Product Name: Leukine, Neulasta, Neulasta Onpro, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)

Approval Length	3 months or duration of therapy.
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEULASTA	PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157000E520	Brand
NEULASTA ONPRO KIT	PEGFILGRASTIM SOLN PREFILLED SYRINGE KIT 6 MG/0.6ML	8240157000F820	Brand
LEUKINE	SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG	82402050002120	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152060E530	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152060E540	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML	8240157010D520	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157010E520	Brand
UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - ONE of the following:

1.1 One of the following:

- Patient is receiving dose dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) for bladder cancer
- Patient is receiving dose dense AC (doxorubicin, cyclophosphamide) followed by dose-dense paclitaxel for breast cancer
- Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of febrile neutropenia (FN)

OR

1.2 Both of the following:

1.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN

AND

1.2.2 Patient has one or more risk factors for chemotherapy-induced febrile neutropenia such as:

- Persistent neutropenia due to prior chemotherapy, radiation therapy, or bone marrow involvement by tumor (< 500 neutrophils/mcL or < 1,000 neutrophils/mcL and a predicted decline to ≤ 500 neutrophils/mcL over the next 48 hours)
- Liver dysfunction (bilirubin > 2.0)
- Renal dysfunction (creatinine clearance < 50)
- Age greater than 65 years receiving full chemotherapy dose intensity

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Granix, Neupogen, Nivestym, Releuko	
Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy.
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152000E545	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML)	8240152000E550	Brand
NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	Brand
NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	Brand
GRANIX	TBO-FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152070E530	Brand
GRANIX	TBO-FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152070E540	Brand
GRANIX	TBO-FILGRASTIM SUBCUTANEOUS INJ 300 MCG/ML	82401520702020	Brand
GRANIX	TBO-FILGRASTIM SUBCUTANEOUS INJ 480 MCG/1.6ML (300 MCG/ML)	82401520702030	Brand

NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152010E520	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152010E530	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 300 MCG/ML	82401520102020	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML)	82401520102030	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152015E520	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152015E530	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 300 MCG/ML	82401520152020	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML)	82401520152030	Brand

Approval Criteria

1 - ONE of the following:

1.1 One of the following:

- Patient is receiving dose dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) for bladder cancer
- Patient is receiving dose dense AC (doxorubicin, cyclophosphamide) followed by dose-dense paclitaxel for breast cancer
- Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of febrile neutropenia (FN)

OR

1.2 Both of the following:

1.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN

AND

1.2.2 Patient has one or more risk factors for chemotherapy-induced febrile neutropenia such as:

- Persistent neutropenia due to prior chemotherapy, radiation therapy, or bone marrow involvement by tumor (< 500 neutrophils/mcL or < 1,000 neutrophils/mcL and a predicted decline to ≤ 500 neutrophils/mcL over the next 48 hours)
- Liver dysfunction (bilirubin > 2.0)
- Renal dysfunction (creatinine clearance < 50)
- Age greater than 65 years receiving full chemotherapy dose intensity

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Granix vial, Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Granix, Neupogen, Nivestym, or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of contraindication, intolerance, or adverse effect to Zarxio (please specify contraindication, intolerance, or adverse effect)

Product Name: Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend, Ziextenzo	
Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)

Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FULPHILA	PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157020E520	Brand
NYVEPRIA	PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157002E520	Brand
FYLNETRA	PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157060E520	Brand
ROLVEDON	EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML	8240151880E520	Brand
STIMUFEND	PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157015E520	Brand
ZIEXTENZO	PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157005E520	Brand

Approval Criteria

1 - ONE of the following:

1.1 One of the following:

- Patient is receiving dose dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) for bladder cancer
- Patient is receiving dose dense AC (doxorubicin, cyclophosphamide) followed by dose-dense paclitaxel for breast cancer
- Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of neutropenia (FN)

OR

1.2 Both of the following:

1.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN

AND

1.2.2 Patient has one or more risk factors for chemotherapy-induced febrile neutropenia:

- Persistent neutropenia due to prior chemotherapy, radiation therapy or bone marrow involvement by tumor (< 500 neutrophils/mcL or < 1,000 neutrophils/mcL and a predicted decline to ≤ 500 neutrophils/mcL over the next 48 hours)
- Liver dysfunction (bilirubin > 2.0)
- Renal dysfunction (creatinine clearance < 50)
- Age greater than 65 years receiving full chemotherapy dose intensity

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - BOTH of the following:

3.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo than experienced with Neulasta or Udenyca/Udenyca Onbody

AND

3.2 One of the following:

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records
- History of intolerance, contraindication, or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

Product Name: Leukine, Neulasta, Neulasta Onpro, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEULASTA	PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157000E520	Brand

NEULASTA ONPRO KIT	PEGFILGRASTIM SOLN PREFILLED SYRINGE KIT 6 MG/0.6ML	8240157000F820	Brand
LEUKINE	SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG	82402050002120	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152060E530	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152060E540	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML	8240157010D520	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157010E520	Brand
UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 ONE of the following:

1.1.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with a curative intent (curative chemotherapy, chemotherapy in curative adjuvant/neoadjuvant setting)

OR

1.1.1.2 Patient is receiving myelosuppressive anticancer drug(s) with a non-curative intent and use of secondary prophylaxis is in accordance with the United States Food and Drug Administration approved labeling

OR

1.1.1.3 Patient is receiving myelosuppressive anticancer drug(s) for definitive therapy (bridge to stem cell transplant, organ transplant, definitive surgery for oligometastatic disease)

AND

1.1.2 ONE of the following:

1.1.2.1 Patient has a documented history of a neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen at full dose for which primary prophylaxis was not received

OR

1.1.2.2 Patient has a documented history of neutropenic event from a previous course of chemotherapy

OR

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with non-curative intent

AND

1.2.1.2 Patient has a documented history of neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen after a trial of dose reduction

OR

1.2.2 Patient is receiving myelosuppressive anticancer drug(s) where primary prophylaxis is indicated

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Granix, Neupogen, Nivestym, Releuko	
Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)

Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152000E545	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML)	8240152000E550	Brand
NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	Brand
NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	Brand
GRANIX	TBO-FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152070E530	Brand
GRANIX	TBO-FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152070E540	Brand
GRANIX	TBO-FILGRASTIM SUBCUTANEOUS INJ 300 MCG/ML	82401520702020	Brand
GRANIX	TBO-FILGRASTIM SUBCUTANEOUS INJ 480 MCG/1.6ML (300 MCG/ML)	82401520702030	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152010E520	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152010E530	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 300 MCG/ML	82401520102020	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML)	82401520102030	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152015E520	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152015E530	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 300 MCG/ML	82401520152020	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML)	82401520152030	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 ONE of the following:

1.1.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with a curative intent (curative chemotherapy, chemotherapy in curative adjuvant/neoadjuvant setting)

OR

1.1.1.2 Patient is receiving myelosuppressive anticancer drug(s) with a non-curative intent and use of secondary prophylaxis is in accordance with the United States Food and Drug Administration approved labeling

OR

1.1.1.3 Patient is receiving myelosuppressive anticancer drug(s) for definitive therapy (bridge to stem cell transplant, organ transplant, definitive surgery for oligometastatic disease)

AND

1.1.2 ONE of the following:

1.1.2.1 Patient has a documented history of a neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen at full dose for which primary prophylaxis was not received

OR

1.1.2.2 Patient has a documented history of neutropenic event from a previous course of chemotherapy

OR

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with non-curative intent

AND

1.2.1.2 Patient has a documented history of neutropenic event (febrile neutropenia or low

neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen after a trial of dose reduction

OR

1.2.2 Patient is receiving myelosuppressive anticancer drug(s) where primary prophylaxis is indicated

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Granix vial, Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Granix, Neupogen, Nivestym or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name: Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend, Ziextenzo

Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FULPHILA	PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157020E520	Brand
NYVEPRIA	PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157002E520	Brand
FYLNETRA	PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157060E520	Brand
ROLVEDON	EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML	8240151880E520	Brand
STIMUFEND	PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157015E520	Brand
ZIEXTENZO	PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157005E520	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 ONE of the following:

1.1.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with a curative intent (curative chemotherapy, chemotherapy in curative adjuvant/neoadjuvant setting)

OR

1.1.1.2 Patient is receiving myelosuppressive anticancer drug(s) with a non-curative intent and use of secondary prophylaxis is in accordance with the United States Food and Drug Administration approved labeling

OR

1.1.1.3 Patient is receiving myelosuppressive anticancer drug(s) for definitive therapy (bridge to stem cell transplant, organ transplant, definitive surgery for oligometastatic disease)

AND

1.1.2 One of the following:

1.1.2.1 Patient has a documented history of a neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen at full dose for which primary prophylaxis was not received

OR

1.1.2.2 Patient has a documented history of neutropenic event from a previous course of chemotherapy

OR

1.2 One of the following:

1.2.1 Both of the following:

1.2.1.1 Patient is receiving myelosuppressive anticancer drug(s) given with non-curative intent

AND

1.2.1.2 Patient has a documented history of neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen after a trial of dose reduction

OR

1.2.2 Patient is receiving myelosuppressive anticancer drug(s) where primary prophylaxis is indicated

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - BOTH of the following:

3.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo than experienced with Neulasta or Udenyca/Udenyca Onbody

AND

3.2 One of the following:

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

Product Name: Leukine, Neulasta, Neulasta Onpro, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Treatment of Febrile Neutropenia (FN)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEULASTA	PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157000E520	Brand
NEULASTA ONPRO KIT	PEGFILGRASTIM SOLN PREFILLED SYRINGE KIT 6 MG/0.6ML	8240157000F820	Brand
LEUKINE	SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG	82402050002120	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152060E530	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152060E540	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML	8240157010D520	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157010E520	Brand

UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - Diagnosis of febrile neutropenia (FN)

AND

2 - Patient has not received long-acting prophylactic pegfilgrastim in the last 14 days

AND

3 - Patient has one or more risk factors for an infection-associated complication such as:

- Sepsis syndrome
- Greater than 65 years or age
- Absolute Neutrophil Count (ANC) less than 100/mcL
- Neutropenia expected to be greater than 10 days in duration
- Pneumonia
- Clinically documented infections including invasive fungal infection
- Hospitalization at the time of fever
- Prior episode(s) of FN

AND

4 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Releuko	
Diagnosis	Treatment of Febrile Neutropenia (FN)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	Brand

NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152000E545	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML)	8240152000E550	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152010E520	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152010E530	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 300 MCG/ML	82401520102020	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML)	82401520102030	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152015E520	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152015E530	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 300 MCG/ML	82401520152020	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML)	82401520152030	Brand
UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - Diagnosis of febrile neutropenia (FN)

AND

2 - Patient has not received long-acting prophylactic pegfilgrastim in the last 14 days

AND

3 - Patient has one or more risk factors for an infection-associated complication such as:

- Sepsis syndrome
- Greater than 65 years or age
- Absolute Neutrophil Count (ANC) less than 100/mcL
- Neutropenia expected to be greater than 10 days in duration
- Pneumonia
- Clinically documented infections including invasive fungal infection

- Hospitalization at the time of fever
- Prior episode(s) of FN

AND

4 - Prescribed by or in consultation with a hematologist or oncologist

AND

5 - One of the following:

5.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

5.2 Both of the following:

5.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym or Releuko than experienced with Zarxio

AND

5.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name: Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend, Ziextenzo	
Diagnosis	Treatment of Febrile Neutropenia (FN)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

FULPHILA	PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157020E520	Brand
NYVEPRIA	PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157002E520	Brand
FYLNETRA	PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157060E520	Brand
ROLVEDON	EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML	8240151880E520	Brand
STIMUFEND	PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157015E520	Brand
ZIEXTENZO	PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157005E520	Brand

Approval Criteria

1 - Diagnosis of febrile neutropenia (FN)

AND

2 - Patient has not received long-acting prophylactic pegfilgrastim in the last 14 days

AND

3 - Patient has one or more risk factors for an infection-associated complication such as:

- Sepsis syndrome
- Greater than 65 years or age
- Absolute Neutrophil Count (ANC) less than 100/mcL
- Neutropenia expected to be greater than 10 days in duration
- Pneumonia
- Clinically documented infections including invasive fungal infection
- Hospitalization at the time of fever
- Prior episode(s) of FN

AND

4 - Prescribed by or in consultation with a hematologist or oncologist

AND

5 - Both of the following:

5.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo than experienced with Neulasta or Udenyca/Udenyca Onbody

AND

5.2 One of the following:

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

Product Name: Zarxio	
Diagnosis	Severe Chronic Neutropenia (SCN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152060E530	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152060E540	Brand
UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - Diagnosis of severe chronic neutropenia (SCN) [i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count (ANC) less than or equal to 500 neutrophils/microliter]

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Releuko	
Diagnosis	Severe Chronic Neutropenia (SCN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	Brand
NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152000E545	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML)	8240152000E550	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152010E520	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152010E530	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 300 MCG/ML	82401520102020	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML)	82401520102030	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152015E520	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152015E530	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 300 MCG/ML	82401520152020	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML)	82401520152030	Brand
UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - Diagnosis of severe chronic neutropenia (SCN) [i.e., congenital, cyclic, and idiopathic

neutropenias with chronic absolute neutrophil count (ANC) less than or equal to 500 neutrophils/microliter]

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name: Leukine, Neulasta, Zarxio, Udenyca, Udenyca Onbody	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NEULASTA	PEGFILGRASTIM SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157000E520	Brand
LEUKINE	SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG	82402050002120	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152060E530	Brand
ZARXIO	FILGRASTIM-SNDZ SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152060E540	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN AUTO-INJECTOR 6 MG/0.6ML	8240157010D520	Brand
UDENYCA	PEGFILGRASTIM-CBQV SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157010E520	Brand
UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - Patient has been acutely exposed to myelosuppressive doses of radiation

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

Product Name: Neupogen, Nivestym, Releuko	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	Brand
NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152000E545	Brand
NEUPOGEN	FILGRASTIM SOLN PREFILLED SYRINGE 480 MCG/0.8ML (600 MCG/ML)	8240152000E550	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152010E520	Brand
NIVESTYM	FILGRASTIM-AAFI SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152010E530	Brand

NIVESTYM	FILGRASTIM-AAFI INJ 300 MCG/ML	82401520102020	Brand
NIVESTYM	FILGRASTIM-AAFI INJ 480 MCG/1.6ML (300 MCG/ML)	82401520102030	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 300 MCG/0.5ML	8240152015E520	Brand
RELEUKO	FILGRASTIM-AYOW SOLN PREFILLED SYRINGE 480 MCG/0.8ML	8240152015E530	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 300 MCG/ML	82401520152020	Brand
RELEUKO	FILGRASTIM-AYOW INJ SOLN 480 MCG/1.6ML (300 MCG/ML)	82401520152030	Brand
UDENYCA ONBODY	PEGFILGRASTIM-CBQV SOLN PREFILL SYR/INFUSION DEV 6 MG/0.6ML	8240157010E525	Brand

Approval Criteria

1 - Patient has been acutely exposed to myelosuppressive doses of radiation

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - ONE of the following:

3.1 The request is for Neupogen vial, Nivestym vial, or Releuko vial AND the requested dose is less than 0.3 milliliters

OR

3.2 Both of the following:

3.2.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Neupogen, Nivestym or Releuko than experienced with Zarxio

AND

3.2.2 One of the following:

- Failure to Zarxio as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Zarxio (please specify intolerance, contraindication or adverse effect)

Product Name: Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend, Ziextenzo	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FULPHILA	PEGFILGRASTIM-JMDB SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157020E520	Brand
NYVEPRIA	PEGFILGRASTIM-APGF SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157002E520	Brand
FYLNETRA	PEGFILGRASTIM-PBBK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157060E520	Brand
ROLVEDON	EFLAPEGRASTIM-XNST SOLN PREFILLED SYRINGE 13.2 MG/0.6ML	8240151880E520	Brand
STIMUFEND	PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157015E520	Brand
ZIEXTENZO	PEGFILGRASTIM-BMEZ SOLN PREFILLED SYRINGE 6 MG/0.6ML	8240157005E520	Brand

Approval Criteria

1 - Patient has been acutely exposed to myelosuppressive doses of radiation

AND

2 - Prescribed by or in consultation with a hematologist or oncologist

AND

3 - BOTH of the following:

3.1 Physician attestation that in their clinical opinion the clinical response would be expected to be superior with Fulphila, Fylnetra, Nyvepria, Rolvedon, Stimufend or Ziextenzo than experienced with Neulasta or Udenyca/Udenyca Onbody

AND

3.2 One of the following:

- Failure to Neulasta or Udenyca/Udenyca Onbody as confirmed by claims history or submission of medical records
- History of intolerance, contraindication or adverse effect to Neulasta or Udenyca/Udenyca Onbody (please specify intolerance, contraindication or adverse effect)

Combination Basal Insulin/GLP-1 Receptor Agonist

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147277
Guideline Name	Combination Basal Insulin/GLP-1 Receptor Agonist
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Soliqua	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
SOLIQUA 100/33	INSULIN GLARGINE-LIXISENATIDE SOL PEN-INJ 100-33 UNIT-MCG/ML	2799100235D220	Brand

Approval Criteria

1 - Inadequately controlled on ONE of the following as confirmed by claims history or submission of medical records:

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g. Trulicity (dulaglutide), Victoza (liraglutide), Bydureon BCise (exenatide extended-release), Byetta (exenatide), Ozempic (semaglutide), Rybelsus (semaglutide)]
- Basal insulin (e.g. insulin glargine, insulin degludec, insulin detemir)

Product Name: Xultophy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XULTOPHY 100/3.6	INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML	2799100225D220	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus

AND

2 - Inadequately controlled on ONE of the following as confirmed by claims history or submission of medical records:

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g. Victoza (liraglutide injection), Ozempic (semaglutide), Rybelsus (semaglutide)]
- Basal insulin (e.g. insulin glargine, insulin degludec, insulin detemir)

AND

3 - One of the following:

3.1 Failure to Soliqua as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to Soliqua (please specify contraindication or intolerance)

Product Name: Xultophy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XULTOPHY 100/3.6	INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML	2799100225D220	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xultophy therapy

2 . Revision History

Date	Notes
5/13/2024	New; copy core

Cometriq

Prior Authorization Guideline

Guideline ID	GL-146498
Guideline Name	Cometriq
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cometriq	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMETRIQ	CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT	21533010106460	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT	21533010106470	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT	21533010106480	Brand

Approval Criteria

1 - Diagnosis of medullary carcinoma

OR

2 - ALL of the following:

2.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic cell carcinoma
- Papillary carcinoma

AND

2.2 Disease is progressive after treatment with ONE of the following as confirmed by claims history or submission of medical records:

- Lenvima (lenvatinib)
- Nexavar (sorafenib)

AND

2.3 Disease is at least ONE of the following:

- Symptomatic iodine-refractory
- Unresectable locoregional recurrent or persistent disease
- Distant metastatic disease

Product Name: Cometriq	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMETRIQ	CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT	21533010106460	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT	21533010106470	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT	21533010106480	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Cometriq therapy

Product Name: Cometriq	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMETRIQ	CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT	21533010106460	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT	21533010106470	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT	21533010106480	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Positive for RET gene rearrangements

Product Name: Cometriq	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMETRIQ	CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT	21533010106460	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT	21533010106470	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT	21533010106480	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Cometriq therapy

Product Name: Cometriq	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMETRIQ	CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT	21533010106460	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT	21533010106470	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT	21533010106480	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Cometriq	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMETRIQ	CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT	21533010106460	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT	21533010106470	Brand
COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT	21533010106480	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cometriq therapy

Complera

Prior Authorization Guideline

Guideline ID	GL-146310
Guideline Name	Complera
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Complera	
Diagnosis	HIV
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMPLERA	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DF TAB 200-25-300 MG	12109903400320	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)

AND

2 - ONE of the following:

2.1 Patient is NOT an appropriate candidate for ALL of the following (please specify why patient is not a candidate):

- efavirenz/lamivudine/tenofovir disoproxil (generic Symfi or generic Symfi Lo)
- efavirenz/emtricitabine/tenofovir disoproxil (generic Atripla)
- Triumeq (abacavir/dolutegravir/lamivudine)
- Juluca (dolutegravir/rilpivirine)
- Dovato (dolutegravir/lamivudine)

OR

2.2 Patient is currently on Complera therapy

Product Name: Complera	
Diagnosis	Post-Exposure Prophylaxis
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COMPLERA	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DF TAB 200-25-300 MG	12109903400320	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis

Compounds and Bulk Powders

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146311
Guideline Name	Compounds and Bulk Powders
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Compounds or Bulk Powders	
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Bulk Powders			
Compound Preparation			

Approval Criteria

1 - The requested drug component is a covered medication

AND

2 - ONE of the following:

2.1 The requested drug component is to be administered for an FDA (Food and Drug Administration)-approved indication

OR

2.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

AND

4 - If the drug component is no longer available commercially, it must not have been withdrawn for safety reasons

AND

5 - ONE of the following:

5.1 A unique vehicle is required

OR

5.2 A unique dosage form is required for a commercially available product due to patient's age, weight, or inability to take a solid dosage form

OR

5.3 A unique formulation is required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product

OR

5.4 There is a shortage of the commercially available product per the FDA Drug Shortage database or the ASHP (American Society of Health-System Pharmacists) Current Drug Shortages tracking log

AND

6 - Coverage for compounds and bulk powders will NOT be approved for any of the following:

6.1 For topical compound preparations (e.g., creams, ointments, lotions, or gels to be applied to the skin for transdermal, transcutaneous, or any other topical route), if the requested compound contains any FDA approved ingredient that is not FDA approved for TOPICAL use (see Table 1 in Background section)

OR

6.2 If the requested compound contains topical fluticasone, topical fluticasone will NOT be approved unless both of the following are met:

6.2.1 Topical fluticasone is intended to treat a dermatologic condition (scar treatments are considered cosmetic and will not be covered)

AND

6.2.2 Patient has a contraindication to all commercially available topical fluticasone formulations

OR

6.3 Requested compound contains any ingredients when used for cosmetic purposes (see Table 2 in Background section)

OR

6.4 Requested compound contains any ingredient(s) which are on the FDA's Do Not Compound List (see Table 3 in Background section)

2 . Background

Benefit/Coverage/Program Information

Table 1: Example topical compound preparations that contain any FDA approved ingredient that are not FDA approved for TOPICAL use, including but NOT LIMITED TO the following:

(1) Ketamine

(2) Gabapentin

(3) Flurbiprofen (topical ophthalmic use not included)

(4) Ketoprofen

(5) Morphine

(6) Nabumetone

(7) Oxycodone

(8) Cyclobenzaprine

(9) Baclofen

(10) Tramadol

(11) Hydrocodone

(12) Meloxicam

(13) Amitriptyline

(14) Pentoxifylline

(15) Orphenadrine

(16) Piroxicam

(17) Levocetirizine

(18) Amantadine

(19) Oxytocin

(20) Sumatriptan

(21) Chorionic gonadotropin (human)

(22) Clomipramine

(23) Dexamethasone

(24) Hydromorphone

(25) Methadone

(26) Papaverine

(27) Mefenamic acid

(28) Promethazine

(29) Succimer DMSA

(30) Tizanidine

(31) Apomorphine

(32) Carbamazepine

(33) Ketorolac

(34) Dimercaptopropane-sulfonate

(35) Dimercaptosuccinic acid

(36) Duloxetine

(37) Fluoxetine

(38) Bromfenac (topical ophthalmic use not included)

(39) Nepafenac (topical ophthalmic use not included)

Table 2: Example compounds that contain ingredients for cosmetic purposes:

(1) Hydroquinone

(2) Acetyl hexapeptide-8

(3) Tocopheryl Acid Succinate

(4) PracaSil TM-Plus

(5) Chrysaderm Day Cream

(6) Chrysaderm Night Cream

(7) PCCA Spira-Wash

(8) Lipopen Ultra

(9) Versapro

(10) Fluticasone

(11) Mometasone

(12) Halobetasol

(13) Betamethasone

(14) Clobetasol

(15) Triamcinolone

(16) Minoxidil

(17) Tretinoin

(18) Dexamethasone

(19) Spironolactone

(20) Cycloserine

(21) Tamoxifen

(22) Sermorelin

(23) Mederma Cream

(24) PCCA Cosmetic HRT Base

(25) Sanare Scar Therapy Cream

(26) Scarcin Cream

(27) Apothederm

(28) Stera Cream

(29) Copasil

(30) Collagenase

(31) Arbutin Alpha

(32) Nourisil

(33) Freedom Cepapro

(34) Freedom Silomac Andydrous

(35) Retinaldehyde

(36) Apothederm

Table 3: Example ingredients on the FDA's Do Not Compound List:

(1) 3,3′,4′,5-tetrachlorosalicylanilide

(2) Adenosine phosphate

(3) Adrenal cortex

(4) Alatrofloxacin mesylate

(5) Aminopyrine

(6) Astemizole

(7) Azaribine

(8) Benoxaprofen

(9) Bithionol

(10) Camphorated oil

(11) Carbetapentane citrate

(12) Casein, iodinated

(13) Cerivastatin sodium

(14) Chlormadinone acetate

(15) Chloroform

(16) Cisapride

(17) Defenfluramine hydrochloride

(18) Diamthazole dihydrochloride

(19) Dibromsalan

(20) Dihydrostreptomycin sulfate

(21) Dipyrone

(22) Encainide hydrochloride

(23) Etretinate

(24) Fenfluramine hydrochloride

(25) Flosequinan

(26) Glycerol, iodinated

(27) Grepafloxacin

(28) Mepazine

(29) Metabromsalan

(30) Methapyrilene

(31) Methopholine

(32) Methoxyflurane

(33) Mibefradil dihydrochloride

(34) Nomifensine maleate

(35) Novobiocin sodium

(36) Oxyphenisatin acetate

(37) Oxyphenisatin

(38) Pemoline

(39) Pergolide mesylate

(40) Phenacetin

(41) Phenformin hydrochloride

(42) Phenylpropanolamine

(43) Pipamazine

(44) Potassium arsenite

(45) Propoxyphene

(46) Rapacuronium bromide

(47) Rofecoxib

(48) Sibutramine hydrochloride

(49) Sparteine sulfate

(50) Sulfadimethoxine

(51) Sweet spirits of nitre

(52) Tegaserod maleate

(53) Temafloxacin hydrochloride

(54) Terfenadine

(55) Ticrynafen

(56) Tribromsalan

(57) Trichloroethane

(58) Troglitazone

(59) Trovafloxacin mesylate:

(60) Urethane

(61) Valdecoxib

(62) Zomepirac sodium

Constipation Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146312
Guideline Name	Constipation Agents
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic lubiprostone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUBIPROSTONE	LUBIPROSTONE CAP 8 MCG	52450045000110	Generic
LUBIPROSTONE	LUBIPROSTONE CAP 24 MCG	52450045000120	Generic

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Diagnosis of opioid-induced constipation in an adult with chronic, non-cancer pain

OR

1.1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

OR

2 - BOTH of the following:

2.1 Diagnosis of chronic idiopathic constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

OR

3 - ALL of the following:

3.1 Diagnosis of irritable bowel syndrome with constipation

AND

3.2 Patient was female at birth

AND

3.3 ONE of the following:

3.3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

Product Name: Brand Amitiza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AMITIZA	LUBIPROSTONE CAP 8 MCG	52450045000110	Brand
AMITIZA	LUBIPROSTONE CAP 24 MCG	52450045000120	Brand

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

1.1.1 Diagnosis of opioid-induced constipation in an adult with chronic, non-cancer pain

OR

1.1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

1.3 ONE of the following:

1.3.1 Failure to Movantik as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to Movantik (please specify intolerance or contraindication)

AND

1.4 ONE of the following:

1.4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of chronic idiopathic constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.3 ONE of the following:

2.3.1 Failure to Motegrity as confirmed by claims history or submission of medical records

OR

2.3.2 History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

AND

2.4 ONE of the following:

2.4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

OR

3 - ALL of the following:

3.1 Diagnosis of irritable bowel syndrome with constipation

AND

3.2 Patient was female at birth

AND

3.3 ONE of the following:

3.3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3.4 ONE of the following:

3.4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Linzess	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LINZESS	LINACLOTIDE CAP 72 MCG	52557050000110	Brand
LINZESS	LINACLOTIDE CAP 145 MCG	52557050000120	Brand
LINZESS	LINACLOTIDE CAP 290 MCG	52557050000140	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic idiopathic constipation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

1.3 ONE of the following:

1.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

1.4 ONE of the following:

1.4.1 Failure to Motegrity as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of irritable bowel syndrome with constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.3 ONE of the following:

2.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

OR

3 - BOTH of the following:

3.1 Diagnosis of functional constipation

AND

3.2 ONE of the following:

3.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

Product Name: Trulance	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRULANCE	PLECANATIDE TAB 3 MG	52543060000320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic idiopathic constipation

AND

1.2 ONE of the following:

1.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

1.3 ONE of the following:

1.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

1.4 ONE of the following:

1.4.1 Failure to Motegrity as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to Motegrity (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of irritable bowel syndrome with constipation

AND

2.2 ONE of the following:

2.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.3 ONE of the following:

2.3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Motegrity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT)	52560060200320	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 2 MG (BASE EQUIVALENT)	52560060200330	Brand

Approval Criteria

1 - Diagnosis of chronic idiopathic constipation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Movantik	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOVANTIK	NALOXEGOL OXALATE TAB 12.5 MG (BASE EQUIVALENT)	52580060300320	Brand
MOVANTIK	NALOXEGOL OXALATE TAB 25 MG (BASE EQUIVALENT)	52580060300330	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain

OR

1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Symproic	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYMPROIC	NALDEMEDINE TOSYLATE TAB 0.2 MG (BASE EQUIVALENT)	52580057200320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of opioid-induced constipation in a patient being treated for chronic, non-cancer pain

OR

1.2 Diagnosis of opioid-induced constipation in a patient with chronic pain related to prior cancer diagnosis or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Failure to Movantik as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Movantik (please specify intolerance or contraindication)

Product Name: Zelnorm	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELNORM	TEGASEROD MALEATE TAB 6 MG (BASE EQUIVALENT)	52555060200320	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with constipation

AND

2 - Patient was female at birth

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

4 - ONE of the following:

4.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Ibsrela	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBSRELA	TENAPANOR HCL TAB 50 MG	52558580100320	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with constipation

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lactulose
- Polyethylene glycol (Miralax)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - ONE of the following:

3.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

Product Name: Brand Amitiza, generic lubiprostone, Ibsrela, Linzess, Motegrity, Movantik, Symproic, Trulance, Zelnorm	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AMITIZA	LUBIPROSTONE CAP 8 MCG	52450045000110	Brand
LUBIPROSTONE	LUBIPROSTONE CAP 8 MCG	52450045000110	Generic
AMITIZA	LUBIPROSTONE CAP 24 MCG	52450045000120	Brand
LUBIPROSTONE	LUBIPROSTONE CAP 24 MCG	52450045000120	Generic
IBSRELA	TENAPANOR HCL TAB 50 MG	52558580100320	Brand
LINZESS	LINACLOTIDE CAP 72 MCG	52557050000110	Brand
LINZESS	LINACLOTIDE CAP 145 MCG	52557050000120	Brand
LINZESS	LINACLOTIDE CAP 290 MCG	52557050000140	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 1 MG (BASE EQUIVALENT)	52560060200320	Brand
MOTEGRITY	PRUCALOPRIDE SUCCINATE TAB 2 MG (BASE EQUIVALENT)	52560060200330	Brand
MOVANTIK	NALOXEGOL OXALATE TAB 12.5 MG (BASE EQUIVALENT)	52580060300320	Brand
MOVANTIK	NALOXEGOL OXALATE TAB 25 MG (BASE EQUIVALENT)	52580060300330	Brand
SYMPROIC	NALDEMEDINE TOSYLATE TAB 0.2 MG (BASE EQUIVALENT)	52580057200320	Brand
TRULANCE	PLECANATIDE TAB 3 MG	52543060000320	Brand
ZELNORM	TEGASEROD MALEATE TAB 6 MG (BASE EQUIVALENT)	52555060200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Continuous Glucose Monitors

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156368
Guideline Name	Continuous Glucose Monitors
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEXCOM G6 RECEIVER	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G7 RECEIVER	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 14 DAY/READER/FLASH MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

FREESTYLE LIBRE 2/READER/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G6 SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G7 SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
ENLITE GLUCOSE SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE E3 SENSOR/HOLDER	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE SENSOR/HOLDER	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3 PLUS/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR (3)	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR 3	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN 4 GLUCOSE SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G6 TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

GUARDIAN CONNECT TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN LINK 3 TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN 4 TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINILINK REAL-TIME TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINIMED 630G GUARDIAN PRESS STARTER TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
PARADIGM REAL-TIME TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

Approval Criteria

1 - Diagnosis of diabetes

AND

2 - One of the following:

2.1 Patient is on an intensive insulin regimen (3 or more insulin injections per day or uses continuous subcutaneous insulin infusion pump)

OR

2.2 One of the following:

- Patient has a history of a level 3 hypoglycemic event
- Patient has a history of more than one level 2 hypoglycemia events that persist despite multiple attempts to adjust medication(s) or modify diabetes treatment plan

AND

3 - Patient regularly monitors blood glucose 4 or more times per day

AND

4 - If the request is for a Guardian Connect (all components), Guardian 3 (all components), Guardian 4 (all components), or Freestyle Libre 3 (all components), ONE of the following:

4.1 BOTH of the following:

4.1.1 Patient has a physical or mental limitation that makes utilization of Dexcom G6 and Dexcom G7 unsafe, inaccurate, or otherwise not feasible (e.g., manual dexterity; document limitation)

AND

4.1.2 Patient has a physical or mental limitation that makes utilization of the preferred Freestyle Libre product unsafe, inaccurate, or otherwise not feasible (e.g., manual dexterity; document limitation)

OR

4.2 Provider submits documentation why the patient requires use of the Guardian Connect, Guardian 3, Guardian 4, or Freestyle Libre 3 for treatment of diabetes

Product Name: Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEXCOM G6 RECEIVER	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G7 RECEIVER	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 14 DAY/READER/FLASH MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE 2/READER/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand

FREESTYLE LIBRE 3/READER/GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
FREESTYLE LIBRE/READER/FLASH MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
GUARDIAN REAL-TIME REPLACEMENT MONITOR PEDIATRIC	*CONTINUOUS GLUCOSE SYSTEM RECEIVER***	97202012026200	Brand
DEXCOM G6 SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G7 SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
ENLITE GLUCOSE SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE E3 SENSOR/HOLDER	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
EVERSENSE SENSOR/HOLDER	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 2/SENSOR/FLASH GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3 PLUS/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
FREESTYLE LIBRE 3/SENSOR/GLUCOSE MONITORING SYSTEM	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR (3)	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN SENSOR 3	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
GUARDIAN 4 GLUCOSE SENSOR	*CONTINUOUS GLUCOSE SYSTEM SENSOR***	97202012046300	Brand
DEXCOM G6 TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE E3 SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
EVERSENSE SMART TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN CONNECT TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

GUARDIAN LINK 3 TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
GUARDIAN 4 TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINILINK REAL-TIME TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
MINIMED 630G GUARDIAN PRESS STARTER TRANSMITTER KIT	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand
PARADIGM REAL-TIME TRANSMITTER	*CONTINUOUS GLUCOSE SYSTEM TRANSMITTER***	97202012066300	Brand

Approval Criteria

1 - Documentation of positive clinical response

2 . Revision History

Date	Notes
9/26/2024	Clarified nonpreferred CGM criteria

Copiktra

Prior Authorization Guideline

Guideline ID	GL-146499
Guideline Name	Copiktra
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Copiktra	
Diagnosis	Chronic Lymphocytic Leukemia (CLL) / Small Lymphocytic Lymphoma (SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COPIKTRA	DUVELISIB CAP 15 MG	21538030000120	Brand
COPIKTRA	DUVELISIB CAP 25 MG	21538030000130	Brand

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)

AND

2 - Disease is relapsed or refractory

AND

3 - ONE of the following:

3.1 Failure to at least TWO prior therapies for CLL/SLL confirmed by claims history or submitted medical records. Examples include, but not limited to, regimens consisting of: [Leukeran (chlorambucil), Gazyva (obinutuzumab), Arzerra (ofatumumab), Bendeka (bendamustine), Imbruvica (ibrutinib), Calquence (acalabrutinib), Venclexta (venetoclax), etc.]

OR

3.2 History of intolerance or contraindication to at least TWO prior therapies for CLL/SLL. Examples include, but not limited to, regimens consisting of: [Leukeran (chlorambucil), Gazyva (obinutuzumab), Arzerra (ofatumumab), Bendeka (bendamustine), Imbruvica (ibrutinib), Calquence (acalabrutinib), Venclexta (venetoclax), etc.] (please specify intolerance or contraindication)

Product Name: Copiktra	
Diagnosis	Chronic Lymphocytic Leukemia (CLL) / Small Lymphocytic Lymphoma (SLL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COPIKTRA	DUVELISIB CAP 15 MG	21538030000120	Brand

COPIKTRA	DUVELISIB CAP 25 MG	21538030000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Copiktra therapy

Product Name: Copiktra	
Diagnosis	T-cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COPIKTRA	DUVELISIB CAP 15 MG	21538030000120	Brand
COPIKTRA	DUVELISIB CAP 25 MG	21538030000130	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Hepatosplenic T-cell lymphoma
- Breast implant-associated anaplastic large cell lymphoma
- Peripheral T-cell lymphomas

AND

2 - Disease is relapsed or refractory

AND

3 - ONE of the following:

3.1 Failure to at least TWO prior systemic therapies confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to at least TWO prior systemic therapies (please specify intolerance or contraindication)

Product Name: Copiktra	
Diagnosis	T-cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COPIKTRA	DUVELISIB CAP 15 MG	21538030000120	Brand
COPIKTRA	DUVELISIB CAP 25 MG	21538030000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Copiktra therapy

Product Name: Copiktra	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COPIKTRA	DUVELISIB CAP 15 MG	21538030000120	Brand
COPIKTRA	DUVELISIB CAP 25 MG	21538030000130	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Copiktra	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COPIKTRA	DUVELISIB CAP 15 MG	21538030000120	Brand
COPIKTRA	DUVELISIB CAP 25 MG	21538030000130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Copiktra therapy

Copper Chelating Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149088
Guideline Name	Copper Chelating Agents
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Depen Titratabs, generic penicillamine tablets	
Diagnosis	Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEPEN TITRATABS	PENICILLAMINE TAB 250 MG	99200030000305	Brand
PENICILLAMINE	PENICILLAMINE TAB 250 MG	99200030000305	Generic

Approval Criteria

1 - Diagnosis of severe active rheumatoid arthritis

Product Name: Brand Depen Titratabs, generic penicillamine tablets	
Diagnosis	Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEPEN TITRATABS	PENICILLAMINE TAB 250 MG	99200030000305	Brand
PENICILLAMINE	PENICILLAMINE TAB 250 MG	99200030000305	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Brand Depen Titratabs, generic penicillamine tablets	
Diagnosis	Wilson’s disease, Cystinuria
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEPEN TITRATABS	PENICILLAMINE TAB 250 MG	99200030000305	Brand
PENICILLAMINE	PENICILLAMINE TAB 250 MG	99200030000305	Generic

Approval Criteria

1 - ONE of the following diagnoses:

- Wilson's disease (i.e., hepatolenticular degeneration)
- Cystinuria

Product Name: Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Wilson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PENICILLAMINE	PENICILLAMINE CAP 250 MG	99200030000110	Generic
CUPRIMINE	PENICILLAMINE CAP 250 MG	99200030000110	Brand

Approval Criteria

1 - Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration)

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- penicillamine tablets (generic Depen Titratabs)
- trientine 250 mg capsules (generic Syprine)

OR

2.2 History of intolerance to BOTH of the following (please specify intolerance):

- penicillamine tablets (generic Depen Titratabs)

- trientine 250 mg capsules (generic Syprine)

Product Name: Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Cystinuria, Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PENICILLAMINE	PENICILLAMINE CAP 250 MG	99200030000110	Generic
CUPRIMINE	PENICILLAMINE CAP 250 MG	99200030000110	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Cystinuria
- Severe active rheumatoid arthritis

AND

2 - ONE of the following:

2.1 Failure to penicillamine tablets (generic Depen Titratabs) as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance to penicillamine tablets (generic Depen Titratabs) (please specify intolerance)

Product Name: Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Wilson’s disease, Cystinuria, Severe active rheumatoid arthritis

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PENICILLAMINE	PENICILLAMINE CAP 250 MG	99200030000110	Generic
CUPRIMINE	PENICILLAMINE CAP 250 MG	99200030000110	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Brand Syprine, generic trientine hcl 250 mg capsules	
Diagnosis	Wilson’s disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRIENTINE HYDROCHLORIDE	TRIENTINE HCL CAP 250 MG	99200020100110	Generic
SYPRINE	TRIENTINE HCL CAP 250 MG	99200020100110	Brand

Approval Criteria

1 - Diagnosis of Wilson’s disease (i.e., hepatolenticular degeneration)

Product Name: Brand Syprine, generic trientine hcl 250 mg capsules	
Diagnosis	Wilson’s disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRIENTINE HYDROCHLORIDE	TRIENTINE HCL CAP 250 MG	99200020100110	Generic
SYPRINE	TRIENTINE HCL CAP 250 MG	99200020100110	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: trientine hcl 500 mg capsules	
Diagnosis	Wilson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRIENTINE HYDROCHLORIDE	TRIENTINE HCL CAP 500 MG	99200020100130	Generic

Approval Criteria

1 - Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration)

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- penicillamine tablets (generic Depen Titratabs)
- trientine 250 mg capsules (generic Syprine)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- penicillamine tablets (generic Depen Titratabs)
- trientine 250 mg capsules (generic Syprine)

Product Name: trientine hcl 500 mg capsules	
Diagnosis	Wilson's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRIENTINE HYDROCHLORIDE	TRIENTINE HCL CAP 500 MG	99200020100130	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
6/28/2024	Updated trial/failure requirements for Cuprimine, Syprine, and trientin e 500 mg capsules.

Corlanor

Prior Authorization Guideline

Guideline ID	GL-146314
Guideline Name	Corlanor
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Corlanor	
Diagnosis	Symptomatic Chronic Heart Failure
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL TAB 5 MG (BASE EQUIV)	40700035100320	Brand
CORLANOR	IVABRADINE HCL TAB 7.5 MG (BASE EQUIV)	40700035100330	Brand
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - ALL of the following:

1.1 Worsening heart failure in a diagnosis of stable, symptomatic, chronic [e.g., New York Heart Association (NYHA) class II, III, or IV] heart failure

AND

1.2 Patient has a left ventricular ejection fraction (EF) less than or equal to 35%

AND

1.3 The patient is in sinus rhythm

AND

1.4 Patient has a resting heart rate greater than or equal to 70 beats per minute

AND

1.5 ONE of the following:

1.5.1 Patient is on a stabilized dose and receiving concomitant therapy with maximum tolerated beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records

OR

1.5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify contraindication or intolerance)

AND

1.6 ONE of the following:

1.6.1 Patient is on a stabilized dose and receiving concomitant therapy with Farxiga (includes combination products containing dapagliflozin) as confirmed by claims history or submission of medical records

OR

1.6.2 Patient has a contraindication or intolerance to SGLT2 (sodium-glucose co-transporter 2) inhibitor therapy (please specify contraindication or intolerance)

AND

1.7 ONE of the following:

1.7.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, as confirmed by claims history or submission of medical records:

1.7.1.1 Angiotensin-converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)

OR

1.7.1.2 Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

1.7.1.3 Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

1.7.2 Patient has a contraindication or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify contraindication or intolerance)

AND

1.8 ONE of the following:

1.8.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., eplerenone, spironolactone) as confirmed by claims history or submission of medical records

OR

1.8.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify contraindication or intolerance)

AND

1.9 Prescribed by or in consultation with a cardiologist

OR

2 - ALL of the following:

2.1 Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM)

AND

2.2 Patient is in sinus rhythm

AND

2.3 Patient has an elevated heart rate

AND

2.4 Prescribed by or in consultation with a cardiologist

OR

3 - Patient is currently established on Corlanor therapy

Product Name: Corlanor	
Diagnosis	Inappropriate Sinus Tachycardia (IST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL TAB 5 MG (BASE EQUIV)	40700035100320	Brand
CORLANOR	IVABRADINE HCL TAB 7.5 MG (BASE EQUIV)	40700035100330	Brand
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - All of the following

1.1 Diagnosis of inappropriate sinus tachycardia (IST)

AND

1.2 Patient is in sinus rhythm

AND

1.3 One of the following:

- Patient has tried and failed or had an inadequate response to a beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records
- Patient has a contraindication or intolerance to beta-blocker therapy (please specify contraindication or intolerance)

AND

1.4 Prescribed by or in consultation with a cardiologist

OR

2 - Patient is currently established on Corlanor therapy

Product Name: Corlanor	
Diagnosis	Symptomatic Chronic Heart Failure, Inappropriate Sinus Tachycardia (IST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CORLANOR	IVABRADINE HCL TAB 5 MG (BASE EQUIV)	40700035100320	Brand
CORLANOR	IVABRADINE HCL TAB 7.5 MG (BASE EQUIV)	40700035100330	Brand
CORLANOR	IVABRADINE HCL ORAL SOLN 5 MG/5ML (BASE EQUIV)	40700035102020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Corlanor therapy

Cosentyx

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146886
Guideline Name	Cosentyx
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cosentyx	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand

COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Enbrel (etanercept)]

OR

4.2.1.2 ALL of the following:

4.2.1.2.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

4.2.1.2.2 ONE of the following:

- Failure of ONE of the following confirmed by claims history or submitted medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 ONE of the following:

- Failure of a 3 month trial of methotrexate, at the maximally indicated doses, confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4.2.2 ONE of the following

- Failure of ONE of the following confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel, Cimzia, Ilumya
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel, Cimzia, Ilumya

Notes	*For a list of preferred adalimumab products please reference drug co verage tools

Product Name: Cosentyx	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to TWO NSAIDs (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib), Enbrel (etanercept)]

AND

4.2.2 ONE of the following:

- Failure of TWO of the following confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel, Cimzia
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel, Cimzia

Notes	*For a list of preferred adalimumab products please reference drug coverage tools

Product Name: Cosentyx	
Diagnosis	Plaque Psoriasis, Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cosentyx therapy

AND

2 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Product Name: Cosentyx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept), Skyrizi (risankizumab-rzaa)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a rheumatologist OR dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure of a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Rinvoq (upadacitinib), Enbrel (etanercept)]

AND

4.2.2 ONE of the following:

- Failure of TWO of the following confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel, Cimzia
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel, Cimzia

Notes	*For a list of preferred adalimumab products please reference drug co verage tools

Product Name: Cosentyx	
Diagnosis	Non-radiographic axial spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Diagnosis of active non-radiographic axial spondyloarthritis

AND

2 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept), Skyrizi (risankizumab-rzaa)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a biologic DMARD FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab)]

AND

4.2.2 ONE of the following:

- Failure of Cimzia confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cimzia (please specify intolerance or contraindication)

Product Name: Cosentyx	
Diagnosis	Enthesitis-Related Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand

COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Diagnosis of active enthesitis-related arthritis

AND

2 - ONE of the following:

2.1 Failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

2.3 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept), Skyrizi (risankizumab-rzaa)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Cosentyx	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)

AND

2 - ONE of the following:

2.1 Failure to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) (please specify contraindication or intolerance)

OR

2.3 Patient is currently on Cosentyx therapy as confirmed by claims history or submission of medical records

AND

3 - ONE of the following:

3.1 Failure to at least one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to one of the preferred adalimumab products* (please specify contraindication or intolerance)

AND

4 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept), Skyrizi (risankizumab-rzaa)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

5 - Prescribed by or in consultation with a dermatologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools

Product Name: Cosentyx	
Diagnosis	Psoriatic Arthritis (PsA), Non-radiographic Axial Spondyloarthritis, Enthesitis-Related Arthritis, Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cosentyx therapy

AND

2 - Patient is NOT receiving Cosentyx in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Taltz (ixekizumab), Orencia (abatacept), Skyrizi (risankizumab-rzaa)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

2 . Background

Benefit/Coverage/Program Information
PDL Links: NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Cotellic

Prior Authorization Guideline

Guideline ID	GL-146502
Guideline Name	Cotellic
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cotellic	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COTELLIC	COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT)	21533530200320	Brand

Approval Criteria

1 - Diagnosis of melanoma

AND

2 - Disease is ONE of the following:

- Unresectable
- Metastatic

AND

3 - Disease is positive for ONE of the following mutations:

- BRAF V600E
- BRAF V600K

AND

4 - Used in combination with Zelboraf (vemurafenib)

Product Name: Cotellic	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COTELLIC	COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT)	21533530200320	Brand

Approval Criteria

1 - Diagnosis of Central Nervous System (CNS) Cancer

AND

2 - Disease is BRAF V600E positive

AND

3 - Used in combination with Zelboraf (vemurafenib)

Product Name: Cotellic	
Diagnosis	Melanoma, Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COTELLIC	COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT)	21533530200320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Cotellic therapy

AND

2 - Used in combination with Zelboraf (vemurafenib)

Product Name: Cotellic	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COTELLIC	COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT)	21533530200320	Brand

Approval Criteria

1 - Diagnosis of histiocytic neoplasms

Product Name: Cotellic	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COTELLIC	COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT)	21533530200320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Cotellic therapy

Product Name: Cotellic	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COTELLIC	COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT)	21533530200320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Cotellic	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
COTELLIC	COBIMETINIB FUMARATE TAB 20 MG (BASE EQUIVALENT)	21533530200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cotellic therapy

Cuvrior

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148965
Guideline Name	Cuvrior
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cuvrior	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CUVRIOR	TRIENTINE TETRAHYDROCHLORIDE TAB 300 MG	99200020200330	Brand

Approval Criteria

1 - Diagnosis of Wilson's disease

AND

2 - Patient is de-coppered [i.e., serum non-ceruloplasmin copper (NCC) level greater than or equal to 25 and less than or equal to 150 mcg/L (micrograms/liter)]

AND

3 - Patient is tolerant to penicillamine

AND

4 - Prescriber provides a reason or special circumstance why the patient cannot use penicillamine tablets (generic Depen Titratabs)

AND

5 - ONE of the following:

5.1 Failure to trientine 250 mg capsules (generic Syprine) as confirmed by claims history or submission of medical records

OR

5.2 History of intolerance to trientine 250 mg capsules (generic Syprine) (please specify intolerance)

AND

6 - Prescribed by a hepatologist

Product Name: Cuvrior	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CUVRIOR	TRIENTINE TETRAHYDROCHLORIDE TAB 300 MG	99200020200330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Cuvrior therapy (e.g., increased 24-hour urinary copper excretion from baseline, normalization of serum free copper, prevention of or improvement in symptoms)

AND

2 - Prescribed by a hepatologist

2 . Revision History

Date	Notes
6/26/2024	Updated language on why pt must switch from preferred penicillamine agent, added step through trientine 250 mg capsules, added prescriber requirement, and updated initial/reauth durations to 12 months.

Cystaran, Cystadrops

Prior Authorization Guideline

Guideline ID	GL-146504
Guideline Name	Cystaran, Cystadrops
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Cystaran, Cystadrops	
Diagnosis	Cystinosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CYSTARAN	CYSTEAMINE HCL OPHTH SOLN 0.44% (BASE EQUIVALENT)	86805525102020	Brand
CYSTADROPS	CYSTEAMINE HCL OPHTH SOLN 0.37% (BASE EQUIVALENT)	86805525102015	Brand

Approval Criteria

1 - Diagnosis of cystinosis

Daliresp (roflumilast)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146315
Guideline Name	Daliresp (roflumilast)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic

Approval Criteria

1 - Diagnosis of severe to very severe chronic obstructive pulmonary disease (COPD) (i.e., FEV1 less than or equal to 50% of predicted)

AND

2 - COPD is associated with chronic bronchitis

AND

3 - History of COPD exacerbation(s)

Product Name: Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DALIRESP	ROFLUMILAST TAB 250 MCG	44450065000310	Brand
DALIRESP	ROFLUMILAST TAB 500 MCG	44450065000320	Brand
ROFLUMILAST	ROFLUMILAST TAB 250 MCG	44450065000310	Generic
ROFLUMILAST	ROFLUMILAST TAB 500 MCG	44450065000320	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

Daraprim

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146505
Guideline Name	Daraprim
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Daraprim, generic pyrimethamine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DARAPRIM	PYRIMETHAMINE TAB 25 MG	13000040000310	Brand
PYRIMETHAMINE	PYRIMETHAMINE TAB 25 MG	13000040000310	Generic

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

1.1 Treatment of severe acquired toxoplasmosis, including toxoplasmic encephalitis

OR

1.2 Treatment of congenital toxoplasmosis

OR

1.3 Secondary prophylaxis of toxoplasmic encephalitis

OR

1.4 ALL of the following:

1.4.1 Primary pneumocystis pneumonia (PCP) prophylaxis in human immunodeficiency virus (HIV)-infected patients or as secondary prophylaxis in HIV-infected patients who have been treated for an acute episode of pneumocystis pneumonia

AND

1.4.2 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.4.3 One of the following:

1.4.3.1 Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

OR

1.4.3.2 Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past [e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome]

OR

1.5 ALL of the following:

1.5.1 Primary prophylaxis of toxoplasmic encephalitis

AND

1.5.2 Toxoplasma immunoglobulin G (IgG) positive

AND

1.5.3 CD4 (cluster of differentiation 4) less than or equal to 100 cells per mm^3 if initiating prophylaxis or CD4 100-200 cells per mm^3 if reinstituting prophylaxis*

AND

1.5.4 Will be used in combination with dapsone or atovaquone

AND

1.5.5 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.5.6 ONE of the following:

1.5.6.1 Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

OR

1.5.6.2 Evidence of moderately severe or life threatening-reaction to trimethoprim-

sulfamethoxazole (TMP-SMX) in the past [e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome]	
Notes	*Consider discontinuation of primary prophylaxis if CD4 > 200 cells/mm^3 for > 3 months after institution of combination antiretroviral therapy.

Product Name: Brand Daraprim*, generic pyrimethamine*	
Guideline Type	Reject 88 - Therapeutic Duplication

Product Name	Generic Name	GPI	Brand/Generic
DARAPRIM	PYRIMETHAMINE TAB 25 MG	13000040000310	Brand
PYRIMETHAMINE	PYRIMETHAMINE TAB 25 MG	13000040000310	Generic

Approval Criteria

1 - There is a reason or special circumstances why the patient must be on Daraprim (pyrimethamine) commercial tablets and a compound containing pyrimethamine at the same time

Notes	*Approval Length: 2 months (if deemed medically necessary for long-term use by the prescriber, authorization will be issued for 12 months)

Daurismo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146506
Guideline Name	Daurismo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Daurismo	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAURISMO	GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT)	21370030300320	Brand
DAURISMO	GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT)	21370030300335	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of newly-diagnosed acute myeloid leukemia (AML)

OR

1.2 Relapsed/refractory disease with ALL of the following:

1.2.1 Given as a component of repeating the initial successful induction regimen

AND

1.2.2 Late relapse (greater than or equal to 12 months since induction regimen)

AND

1.2.3 Initial therapy was not administered continuously

AND

1.2.4 Initial therapy was not stopped due to development of clinical resistance

AND

2 - Daurismo therapy to be given in combination with low-dose cytarabine

AND

3 - ONE of the following:

3.1 Patient is at least 75 years old

OR

3.2 Patient has significant comorbidities that preclude the use of intensive induction chemotherapy [e.g., severe cardiac disease, Eastern Cooperative Oncology Group (ECOG) performance status greater than or equal to 2, baseline creatinine greater than 1.3 milligrams/deciliter]

Product Name: Daurismo	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAURISMO	GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT)	21370030300320	Brand
DAURISMO	GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT)	21370030300335	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Daurismo therapy

Product Name: Daurismo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAURISMO	GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT)	21370030300320	Brand
DAURISMO	GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT)	21370030300335	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Daurismo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAURISMO	GLASDEGIB MALEATE TAB 25 MG (BASE EQUIVALENT)	21370030300320	Brand
DAURISMO	GLASDEGIB MALEATE TAB 100 MG (BASE EQUIVALENT)	21370030300335	Brand

Approval Criteria

1 - Documentation of positive clinical response to Daurismo therapy

Daybue

Prior Authorization Guideline

Guideline ID	GL-150913
Guideline Name	Daybue
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/3/2024

1 . Criteria

Product Name: Daybue	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAYBUE	TROFINETIDE ORAL SOLN 200 MG/ML	74653075002020	Brand

Approval Criteria

1 - Diagnosis of Rett Syndrome (RTT) confirmed by ONE of the following:

1.1 ALL of the following clinical signs and symptoms:

- A pattern of development, regression, then recovery or stabilization
- Partial or complete loss of purposeful hand skills such as grasping with fingers, reaching for things, or touching things on purpose
- Partial or complete loss of spoken language
- Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing
- Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait

OR

1.2 Confirmed genetic mutation in the MECP2 gene

AND

2 - Prescribed by, or in consultation with, ONE of the following:

- Geneticist
- Pediatrician who specializes in childhood neurological or developmental disorders
- Neurologist

Product Name: Daybue	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAYBUE	TROFINETIDE ORAL SOLN 200 MG/ML	74653075002020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Daybue therapy

2 . Revision History

Date	Notes
8/2/2024	Updated initial approval duration from 6 months to 12 months.

DEKAs Plus

Prior Authorization Guideline

Guideline ID	GL-146316
Guideline Name	DEKAs Plus
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: DEKAs Plus Ocean, DEKAs Plus	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEKAS PLUS OCEAN	*MULTIPLE VITAMINS W/ MINERALS CAP**	78310000000100	Brand
DEKAS PLUS	*MULTIPLE VITAMINS W/ MINERALS CAP**	78310000000100	Brand
DEKAS PLUS	*MULTIPLE VITAMINS W/ MINERALS CHEW TAB**	78310000000500	Brand

DEKAS PLUS	*PEDIATRIC MULTIPLE VITAMIN W/ MINERALS LIQUID**	78420000000900	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis

Descovy

Prior Authorization Guideline

Guideline ID	GL-150882
Guideline Name	Descovy
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	8/2/2024

1 . Criteria

Product Name: Descovy	
Diagnosis	Human Immunodeficiency Virus-1 (HIV-1)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG	12109902290320	Brand
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 120-15 MG	12109902290310	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus-1 (HIV-1)

AND

2 - ONE of the following:

2.1 Submission of medical records documenting a history of adverse event or intolerance to prior use of emtricitabine/tenofovir disoproxil fumarate (generic Truvada)

OR

2.2 Patient is currently on Descovy therapy

OR

2.3 Submission of medical records documenting an estimated GFR (glomerular filtration rate) below 90 mL/min (milliliters/minute)

OR

2.4 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD (bone mineral density) T-score less than or equal to -2.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-score]

OR

2.5 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

2.6 Patient is less than 20 years of age

OR

2.7 Submission of medical records documenting a diagnosis of osteopenia as defined by a BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-scores] with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan

Product Name: Descovy	
Diagnosis	Post-Exposure Prophylaxis (PEP)
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG	12109902290320	Brand
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 120-15 MG	12109902290310	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis (PEP)

Product Name: Descovy 200/25 mg	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis (PrEP)
Approval Length	Authorization will be issued for 12 months at GPI-14 level to approve only the 200/25mg strength
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DESCOVY	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TAB 200-25 MG	12109902290320	Brand

Approval Criteria

1 - Request is for 200/25 mg strength

AND

2 - Used for HIV-1 pre-exposure prophylaxis (PrEP)

AND

3 - ONE of the following:

3.1 Submission of medical records documenting a history of adverse event or intolerance to prior use of emtricitabine/tenofovir disoproxil fumarate (generic Truvada)

OR

3.2 Submission of medical records documenting an estimated GFR (glomerular filtration rate) below 90 mL/min (milliliters/minute)

OR

3.3 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD (bone mineral density) T-score less than or equal to -2.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-score]

OR

3.4 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

3.5 Patient is less than 20 years of age

OR **3.6** Submission of medical records documenting a diagnosis of osteopenia as defined by a BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [Provider must submit patient specific BMD T-scores] with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan

2 . Revision History

Date	Notes
8/2/2024	Minor update to specify type 1 infection for HIV diagnosis without cha nge to clinical intent.

Dificid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154718
Guideline Name	Dificid
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Dificid	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DIFICID	FIDAXOMICIN TAB 200 MG	03530025000320	Brand
DIFICID	FIDAXOMICIN FOR SUSP 40 MG/ML	03530025001920	Brand

Approval Criteria

1 - Diagnosis of Clostridioides difficile-associated diarrhea (CDAD) [previously known as Clostridium difficile-associated diarrhea]

AND

2 - ONE of the following:

2.1 Failure to one of the following:

- Firvanq (vancomycin) oral solution
- vancomycin 125 mg or 250 mg capsules
- vancomycin 25 mg/ml or 50 mg/ml oral solution

OR

2.2 History of intolerance or contraindication to all of the following: (please specify intolerance or contraindication)

- Firvanq (vancomycin) oral solution
- vancomycin 125 mg or 250 mg capsules
- vancomycin 25 mg/ml or 50 mg/ml oral solution

OR

2.3 For continuation of prior Dificid therapy

Dojolvi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149530
Guideline Name	Dojolvi
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/3/2024

1 . Criteria

Product Name: Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOJOLVI	TRIHEPTANOIN ORAL LIQUID 100%	80200080000920	Brand

Approval Criteria

1 - Submission of medical records confirming the diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) with at least two of the following diagnostic criteria:

- Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma
- Low enzyme activity in cultured fibroblasts
- Genetic testing demonstrating one or more pathogenic mutations in a gene associated with long-chain fatty acid oxidation disorders (e.g., CPT2, ACADVL, HADHA, or HADHB)

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) products

AND

3 - Prescribed by a board certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

AND

6 - If not diagnosed by newborn screening, patient has a history of clinical manifestations of long-chain fatty acid oxidation disorders LC-FAOD (e.g., rhabdomyolysis)

Product Name: Dojolvi	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOJOLVI	TRIHEPTANOIN ORAL LIQUID 100%	80200080000920	Brand

Approval Criteria

1 - Documentation of positive clinical response to Dojolvi therapy (e.g., increased cardiac efficiency, decreased left ventricular wall mass, decreased incidence of rhabdomyolysis, etc.)

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by a board certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

2 . Revision History

Date	Notes

7/3/2024	New guideline.

Donepezil 23mg

Prior Authorization Guideline

Guideline ID	GL-146319
Guideline Name	Donepezil 23mg
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic donepezil 23 mg	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
DONEPEZIL HYDROCHLORIDE	DONEPEZIL HYDROCHLORIDE TAB 23 MG	62051025100330	Generic
DONEPEZIL HCL	DONEPEZIL HYDROCHLORIDE TAB 23 MG	62051025100330	Generic

Approval Criteria

1 - Failure to donepezil at a minimum dose of 10 mg (milligrams) daily for 90 days, as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to donepezil 10 mg (please specify contraindication or intolerance)

Doptelet

Prior Authorization Guideline

Guideline ID	GL-146508
Guideline Name	Doptelet
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Doptelet	
Diagnosis	Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOPTELET	AVATROMBOPAG MALEATE TAB 20 MG (BASE EQUIV)	82405010200320	Brand

Approval Criteria

1 - Diagnosis of thrombocytopenia

AND

2 - Patient has chronic liver disease

AND

3 - Patient is scheduled to undergo a procedure

AND

4 - ONE of the following:

4.1 Failure to Mulpleta (lusutrombopag) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Mulpleta (lusutrombopag) (please specify contraindication or intolerance)

Product Name: Doptelet	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOPTELET	AVATROMBOPAG MALEATE TAB 20 MG (BASE EQUIV)	82405010200320	Brand

Approval Criteria

1 - Diagnosis of chronic immune thrombocytopenia (ITP)

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to at least ONE of the following as confirmed by claims history or submission of medical records:

- Corticosteroids
- Immunoglobulins

OR

2.1.1.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Corticosteroids
- Immunoglobulins

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to Promacta (eltrombopag) as confirmed by claims history or submission of medical records

OR

2.1.2.2 History of contraindication or intolerance to Promacta (eltrombopag) (please specify contraindication or intolerance)

OR

2.2 Patient is currently on Doptelet therapy

Product Name: Doptelet	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DOPTELET	AVATROMBOPAG MALEATE TAB 20 MG (BASE EQUIV)	82405010200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Doptelet therapy

DPP-4 Inhibitors

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146320
Guideline Name	DPP-4 Inhibitors
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nesina, Alogliptin, Kazano, Alogliptin/metformin, Oseni, Alogliptin/pioglitazone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NESINA	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Generic
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic

KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG	27994002100320	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Generic
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Brand
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Brand
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Brand
ALOGLIPTIN/METFORMIN HCL	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Brand
ALOGLIPTIN/METFORMIN HYDROCHLORIDE	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - One of the following:

2.1 Suboptimal response (i.e. suboptimal glycemic control) to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

Product Name: Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Zituvimet, Zituvio

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-500 MG	27992502700320	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-1000 MG	27992502700340	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27992502707530	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 100-1000 MG	27992502707540	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27992502707520	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 25 MG (BASE EQUIV)	27550070100320	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 50 MG (BASE EQUIV)	27550070100330	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 100 MG (BASE EQUIV)	27550070100340	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-500 MG	27992502400320	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-850 MG	27992502400330	Brand

JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-1000 MG	27992502400340	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502407530	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502407520	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Brand
TRADJENTA	LINAGLIPTIN TAB 5 MG	27550050000320	Brand
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Generic
ZITUVIO	SITAGLIPTIN TAB 25 MG	27550070000320	Brand
ZITUVIO	SITAGLIPTIN TAB 50 MG	27550070000330	Brand
ZITUVIO	SITAGLIPTIN TAB 100 MG	27550070000340	Brand
ZITUVIMET			

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response (i.e. suboptimal glycemic control) to metformin at a minimum dose of 1500 mg daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to a 90 day trial with ONE of the following as confirmed by claims history or submission of medical records:

- Alogliptin (generic Nesina)
- Alogliptin/metformin (generic Kazano)
- Alogliptin/pioglitazone (generic Oseni)

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication)

- Alogliptin (generic Nesina)
- Alogliptin/metformin (generic Kazano)
- Alogliptin/pioglitazone (generic Oseni)

Dry Eye Disease

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154758
Guideline Name	Dry Eye Disease
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Restasis Multidose, Brand Restasis, Cequa, Tyrvaya, Vevye, Miebo, Xiidra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RESTASIS MULTIDOSE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
RESTASIS	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
CEQUA	CYCLOSPORINE (OPHTH) SOLN 0.09% (PF)	86720020002040	Brand
TYRVAYA	VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT	86280080202020	Brand

MIEBO	PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML	868070180020	Brand
VEVYE	CYCLOSPORINE (OPHTH) SOLN 0.1%	86720020002043	Brand
XIIDRA	LIFITEGRAST OPHTH SOLN 5%	86734050002020	Brand

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Not prescribed to manage dry eyes peri-operative elective eye surgery [e.g., LASIK (laser-assisted in situ keratomileusis)]

AND

3 - Failure to at least one OTC (over-the-counter) artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records

AND

4 - One of the following:

4.1 Failure to cyclosporine emulsion 0.05% (generic Restasis) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to cyclosporine emulsion 0.05% (generic Restasis) (please specify contraindication or intolerance)

AND

5 - Medication will not be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)

AND

6 - Prescribed by or in consultation with one of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

Product Name: generic cyclosporine	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CYCLOSPORINE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Generic

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Not prescribed to manage dry eyes peri-operative elective eye surgery [e.g., LASIK (laser-assisted in situ keratomileusis)]

AND

3 - Failure to at least one OTC (over-the-counter) artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records

AND

4 - Medication will not be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)

AND

5 - Prescribed by or in consultation with one of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

Product Name: Restasis Multidose, Brand Restasis, generic cyclosporine, Xiidra, Cequa, Tyrvaya, Vevye, Miebo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RESTASIS MULTIDOSE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
RESTASIS	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Brand
XIIDRA	LIFITEGRAST OPHTH SOLN 5%	86734050002020	Brand
CEQUA	CYCLOSPORINE (OPHTH) SOLN 0.09% (PF)	86720020002040	Brand
TYRVAYA	VARENICLINE TARTRATE NASAL SOLN 0.03 MG/ACT	86280080202020	Brand
CYCLOSPORINE	CYCLOSPORINE (OPHTH) EMULSION 0.05%	86720020001620	Generic

MIEBO	PERFLUOROHEXYLOCTANE OPHTH SOLN 1.338 GM/ML	86807018002020	Brand
VEVYE	CYCLOSPORINE (OPHTH) SOLN 0.1%	86720020002043	Brand

Approval Criteria

1 - Patient has demonstrated clinically significant improvement with therapy

AND

2 - Medication will not be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)

Duexis and Vimovo

Prior Authorization Guideline

Guideline ID	GL-146887
Guideline Name	Duexis and Vimovo
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Duexis, generic ibuprofen/famotidine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUEXIS	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Brand
IBUPROFEN/FAMOTIDINE	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Generic

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug)-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori (helicobacter pylori) gastritis
- Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g., warfarin, heparin)
- Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel)

AND

2 - ONE of the following:

2.1 Failure to THREE combinations of preferred* NSAIDS, one of which must be celecoxib (generic Celebrex), taken concomitantly with preferred* H2-receptor antagonists, as confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to ALL preferred* NSAIDs and ALL preferred* H2-receptor antagonists (please specify contraindication or intolerance)

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Duexis instead of taking individual products in combination

Notes	*PDL links in Background

Product Name: Brand Vimovo, generic naproxen/esomeprazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Brand

NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Generic
VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Brand
NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Generic

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug)-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori (helicobacter pylori) gastritis
- Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g., warfarin, heparin)
- Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel)

AND

2 - ONE of the following:

2.1 Failure to THREE combinations of preferred* NSAIDS, one of which must be celecoxib (generic Celebrex), taken concomitantly with preferred* proton pump inhibitors, as confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to ALL preferred* NSAIDs and ALL preferred* proton pump inhibitors (please specify contraindication or intolerance)

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Vimovo instead of taking individual products in combination

Notes	*PDL links in Background

2 . Background

Benefit/Coverage/Program Information
PDL links NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Duopa

Prior Authorization Guideline

Guideline ID	GL-146323
Guideline Name	Duopa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Duopa	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUOPA	CARBIDOPA-LEVODOPA ENTERAL SUSP 4.63-20 MG/ML	73209902101820	Brand

Approval Criteria

1 - Diagnosis of advanced Parkinson's disease

AND

2 - Patient is levodopa-responsive

AND

3 - Patient experiences disabling “off” periods for a minimum of 3 hours per day

AND

4 - Disabling “off" periods occur despite therapy with BOTH of the following, as confirmed by claims history or submission of medical records:

- Oral levodopa-carbidopa
- One drug from a different class of anti-Parkinson's disease therapy (e.g., COMT [catechol-O-methyltransferase] inhibitor [entacapone, tolcapone], MAO-B [monoamine oxidase-B] inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole])

AND

5 - Has undergone or has planned placement of a procedurally-placed tube

AND

6 - Prescribed by or in consultation with a neurologist

Product Name: Duopa	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUOPA	CARBIDOPA-LEVODOPA ENTERAL SUSP 4.63-20 MG/ML	73209902101820	Brand

Approval Criteria

1 - Documentation of positive clinical response to Duopa therapy

Dupixent

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147442
Guideline Name	Dupixent
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand

DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 Failure to TWO of the following therapeutic classes of topical therapies as confirmed by claims history or submission of medical records:

- One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.2 History of contraindication or intolerance to ALL of the following therapeutic classes of topical therapies (please specify contraindication or intolerance):

- One medium, high, or very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.3 Patient is currently on Dupixent therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Dupixent in combination with either of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

2 - Patient is NOT receiving Dupixent in combination with either of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

3 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Dupixent	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Diagnosis of moderate-to-severe asthma

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

- Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20]
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal)]
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

2.1.2 Dupixent will be used in combination with ONE of the following:

2.1.2.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] (see Table 2 in Background)

OR

2.1.2.2 Combination therapy including BOTH of the following:

2.1.2.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] (see Table 2 in Background)

AND

2.1.2.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

2.1.3 ONE of the following:

2.1.3.1 Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter

OR

2.1.3.2 Patient is currently dependent on oral corticosteroids for the treatment of asthma

OR

2.2 BOTH of the following:

2.2.1 Patient is currently on Dupixent therapy as confirmed by claims history or submission of medical records

AND

2.2.2 Dupixent will be used in combination with ONE of the following:

2.2.2.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

2.2.2.2 Combination therapy including BOTH of the following:

2.2.2.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

2.2.2.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

2 - Dupixent will be used in combination with ONE of the following:

2.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

2.2 Combination therapy including BOTH of the following:

2.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

2.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand

DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

1.1.1 TWO or more of the following symptoms for longer than 12 weeks duration:

- Nasal mucopurulent discharge
- Nasal obstruction, blockage, or congestion
- Facial pain, pressure, and/or fullness
- Reduction or loss of sense of smell

AND

1.1.2 ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

1.1.3 ONE of the following:

- Presence of bilateral nasal polyposis
- Patient has previously required surgical removal of bilateral nasal polyps

AND

1.1.4 ONE of the following:

1.1.4.1 Patient has required prior sinus surgery

OR

1.1.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years

OR

1.1.4.3 Patient has been unable to obtain symptom relief after trial of TWO of the following classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)

AND

1.2.2 Patient is currently on Dupixent therapy as confirmed by claims history or submission of medical records

AND

2 - Patient will receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

2 - Patient will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone), as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis
Approval Length	6 month(s)*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand

DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Diagnosis of eosinophilic esophagitis

AND

2 - Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that is often centrally located and may not respond to antacids, gastroesophageal reflux disease-like symptoms/refractory heartburn, upper abdominal pain)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eosinophil-predominant inflammation on esophageal biopsy, consisting of a peak value of 15 or more intraepithelial eosinophils per high power field (HPF) [or 60 eosinophils per mm^2 (square millimeters)]

AND

4 - Secondary causes of esophageal eosinophilia have been ruled out

AND

5 - Mucosal eosinophilia is isolated to the esophagus and symptoms have persisted after an 8-week trial of at least ONE of the following, as confirmed by claims history or submission of medical records:

- Proton pump inhibitors (e.g., pantoprazole, omeprazole)
- Topical (esophageal) corticosteroids (e.g., budesonide, fluticasone)

AND

6 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by ONE of the following:

- Allergist
- Gastroenterologist

Notes	*If clinical criteria is met, enter a GPI-10 authorization with a MDD of 0 .3 mL.

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis
Approval Length	6 month(s)*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy as evidenced by improvement of at least ONE of the following from baseline:

- Symptoms (e.g., dysphagia, chest pain, heartburn)
- Histologic measures (e.g., esophageal intraepithelial eosinophil count)
- Endoscopic measures (e.g., edema, furrows, exudates, rings, strictures)

AND

2 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

3 - Prescribed by or in consultation with a gastroenterologist or allergist

Notes	*If clinical criteria is met, enter a GPI-10 authorization with a MDD of 0 .3 mL.

Product Name: Dupixent	
Diagnosis	Prurigo Nodularis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand

DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Diagnosis of prurigo nodularis

AND

2 - Patient has greater than or equal to 20 nodular lesions

AND

3 - ONE of the following:

3.1 Failure to at least one previous prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to all other prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin) (please specify contraindication or intolerance)

AND

4 - Patient is NOT receiving Dupixent in combination with either of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

5 - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Dupixent	
Diagnosis	Prurigo Nodularis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

2 - Patient is NOT receiving Dupixent in combination with either of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

3 - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	tridifloronide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1

	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

Table 2: Low, medium, and high daily doses of inhaled corticosteroids. Adults and adolescents (12 years of age and older)

Drug	Daily dose (mcg)		
	Low	Medium	High

Beclomethasone dipropionate (CFC)	200-500	>500-1000	>1000
Beclomethasone dipropionate (HFA)	100-200	>200-400	>400
Budesonide DPI	200-400	>400-800	>800
Ciclesonide (HFA)	80-160	>160-320	>320
Fluticasone furoate (DPI)	100	N/A	200
Fluticasone propionate (DPI)	100-250	>250-500	>500
Fluticasone propionate (HFA)	100-250	>250-500	>500
Mometasone furoate	110-220	>220-440	>440
Triamcinolone acetonide	400-1000	>1000-2000	>2000

3 . Revision History

Date	Notes
5/15/2024	Clarified language regarding topical steroid potency in initial auth section for AD. Removed weight requirement in initial auth section for Eo E. Updated example from "Adbry (tralokinumab)" to "Adbry (tralokinumab-ldrm)" where applicable.

Duvyzat

Prior Authorization Guideline

Guideline ID	GL-155733
Guideline Name	Duvyzat
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Duvyzat	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUVYZAT	GIVINOSTAT HCL ORAL SUSP 8.86 MG/ML	74603025201820	Brand

Approval Criteria

1 - Diagnosis of Duchenne muscular dystrophy (DMD)

AND

2 - Diagnosis confirmed by the presence of a mutation in the DMD gene

AND

3 - Patient is 6 years of age or older

AND

4 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.)

AND

5 - Patient has been or will be established on a stable corticosteroid regimen

AND

6 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD

AND

7 - Patient has not received gene therapy for DMD [e.g., Elevidys (delandistrogene moxparvovec-rokl)]

AND

8 - Patient will not receive Duvyzat in combination with exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

Product Name: Duvyzat	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DUVYZAT	GIVINOSTAT HCL ORAL SUSP 8.86 MG/ML	74603025201820	Brand

Approval Criteria

1 - Physician attestation that patient would benefit from continued administration

AND

2 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.)

AND

3 - Patient continues to receive concomitant corticosteroid regimen

AND

4 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD

AND

5 - Patient has not received gene therapy for DMD [e.g., Elevidys (delandistrogene moxparvovec-rokl)]

AND

6 - Patient will not receive Duvyzat in combination with exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
9/23/2024	New guideline.

Egrifta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146510
Guideline Name	Egrifta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Egrifta SV	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EGRIFTA SV	TESAMORELIN ACETATE FOR INJ 2 MG (BASE EQUIV)	30150085102130	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy

Elidel-Protopic

Prior Authorization Guideline

Guideline ID	GL-148510
Guideline Name	Elidel-Protopic
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Elidel, generic pimecrolimus, generic tacrolimus 0.03%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ELIDEL	PIMECROLIMUS CREAM 1%	90784060003720	Brand
PIMECROLIMUS	PIMECROLIMUS CREAM 1%	90784060003720	Generic
TACROLIMUS	TACROLIMUS OINT 0.03%	90784075004210	Generic

Approval Criteria

1 - The patient is 2 years of age or older

AND

2 - ONE of the following:

2.1 Failure to one topical corticosteroid in the past 90 days as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to one topical corticosteroid (please specify contraindication or intolerance)

OR

2.3 Drug is being prescribed for the facial or groin area

Product Name: Generic tacrolimus 0.1%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TACROLIMUS	TACROLIMUS OINT 0.1%	90784075004230	Generic

Approval Criteria

1 - The patient is 16 years of age or older

AND

2 - ONE of the following:

2.1 Failure to one topical corticosteroid in the past 90 days as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to one topical corticosteroid (please specify contraindication or intolerance)

OR

2.3 Drug is being prescribed for the facial or groin area

2 . Revision History

Date	Notes
6/13/2024	Removed Protopic from GPI table since it is obsolete.

Elmiron

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146325
Guideline Name	Elmiron
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Elmiron	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ELMIRON	PENTOSAN POLYSULFATE SODIUM CAPS 100 MG	56500060100110	Brand

Approval Criteria

1 - Patient has a documented diagnosis of bladder pain or discomfort associated with interstitial cystitis

Emflaza

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146511
Guideline Name	Emflaza
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Emflaza			
Diagnosis	Duchenne Muscular Dystrophy		
Guideline Type	Prior Authorization		
Product Name	**Generic Name**	**GPI**	**Brand/Generic**
EMFLAZA	DEFLAZACORT TAB 6 MG	22100017000340	Brand
EMFLAZA	DEFLAZACORT TAB 18 MG	22100017000350	Brand
EMFLAZA	DEFLAZACORT TAB 30 MG	22100017000360	Brand
EMFLAZA	DEFLAZACORT TAB 36 MG	22100017000365	Brand
EMFLAZA	DEFLAZACORT SUSP 22.75 MG/ML	22100017001830	Brand

Approval Criteria **1** - Published clinical evidence shows Emflaza is likely to produce equivalent therapeutic results as other available corticosteroids (e.g., prednisone); therefore, Emflaza is not medically necessary for treatment of Duchenne muscular dystrophy	
Notes	All requests for authorization will be denied by OptumRx and must be submitted through the appeals process to the UnitedHealthcare Community Plan Pharmacy Appeals team for consideration.

Empaveli

Prior Authorization Guideline

Guideline ID	GL-148077
Guideline Name	Empaveli
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Empaveli	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMPAVELI	PEGCETACOPLAN SUBCUTANEOUS SOLN 1080 MG/20ML (54 MG/ML)	85804065002020	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following:

1.1 Flow cytometry analysis confirming presence of PNH clones

AND

1.2 Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

2 - ONE of the following:

2.1 Patient will not be prescribed Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Fabhalta, Soliris, Ultomiris)

OR

2.2 Patient is currently receiving another complement inhibitor (e.g., Fabhalta, Soliris, Ultomiris) which will be discontinued and Empaveli will be initiated in accordance with the United States Food and Drug Administration approved labeling

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist

Product Name: Empaveli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMPAVELI	PEGCETACOPLAN SUBCUTANEOUS SOLN 1080 MG/20ML (54 MG/ML)	85804065002020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Empaveli therapy [e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH (lactate dehydrogenase), increased reticulocyte count, etc.]

AND

2 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) (e.g., Fabhalta, Soliris, Ultomiris)

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist

2 . Revision History

Date	Notes
6/4/2024	In initial auth section, simplified criteria language for converting to ne w complement inhibitor therapy.

Enbrel

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146513
Guideline Name	Enbrel
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Enbrel	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand

ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to one non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of rheumatoid arthritis confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]

- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active rheumatoid arthritis

AND

2.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name: Enbrel	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2 - Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name: Enbrel	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]

AND

1.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Enbrel	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of moderate to severe chronic plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

1.2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure to one of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to all of the following topical therapy classes (please specify intolerance or contraindication)

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.2.1.3 ONE of the following:

1.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

1.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a biologic or targeted DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

AND

1.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with a dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderate to severe chronic plaque psoriasis

AND

2.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a dermatologist

Product Name: Enbrel	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of active ankylosing spondylitis

AND

1.2 ONE of the following:

1.2.1 Failure to two non-steroidal anti-inflammatory drugs (NSAIDs: e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab)]

AND

1.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - All of the following:

2.1 Patient is currently on Enbrel therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name: Enbrel	
Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Plaque Psoriasis, Ankylosing Spondylitis, Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand

Approval Criteria

1 - Documentation of positive clinical response to Enbrel therapy

AND

2 - Patient is not receiving Enbrel in combination with one of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Endari

Prior Authorization Guideline

Guideline ID	GL-146326
Guideline Name	Endari
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENDARI	GLUTAMINE (SICKLE CELL) POWD PACK 5 GM	82801020003020	Brand

Approval Criteria

1 - BOTH of the following:

- Diagnosis of sickle cell disease
- Used to reduce acute complications of sickle cell disease

AND

2 - ONE of the following:

- Patient is using Endari with concurrent hydroxyurea therapy
- Patient is unable to take hydroxyurea due to a contraindication or intolerance (please specify contraindication or intolerance)

AND

3 - Patient has had 2 or more painful sickle cell crises within the past 12 months

Product Name: Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENDARI	GLUTAMINE (SICKLE CELL) POWD PACK 5 GM	82801020003020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Endari therapy

Enspryng

Prior Authorization Guideline

Guideline ID	GL-146514
Guideline Name	Enspryng
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Enspryng	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENSPRYNG	SATRALIZUMAB-MWGE SUBCUTANEOUS SOLN PREF SYRINGE 120 MG/ML	9940507040E520	Brand

Approval Criteria

1 - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)

AND

2 - Patient has a positive serologic test for anti-aquaporin-4 (AQP4) antibodies

AND

3 - History of failure, contraindication, or intolerance to rituximab therapy

AND

4 - One of the following:

- History of one or more relapses that required rescue therapy during the previous 12 months
- History of two or more relapses that required rescue therapy during the previous 24 months

AND

5 - Prescribed by, or in consultation with, a neurologist

AND

6 - Patient is NOT receiving Enspryng in combination with any of the following:

- Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
- Complement inhibitors [e.g., Soliris (eculizumab)]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

Product Name: Enspryng	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENSPRYNG	SATRALIZUMAB-MWGE SUBCUTANEOUS SOLN PREF SYRINGE 120 MG/ML	9940507040E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Enspryng therapy

AND

2 - Prescribed by, or in consultation with, a neurologist

AND

3 - Patient is NOT receiving Enspryng in combination with any of the following:

- Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
- Complement inhibitors [e.g., Soliris (eculizumab)]
- Anti-IL6 (anti-interleukin-6) therapy [e.g., Actemra (tocilizumab)]
- B-cell depletion therapy [e.g., rituximab, Uplizna (inebilizumab)]

Entocort

Prior Authorization Guideline

Guideline ID	GL-146327
Guideline Name	Entocort
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: budesonide caps	
Diagnosis	Crohn’s Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUDESONIDE	BUDESONIDE DELAYED RELEASE PARTICLES CAP 3 MG	22100012006720	Generic

Approval Criteria

1 - Used for the treatment of Crohn’s disease

Entresto

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156316
Guideline Name	Entresto
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Entresto, Entresto Sprinkles	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTRESTO	SACUBITRIL-VALSARTAN TAB 24-26 MG	40992002600320	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 49-51 MG	40992002600330	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 97-103 MG	40992002600340	Brand
ENTRESTO	SACUBITRIL-VALSARTAN SPRINKLE CAP 6-6 MG	40992002606820	Brand
ENTRESTO	SACUBITRIL-VALSARTAN SPRINKLE CAP 15-16 MG	40992002606830	Brand

Approval Criteria

1 - Request is for continuation of therapy initiated during an inpatient stay

OR

2 - ALL of the following:

2.1 Diagnosis of pediatric heart failure with systemic left ventricular systolic dysfunction which is symptomatic

AND

2.2 Prescribed by or in consultation with a cardiologist

AND

2.3 If the request is for Entresto Sprinkles, the prescriber has given a clinical reason or special circumstance why the patient is unable to use regular Entresto tablets

OR

3 - ALL of the following:

3.1 Diagnosis of heart failure (with or without hypertension)

AND

3.2 ONE of the following:

3.2.1 Ejection fraction is less than or equal to 40 percent

OR

3.2.2 BOTH of the following:

3.2.2.1 Ejection fraction is greater than 40 percent

AND

3.2.2.2 Patient has structural heart disease [i.e., left atrial enlargement (LAE) or left ventricular hypertrophy (LVH)]

AND

3.3 Heart failure is classified as ONE of the following:

- New York Heart Association Class II
- New York Heart Association Class III
- New York Heart Association Class IV

AND

3.4 Patient does not have a history of angioedema

AND

3.5 Patient will discontinue any use of concomitant ACE (angiotensin converting enzyme) Inhibitor or ARB (angiotensin II receptor blocker) before initiating treatment with Entresto*

AND

3.6 Patient is not concomitantly on aliskiren therapy

AND

3.7 Entresto is prescribed by, or in consultation with, a cardiologist

Notes	*ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto.

Product Name: Entresto, Entresto Sprinkles	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTRESTO	SACUBITRIL-VALSARTAN TAB 24-26 MG	40992002600320	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 49-51 MG	40992002600330	Brand
ENTRESTO	SACUBITRIL-VALSARTAN TAB 97-103 MG	40992002600340	Brand
ENTRESTO	SACUBITRIL-VALSARTAN SPRINKLE CAP 6-6 MG	40992002606820	Brand
ENTRESTO	SACUBITRIL-VALSARTAN SPRINKLE CAP 15-16 MG	40992002606830	Brand

Approval Criteria

1 - The Entresto dose has been titrated to a dose of 97 mg (milligrams)/103 mg twice daily or the maximum labeled dose for pediatric patients, or to a maximum dose as tolerated by the patient

AND

2 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
9/26/2024	Added Entresto sprinkles

Entyvio

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152392
Guideline Name	Entyvio
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Entyvio SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTYVIO	VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML	52503080000D520	Brand

Approval Criteria

1 - Submission of medical records documenting clinical rationale for need of subcutaneous Entyvio in place of Entyvio administered intravenously (covered under the medical benefit)

AND

2 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

3 - ONE of the following:

3.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

3.2 Patient has been previously treated with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

4 - Patient is NOT receiving Entyvio in combination with a targeted immunomodulator [e.g., Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by or in consultation with a gastroenterologist

Product Name: Entyvio SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTYVIO	VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML	5250308000D520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Entyvio therapy

AND

2 - Patient is NOT receiving Entyvio in combination with a targeted immunomodulator [e.g., Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

Product Name: Entyvio SC	
Diagnosis	Crohn’s disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTYVIO	VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML	5250308000D520	Brand

Approval Criteria

1 - Submission of medical records documenting clinical rationale for need of subcutaneous Entyvio in place of Entyvio administered intravenously (covered under the medical benefit)

AND

2 - Diagnosis of moderately to severely active Crohn’s disease (CD)

AND

3 - ONE of the following:

3.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine, methotrexate)

OR

3.2 Patient has been previously treated with a biologic disease-modifying antirheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab]

AND

4 - Patient is NOT receiving Entyvio in combination with a targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by or in consultation with a gastroenterologist

Product Name: Entyvio SC	
Diagnosis	Crohn's disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENTYVIO	VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML	5250308000D520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Entyvio therapy

AND

2 - Patient is NOT receiving Entyvio in combination with a targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

2 . Revision History

Date	Notes
8/19/2024	Updated concomitant use language where applicable and added crit eria for Crohn's disease.

Eohilia

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151000
Guideline Name	Eohilia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	8/6/2024

1 . Criteria

Product Name: Eohilia			
Approval Length	12 Week(s)		
Guideline Type	Prior Authorization		

Product Name	Generic Name	GPI	Brand/Generic
EOHILIA	BUDESONIDE ORAL SUSPENSION 2 MG/10ML	22100012001820	Brand

Approval Criteria

1 - Diagnosis of eosinophilic esophagitis (EoE)

AND

2 - Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that is often centrally located and may not respond to antacids, gastroesophageal reflux disease-like symptoms/refractory heartburn, upper abdominal pain)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eosinophil-predominant inflammation on esophageal biopsy, consisting of a peak value of ≥15 intraepithelial eosinophils per high power field (HPF)

AND

4 - Secondary causes of esophageal eosinophilia have been ruled out

AND

5 - One of the following:

5.1 Failure to an 8 week trial of both of the following as confirmed by claims history or submission of medical records:

- Proton pump inhibitor (e.g., pantoprazole, omeprazole)
- Inhalational corticosteroid administered orally [e.g., budesonide inhalation suspension (generic Pulmicort Respules), Fluticasone HFA (Flovent HFA authorized generic)]

OR

5.2 History of contraindication or intolerance to both of the following (please specify intolerance or contraindication):

- Proton pump inhibitor (e.g., pantoprazole, omeprazole)
- Inhalational corticosteroid administered orally [e.g., budesonide inhalation suspension (generic Pulmicort Respules), Fluticasone HFA (Flovent HFA authorized generic)]

AND

6 - Prescribed by or in consultation with one of the following:

- Allergist/Immunologist
- Gastroenterologist

Epaned

Prior Authorization Guideline

Guideline ID	GL-146329
Guideline Name	Epaned
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic enalapril oral soln, Brand Epaned	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENALAPRIL MALEATE	ENALAPRIL MALEATE ORAL SOLN 1 MG/ML	36100020102020	Generic
EPANED	ENALAPRIL MALEATE ORAL SOLN 1 MG/ML	36100020102020	Brand

Approval Criteria

1 - Patient is less than 8 years of age

OR

2 - BOTH of the following:

2.1 ONE of the following diagnoses:

- Hypertension
- Heart failure
- Asymptomatic left ventricular dysfunction, defined as left ventricular ejection fraction less than or equal to 35%

AND

2.2 ONE of the following:

2.2.1 Failure to TWO formulary oral anti-hypertensives [e.g., angiotensin-converting enzyme (ACE) inhibitor, ACE inhibitor combination, angiotensin-receptor blocker (ARB), ARB combination, thiazide diuretic] as confirmed by claims history or submission of medical records

OR

2.2.2 History of contraindication or intolerance to ALL formulary oral anti-hypertensives (e.g., ACE inhibitor, ACE inhibitor combination, ARB, ARB combination, thiazide diuretic) (please specify contraindication or intolerance)

OR

2.2.3 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Oral/motor difficulties
- Dysphagia

Erivedge

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146515
Guideline Name	Erivedge
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Erivedge	
Diagnosis	Basal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERIVEDGE	VISMODEGIB CAP 150 MG	21370070000120	Brand

Approval Criteria

1 - Diagnosis of metastatic basal cell carcinoma

OR

2 - BOTH of the following:

2.1 Diagnosis of locally advanced basal cell carcinoma

AND

2.2 ONE of the following:

- Cancer has recurred following surgery
- Patient is not a candidate for surgery
- Patient is not a candidate for radiation

Product Name: Erivedge	
Diagnosis	Medulloblastoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERIVEDGE	VISMODEGIB CAP 150 MG	21370070000120	Brand

Approval Criteria

1 - Diagnosis of medulloblastoma

AND

2 - Patient has mutations in the sonic hedgehog pathway

AND

3 - Patient has failed prior chemotherapy

Product Name: Erivedge	
Diagnosis	Basal Cell Carcinoma, Medulloblastoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERIVEDGE	VISMODEGIB CAP 150 MG	21370070000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Erivedge therapy

Product Name: Erivedge	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERIVEDGE	VISMODEGIB CAP 150 MG	21370070000120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Erivedge	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERIVEDGE	VISMODEGIB CAP 150 MG	21370070000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Erivedge therapy

Erleada

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146516
Guideline Name	Erleada
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Erleada	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERLEADA	APALUTAMIDE TAB 60 MG	21402410000320	Brand
ERLEADA	APALUTAMIDE TAB 240 MG	21402410000360	Brand

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Disease is castration-resistant or recurrent
- Disease is non-metastatic

OR

2.2 BOTH of the following:

- Disease is castration-sensitive or naïve
- Disease is metastatic

AND

3 - ONE of the following:

3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

3.2 Patient has had bilateral orchiectomy

Product Name: Erleada	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERLEADA	APALUTAMIDE TAB 60 MG	21402410000320	Brand
ERLEADA	APALUTAMIDE TAB 240 MG	21402410000360	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Erleada therapy

Product Name: Erleada	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERLEADA	APALUTAMIDE TAB 60 MG	21402410000320	Brand
ERLEADA	APALUTAMIDE TAB 240 MG	21402410000360	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Erleada	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ERLEADA	APALUTAMIDE TAB 60 MG	21402410000320	Brand

ERLEADA	APALUTAMIDE TAB 240 MG	21402410000360	Brand

Approval Criteria

1 - Documentation of positive clinical response to Erleada therapy

Erythropoietic Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146517
Guideline Name	Erythropoietic Agents
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand

EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand

ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - Hematocrit is less than 30 percent at initiation of therapy

AND

3 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

AND

4 - ONE of the following:

4.1 Patient is on dialysis

OR

4.2 ALL of the following:

4.2.1 Patient is NOT on dialysis

AND

4.2.2 The rate of hematocrit decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

AND

4.2.3 Therapeutic goal is reducing the risk of alloimmunization and/or other RBC transfusion-related risks

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand

ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient is on dialysis

AND

2.1.2 Hematocrit remains less than 33 percent

OR

2.2 ALL of the following:

2.2.1 Patient is NOT on dialysis

AND

2.2.2 Hematocrit remains less than 30 percent

AND

2.2.3 Therapeutic goal is reducing the risk of alloimmunization and/or other RBC transfusion

Product Name: Epogen, Procrit, Retacrit	
Diagnosis	Anemia Associated with Zidovudine Treatment in HIV-Infected Patients
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Patient is receiving zidovudine administered at less than or equal to 4200 milligrams per week

AND

2 - Endogenous serum erythropoietin level is less than or equal to 500 milliunits per milliliter

AND

3 - Hematocrit is less than 30 percent at initiation of therapy

AND

4 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

Product Name: Epogen, Procrit, Retacrit	
Diagnosis	Anemia Associated with Zidovudine Treatment in HIV-Infected Patients
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy

AND

2 - Patient is receiving zidovudine administered at less than or equal to 4200 milligrams per week

AND

3 - Endogenous serum erythropoietin level less than or equal to 500 milliunits per milliliter

AND

4 - Hematocrit remains less than or equal to 36 percent for continuation of therapy

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Due to Cancer Chemotherapy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand

EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand

RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Hematocrit less than or equal to 30 percent at initiation of therapy

AND

2 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency) and there is documentation of normal iron stores

AND

3 - One of the following:

3.1 Patient has moderate to severe chronic kidney disease (CKD)

OR

3.2 Undergoing palliative treatment

OR

3.3 Receiving myelosuppressive chemotherapy not given with curative intent

OR

3.4 Both of the following:

- Receiving myelosuppressive chemotherapy with curative intent
- Patient is refusing blood transfusion(s)

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Due to Cancer Chemotherapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand

ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy

AND

2 - Chemotherapy is given as palliative treatment

AND

3 - Hematocrit remains less than 30 percent for continuation of therapy

Product Name: Epogen, Procrit, Retacrit	
Diagnosis	Preoperative Use for Reduction of Allogeneic Blood Transfusions in Surgery Patients
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Perioperative hematocrit is greater than 30 percent and less than or equal to 39 percent

AND

2 - Patient is expected to require at least 2 units of blood during the surgical procedure

AND

3 - Patient is at high risk for blood loss during surgery

AND

4 - Patient is unable or unwilling to donate autologous blood

AND

5 - Surgery procedure is elective, non-cardiac, and non-vascular

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia Associated with Myelodysplastic Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand

EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand

RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Diagnosis of myelodysplastic syndrome (MDS)

AND

2 - Serum erythropoietin level less than or equal to 500 milliunits per milliliter

AND

3 - Hematocrit is less than or equal to 30 percent at the initiation of therapy

AND

4 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

AND

5 - Treatment of lower risk [defined as IPSS-R (Very Low, Low, Intermediate)] disease with symptomatic anemia

AND

6 - One of the following:

6.1 Patient is with del(5q) chromosomal abnormality

OR

6.2 Both of the following:

- Patient is without del(5q) chromosomal abnormality
- Ring sideroblasts less than 15% (or ring sideroblasts less than 5% with an SF3B1 mutation)

OR

6.3 All of the following:

- Patient is without del(5q) chromosomal abnormality
- Ring sideroblasts greater than or equal to15% (or ring sideroblasts greater than or equal to 5% with an SF3B1 mutation)
- Following no response to Reblozyl (luspatercept-aamt)

Product Name: Aranesp, Epogen, Procrit, or Retacrit	
Diagnosis	Anemia Associated with Myelodysplastic syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand

EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand

RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Hematocrit remains less than or equal to 36 percent for continuation of therapy

AND

2 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy

AND

3 - Serum erythropoietin level less than or equal to 500 milliunits per milliliter

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia associated with Myeloproliferative Neoplasms – Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand

PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand

RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Serum erythropoietin level less than or equal to 500 mUnits/mL

AND

2 - Hematocrit is less than or equal to 30 percent at the initiation of therapy

AND

3 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Anemia associated with Myeloproliferative Neoplasms – Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand

EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand

RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy

AND

2 - Serum erythropoietin level less than or equal to 500 mUnits/mL

AND

3 - Hematocrit remains less than or equal to 36 percent for continuation of therapy

Product Name: Epogen, Procrit, Retacrit	
Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand

EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Diagnosis of hepatitis C virus (HCV) infection

AND

2 - Patient is receiving ribavirin and interferon therapy

AND

3 - Hematocrit is less than or equal to 30 percent at initiation of therapy

AND

4 - Patient does not have evidence of other causes of anemia (e.g., iron deficiency, hemolysis, vitamin B12 deficiency)

Product Name: Epogen, Procrit, Retacrit

Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Hematocrit remains less than or equal to 36 percent for continuation of care

AND

2 - Documentation of positive clinical response to erythropoietin stimulating agent (ESA) therapy

AND

3 - Patient is receiving ribavirin and interferon therapy

Product Name: Aranesp, Epogen, Procrit, Retacrit	
Diagnosis	Erythropoietin Stimulating Agents -Off-Label Uses
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	Brand
EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	Brand
EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	Brand
EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	Brand
EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 10 MCG/0.4ML	8240101510E510	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 25 MCG/0.42ML	8240101510E528	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 40 MCG/0.4ML	8240101510E543	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 60 MCG/0.3ML	8240101510E552	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 100 MCG/0.5ML	8240101510E560	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 150 MCG/0.3ML	8240101510E575	Brand

ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 200 MCG/0.4ML	8240101510E582	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 300 MCG/0.6ML	8240101510E588	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN PREFILLED SYRINGE 500 MCG/ML	8240101510E590	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 25 MCG/ML	82401015102010	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 40 MCG/ML	82401015102020	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 60 MCG/ML	82401015102030	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 100 MCG/ML	82401015102040	Brand
ARANESP ALBUMIN FREE	DARBEPOETIN ALFA SOLN INJ 200 MCG/ML	82401015102060	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 2000 UNIT/ML	82401020042010	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 3000 UNIT/ML	82401020042015	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 4000 UNIT/ML	82401020042020	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 10000 UNIT/ML	82401020042040	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 20000 UNIT/ML	82401020042050	Brand
RETACRIT	EPOETIN ALFA-EPBX INJ 40000 UNIT/ML	82401020042060	Brand
PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	82401020002060	Brand

Approval Criteria

1 - Off-label requests will be evaluated on a case-by-case basis by a clinical pharmacist

AND

2 - Requests for coverage in patients with hemoglobin (Hgb) greater than 10 grams per deciliter or hematocrit (Hct) greater than 30 percent will not be approved

Esbriet, Ofev

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146518
Guideline Name	Esbriet, Ofev
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Esbriet, generic pirfenidone, Ofev	
Diagnosis	Idiopathic Pulmonary Fibrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ESBRIET	PIRFENIDONE CAP 267 MG	45550060000120	Brand
ESBRIET	PIRFENIDONE TAB 267 MG	45550060000325	Brand
ESBRIET	PIRFENIDONE TAB 801 MG	45550060000345	Brand

OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand
PIRFENIDONE	PIRFENIDONE CAP 267 MG	45550060000120	Generic
PIRFENIDONE	PIRFENIDONE TAB 267 MG	45550060000325	Generic
PIRFENIDONE	PIRFENIDONE TAB 801 MG	45550060000345	Generic
PIRFENIDONE	PIRFENIDONE TAB 534 MG	45550060000333	Generic

Approval Criteria

1 - Diagnosis of idiopathic pulmonary fibrosis (IPF) as documented by ALL of the following:

1.1 Exclusion of other known causes of interstitial lung disease (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity), as documented by an ICD-10 Code of J84.112 (idiopathic pulmonary fibrosis)

AND

1.2 ONE of the following:

1.2.1 If the patient was NOT subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF

OR

1.2.2 If the patient was subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF

AND

2 - ONE of the following:

2.1 If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

OR

2.2 If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name: Brand Esbriet, generic pirfenidone, Ofev	
Diagnosis	Idiopathic Pulmonary Fibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ESBRIET	PIRFENIDONE CAP 267 MG	45550060000120	Brand
ESBRIET	PIRFENIDONE TAB 267 MG	45550060000325	Brand
ESBRIET	PIRFENIDONE TAB 801 MG	45550060000345	Brand
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand
PIRFENIDONE	PIRFENIDONE CAP 267 MG	45550060000120	Generic
PIRFENIDONE	PIRFENIDONE TAB 267 MG	45550060000325	Generic
PIRFENIDONE	PIRFENIDONE TAB 801 MG	45550060000345	Generic
PIRFENIDONE	PIRFENIDONE TAB 534 MG	45550060000333	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - ONE of the following:

2.1 If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

OR

2.2 If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name: Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand

Approval Criteria

1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by ALL of the following:

1.1 ONE of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 At least TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)
- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud's phenomenon
- SSc-related autoantibodies [e.g., anticentromere, anti-topoisomerase I, anti-RNA (ribonucleic acid) polymerase III]

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on high-resolution computed tomography (HRCT), involving at least 10% of the lungs

AND

2 - Ofev is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name: Ofev	
Diagnosis	Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand

Approval Criteria

1 - Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype as documented by BOTH of the following:

1.1 Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

AND

1.2 Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months:

1.2.1 Forced vital capacity (FVC) decline of greater than 10%

OR

1.2.2 TWO of the following:

- FVC decline of greater than or equal to 5%, but less than 10%
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

AND

2 - Ofev is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name: Ofev

Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease, Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OFEV	NINTEDANIB ESYLATE CAP 100 MG (BASE EQUIVALENT)	45554050200120	Brand
OFEV	NINTEDANIB ESYLATE CAP 150 MG (BASE EQUIVALENT)	45554050200130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ofev therapy

AND

2 - Ofev is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Eucrisa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146330
Guideline Name	Eucrisa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Eucrisa	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
EUCRISA	CRISABOROLE OINT 2%	90230025004220	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide] as confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide] (please specify contraindication or intolerance)

AND

1.2 ONE of the following:

1.2.1 Patient is less than 2 years of age

OR

1.2.2 Patient is greater than or equal to 2 years of age and ONE of the following:

- Failure to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)] (Please specify contraindication or intolerance)

OR

2 - Patient is currently on Eucrisa therapy as confirmed by claims history or submission of medical records

Evrysdi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154626
Guideline Name	Evrysdi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Evrysdi	
Diagnosis	Spinal Muscular Atrophy (SMA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EVRYSDI	RISDIPLAM FOR SOLN 0.75 MG/ML	74706560002120	Brand

Approval Criteria

1 - Diagnosis of spinal muscular atrophy (SMA)

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following:

2.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

2.2 Compound heterozygous mutation of SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - Patient is not receiving concomitant chronic survival motor neuron (SMN)-modifying therapy [e.g., Spinraza (nusinersen)]

AND

6 - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

7 - Submission of medical records (e.g., chart notes, laboratory values) documenting the baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN-modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Revised Upper Limb Module (RULM) Test
- Motor Function Measure 32 (MFM-32) Scale

AND

8 - Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA

Notes	*Baseline assessments for patients less than 2 months of age request ing Evrysdi are not necessary in order not to delay access to initial the rapy in recently diagnosed infants. Initial assessments shortly post-the rapy can serve as baseline with respect to efficacy reauthorization ass essment.

Product Name: Evrysdi	
Diagnosis	Spinal Muscular Atrophy (SMA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EVRYSDI	RISDIPLAM FOR SOLN 0.75 MG/ML	74706560002120	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) with the most recent

results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status [inclusive of baseline assessments prior to receipt of previous chronic survival motor neuron (SMN)-modifying therapy] as demonstrated by at least ONE of the following exams:

1.1 Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) with ONE of the following:

1.1.1 Improvement or maintenance of previous improvement of at least a 4-point increase in score from pretreatment baseline

OR

1.1.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.2 Hammersmith Infant Neurological Exam Part 2 (HINE-2) with ONE of the following:

1.2.1 Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick

OR

1.2.2 Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

OR

1.2.3 The patient exhibited improvement, or maintenance of previous improvement, in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

OR

1.2.4 Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so

OR

1.3 Hammersmith Functional Motor Scale Expanded (HFMSE) with ONE of the following:

1.3.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.3.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.4 Revised Upper Limb Module (RULM) with ONE of the following:

1.4.1 Improvement or maintenance of previous improvement of at least a 2-point increase in score from pretreatment baseline

OR

1.4.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.5 Motor Function Measure 32 (MFM-32) with ONE of the following:

1.5.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.5.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

AND

2 - Patient is not dependent on invasive ventilation or tracheostomy

AND

3 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

4 - Patient is not receiving concomitant chronic SMN-modifying therapy [e.g., Spinraza (nusinersen)]

AND

5 - Patient has not previously received gene replacement therapy for the treatment of spinal muscular atrophy (SMA) [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

6 - Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA

2 . Revision History

Date	Notes
9/9/2024	Annual review. Revised prescriber requirement and updated Upper Li mb Module to Revised Upper Limb Module test. Updated references.

Evrysdi

Prior Authorization Guideline

Guideline ID	GL-146519
Guideline Name	Evrysdi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Evrysdi	
Diagnosis	Spinal Muscular Atrophy (SMA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EVRYSDI	RISDIPLAM FOR SOLN 0.75 MG/ML	74706560002120	Brand

Approval Criteria

1 - Diagnosis of spinal muscular atrophy (SMA)

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following:

2.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

2.2 Compound heterozygous mutation of SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - Patient is not receiving concomitant chronic survival motor neuron (SMN)-modifying therapy [e.g., Spinraza (nusinersen)]

AND

6 - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

7 - Submission of medical records (e.g., chart notes, laboratory values) documenting the baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN-modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test
- Motor Function Measure 32 (MFM-32) Scale

AND

8 - Prescribed by a neurologist with expertise in the treatment of SMA

Notes	*Baseline assessments for patients less than 2 months of age request ing Evrysdi are not necessary in order not to delay access to initial the rapy in recently diagnosed infants. Initial assessments shortly post-the rapy can serve as baseline with respect to efficacy reauthorization ass essment.

Product Name: Evrysdi	
Diagnosis	Spinal Muscular Atrophy (SMA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EVRYSDI	RISDIPLAM FOR SOLN 0.75 MG/ML	74706560002120	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) with the most recent

results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status [inclusive of baseline assessments prior to receipt of previous chronic survival motor neuron (SMN)-modifying therapy] as demonstrated by at least ONE of the following exams:

1.1 Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) with ONE of the following:

1.1.1 Improvement or maintenance of previous improvement of at least a 4-point increase in score from pretreatment baseline

OR

1.1.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.2 Hammersmith Infant Neurological Exam Part 2 (HINE-2) with ONE of the following:

1.2.1 Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick

OR

1.2.2 Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

OR

1.2.3 The patient exhibited improvement, or maintenance of previous improvement, in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

OR

1.2.4 Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so

OR

1.3 Hammersmith Functional Motor Scale Expanded (HFMSE) with ONE of the following:

1.3.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.3.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.4 Upper Limb Module (ULM) with ONE of the following:

1.4.1 Improvement or maintenance of previous improvement of at least a 2-point increase in score from pretreatment baseline

OR

1.4.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.5 Motor Function Measure 32 (MFM-32) with ONE of the following:

1.5.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.5.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

AND

2 - Patient is not dependent on invasive ventilation or tracheostomy

AND

3 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

4 - Patient is not receiving concomitant chronic SMN-modifying therapy [e.g., Spinraza (nusinersen)]

AND

5 - Patient has not previously received gene replacement therapy for the treatment of spinal muscular atrophy (SMA) [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

6 - Prescribed by a neurologist with expertise in the treatment of SMA

Exkivity

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146520
Guideline Name	Exkivity
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Exkivity	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EXKIVITY	MOBOCERTINIB SUCCINATE CAP 40 MG	21360050600120	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is locally advanced or metastatic

AND

3 - Disease is epidermal growth factor receptor (EGFR) exon 20 insertion mutation positive

AND

4 - Subsequent therapy for disease that has progressed on or after platinum-based chemotherapy

Product Name: Exkivity	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EXKIVITY	MOBOCERTINIB SUCCINATE CAP 40 MG	21360050600120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Exkivity therapy

Product Name: Exkivity	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EXKIVITY	MOBOCERTINIB SUCCINATE CAP 40 MG	21360050600120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Exkivity	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EXKIVITY	MOBOCERTINIB SUCCINATE CAP 40 MG	21360050600120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Exkivity therapy

Fabhalta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148058
Guideline Name	Fabhalta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Fabhalta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FABHALTA	IPTACOPAN HCL CAP 200 MG	85807535200130	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the

diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following:

1.1 Flow cytometry analysis confirming presence of PNH clones

AND

1.2 Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

2 - ONE of the following:

2.1 Patient will not be prescribed Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, Soliris, Ultomiris)

OR

2.2 Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the United States Food and Drug Administration approved labeling

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist

Product Name: Fabhalta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FABHALTA	IPTACOPAN HCL CAP 200 MG	85807535200130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Fabhalta therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.)

AND

2 - Patient is not receiving Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, Soliris, Ultomiris)

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist

2 . Revision History

Date	Notes
6/4/2024	Simplified criteria language for converting to new complement inhibit or therapy.

Fasenra

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154990
Guideline Name	Fasenra
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Fasenra Pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FASENRA PEN	BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML	4460402000D520	Brand

Approval Criteria

1 - Patient has been established on therapy with Fasenra under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma

AND

2 - Documentation of positive clinical response to Fasenra therapy as demonstrated by ONE of the following:

2.1 Reduction in the frequency of exacerbations

OR

2.2 Decreased utilization of rescue medications

OR

2.3 Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline

OR

2.4 Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

OR

2.5 Reduction in oral corticosteroid requirements

AND

3 - Fasenra is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

4 - Patient is NOT receiving Fasenra in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Nucala (mepolizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Fasenra Pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FASENRA PEN	BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML	4460402000D520	Brand

Approval Criteria

1 - Diagnosis of severe asthma

AND

2 - Classification of asthma as uncontrolled or inadequately controlled as defined by ONE of the following:

2.1 Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20]

OR

2.2 Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months

OR

2.3 Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)

OR

2.4 Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal)]

OR

2.5 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

4 - Fasenra will be used in combination with ONE of the following:

4.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., fluticasone/salmeterol (authorized generic of AirDuo), fluticasone propionate/salmeterol diskus (generic for Advair Diskus), Wixela Inhub (generic for Advair Diskus), Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol), Dulera (mometasone/formoterol)]

OR

4.2 Combination therapy including BOTH of the following:

4.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR), Arnuity Ellipta (fluticasone furoate)]

AND

4.2.2 ONE additional asthma controller medication [e.g., LABA - Striverdi (olodaterol) or Arcapta (indacaterol); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

5 - Patient is NOT receiving Fasenra in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Nucala (mepolizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Fasenra Pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FASENRA PEN	BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML	4460402000D520	Brand

Approval Criteria

1 - Documentation of positive clinical response as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

2 - Used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is NOT receiving Fasenra in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Nucala (mepolizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

2 . Revision History

Date	Notes
9/16/2024	Modified criteria for existing prior authorization for under the medical benefit.

Febuxostat

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146331
Guideline Name	Febuxostat
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic febuxostat			
Approval Length	12 month(s)		
Guideline Type	Step Therapy		

Product Name	Generic Name	GPI	Brand/Generic
FEBUXOSTAT	FEBUXOSTAT TAB 40 MG	68000030000320	Generic
FEBUXOSTAT	FEBUXOSTAT TAB 80 MG	68000030000330	Generic

Approval Criteria

1 - Failure to allopurinol (generic Zyloprim) as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to allopurinol (generic Zyloprim) (please specify contraindication or intolerance)

Fentanyl IR

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155738
Guideline Name	Fentanyl IR
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Fentanyl citrate lozenges (generic Actiq)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Generic

FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Generic
FENTANYL CITRATE ORAL TRANSMUCOSAL	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Generic

Approval Criteria

1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented)

AND

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Oral morphine sulfate at a doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oral oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- Oral hydrocodone at a dose of greater than or equal to 60 mg/day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

Product Name: Brand Actiq, Brand Fentora, fentanyl citrate buccal tablet (authorized generic of Fentora)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 100 MCG (BASE EQUIV)	65100025100310	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Generic
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic
FENTORA	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Generic

ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 200 MCG	65100025108450	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 400 MCG	65100025108455	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 600 MCG	65100025108460	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 800 MCG	65100025108465	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1200 MCG	65100025108475	Brand
ACTIQ	FENTANYL CITRATE LOZENGE ON A HANDLE 1600 MCG	65100025108485	Brand
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 200 MCG (BASE EQUIV)	65100025100320	Brand
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 400 MCG (BASE EQUIV)	65100025100330	Brand
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 600 MCG (BASE EQUIV)	65100025100340	Brand
FENTANYL CITRATE	FENTANYL CITRATE BUCCAL TAB 800 MCG (BASE EQUIV)	65100025100350	Brand

Approval Criteria

1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented)

AND

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Oral morphine sulfate at a doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oral oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- Oral hydrocodone at a dose of greater than or equal to 60 mg/day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

AND

5 - One of the following:

- Failure to fentanyl citrate lozenges (generic Actiq) confirmed by claims history or submission of medical records
- History of intolerance or contraindication to fentanyl citrate lozenges (generic Actiq) (document intolerance or contraindication)

2 . Revision History

Date	Notes
9/23/2024	Removed Lazanda and Subsys as they are no longer on the market.

Filspari

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146523
Guideline Name	Filspari
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Filspari	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FILSPARI	SPARSENTAN TAB 200 MG	56483065000320	Brand
FILSPARI	SPARSENTAN TAB 400 MG	56483065000340	Brand

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

AND

2 - Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

3 - Used to reduce proteinuria

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m2

AND

5 - BOTH of the following:

5.1 Patient is on a maximized stable dose with ONE of the following prior to initiating therapy confirmed by claims history or submitted medical records

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

5.2 Use of renin-angiotensin-aldosterone system (RAAS) inhibitors (e.g., ACE inhibitors, ARBs), endothelin receptor antagonists [(ERAs) e.g., Letairis, Opsumit, Tracleer)], and Tekturna will be discontinued prior to initiating treatment

AND

6 - ONE of the following:

6.1 Failure to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records.

OR

6.2 History of contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) (please specify intolerance or contraindication)

AND

7 - Prescribed by or in consultation with a nephrologist

Product Name: Filspari	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FILSPARI	SPARSENTAN TAB 200 MG	56483065000320	Brand
FILSPARI	SPARSENTAN TAB 400 MG	56483065000340	Brand

Approval Criteria

1 - Documentation of positive clinical response demonstrated by a reduction in proteinuria

Filsuvez

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147343
Guideline Name	Filsuvez
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Filsuvez	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FILSUVEZ	BIRCH TRITERPENES GEL 10%	90944020004030	Brand

Approval Criteria

1 - Patient is at least 6 months of age or older

AND

2 - One of the following diagnoses:

- Dystrophic epidermolysis bullosa (DEB)
- Junctional epidermolysis bullosa (JEB)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) confirming a genetic mutation associated with DEB or JEB (i.e., COL7A1, LAMA3, LAMB3, LAMC2, COL17A1, ITGA6, ITGB4, ITGA3)

AND

4 - Patient has at least one partial thickness wound that meets ALL of the following criteria:

- 10-50 cm2 in size
- Present for at least 3 weeks
- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection
- No evidence or history of basal or squamous cell carcinomas (SCC)

AND

5 - Prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)

AND

6 - Patient is NOT receiving Filsuvez in combination with Vyjuvek on the same wound(s)

Product Name: Filsuvez	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FILSUVEZ	BIRCH TRITERPENES GEL 10%	90944020004030	Brand

Approval Criteria

1 - Documentation of positive clinical response to Filsuvez therapy (e.g., complete wound closure, reduction in wound size, decrease in procedural pain, less frequent dressing changes, decreased total body wound burden)

AND

2 - Wound(s) being treated meets ALL of the following criteria:

- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection
- No evidence or history of basal or squamous cell carcinomas (SCC)

AND

3 - Filsuvez is prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)

AND

4 - Patient is not receiving Filsuvez in combination with Vyjuvek on the same wound(s)

2 . Revision History

Date	Notes
5/13/2024	Copy core

Firazyr, Sajazir

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148035
Guideline Name	Firazyr, Sajazir
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Sajazir, Brand Firazyr, generic icatibant	
Diagnosis	Hereditary angioedema (HAE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SAJAZIR	ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML	8582004010E520	Generic
FIRAZYR	ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML	8582004010E520	Brand
ICATIBANT ACETATE	ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML	8582004010E520	Generic

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - Prescribed for the acute treatment of HAE attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Kalbitor, or Ruconest)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name: Sajazir, Brand Firazyr, generic icatibant	
Diagnosis	Hereditary angioedema (HAE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SAJAZIR	ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML	8582004010E520	Generic
FIRAZYR	ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML	8582004010E520	Brand
ICATIBANT ACETATE	ICATIBANT ACETATE SUBCUTANEOUS SOLN PREF SYR 30 MG/3ML	8582004010E520	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed for the acute treatment of hereditary angioedema (HAE) attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Kalbitor, or Ruconest)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
6/3/2024	Update to types of genetic variant(s) and diagnostic criteria with nor mal C1 inhibitor levels in initial auth section and minor language upd ate in reauth section.

Firdapse

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146525
Guideline Name	Firdapse
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Firdapse	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FIRDAPSE	AMIFAMPRIDINE PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	76000012100320	Brand

Approval Criteria

1 - Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)

AND

2 - Prescribed by or in consultation with a specialist in the treatment of LEMS (e.g., neurologist or oncologist)

AND

3 - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine)]

Product Name: Firdapse	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FIRDAPSE	AMIFAMPRIDINE PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	76000012100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Firdapse therapy

AND

2 - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine)]

Fortamet, Glumetza

Prior Authorization Guideline

Guideline ID	GL-146333
Guideline Name	Fortamet, Glumetza
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic metformin extended-release (generic Fortamet)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR OSMOTIC 500 MG	27250050007560	Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR OSMOTIC 1000 MG	27250050007570	Generic
Fortamet			

Approval Criteria

1 - History of greater than or equal to 12-week trial of metformin extended-release (generic Glucophage XR) as confirmed by claims history or submission of medical records

AND

2 - One of the following:

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

Product Name: Brand Glumetza, generic metformin extended-release (generic Glumetza)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 500 MG	27250050007580	Generic
METFORMIN HYDROCHLORIDE ER	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 1000 MG	27250050007590	Generic
GLUMETZA	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 500 MG	27250050007580	Brand
GLUMETZA	METFORMIN HCL TAB ER 24HR MODIFIED RELEASE 1000 MG	27250050007590	Brand

Approval Criteria

1 - History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR) as confirmed by claims history or submission of medical records

AND

2 - One of the following:

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

3 - History of greater than or equal to 12 week trial of metformin extended-release (generic Fortamet) as confirmed by claims history or submission of medical records

AND

4 - One of the following:

4.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Fortamet) as evidenced by the hemoglobin A1c level being above the patient's goal

OR

4.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Fortamet) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

5 - Submission of article(s) published in the peer-reviewed medical literature showing that the requested drug is likely to be more efficacious to this patient than metformin extended-release (generic Glucophage XR AND generic Fortamet)

Forteo

Prior Authorization Guideline

Guideline ID	GL-146526
Guideline Name	Forteo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Forteo, Teriparatide	
Diagnosis	Osteoporosis
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TERIPARATIDE	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML	3004407000D221	Brand
FORTEO	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML	3004407000D220	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Patient is female
- Diagnosis of postmenopausal osteoporosis

OR

1.2 BOTH of the following:

- Patient is male
- Diagnosis of osteoporosis

AND

2 - ONE of the following:

2.1 Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than -3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%)]

OR

2.2 Patient has a history of failure to at least one other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate) as confirmed by claims history or submission of medical records

OR

2.3 Patient has contraindication or intolerance to at least one other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate) (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., teriparatide injection, Forteo, Tymlos) during the patient's lifetime

OR

3.2 BOTH of the following:

3.2.1 Patient is currently or has previously been treated with parathyroid hormone analogs (e.g., teriparatide injection, Forteo, Tymlos)

AND

3.2.2 The prescriber attests that the patient remains at or has returned to having a high risk for fracture

AND

4 - ONE of the following:

- Failure to Tymlos as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Tymlos (please specify contraindication or intolerance)

Product Name: Forteo, Teriparatide	
Diagnosis	Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TERIPARATIDE	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML	3004407000D221	Brand
FORTEO	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML	3004407000D220	Brand

Approval Criteria

1 - Diagnosis of glucocorticoid-induced osteoporosis

AND

2 - History of prednisone or its equivalent at a dose greater than or equal to 5 mg (milligrams)/day as confirmed by claims history or submission of medical records

AND

3 - ONE of the following:

3.1 Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than -3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%)]

OR

3.2 Patient has a history of failure to at least one other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate) as confirmed by claims history or submission of medical records

OR

3.3 Patient has contraindication or intolerance to at least one other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate) (please specify contraindication or intolerance)

AND

4 - ONE of the following:

4.1 Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., teriparatide injection, Forteo, Tymlos)

OR

4.2 BOTH of the following:

4.2.1 Patient is currently or has previously been treated with parathyroid hormone analogs (e.g., teriparatide injection, Forteo, Tymlos)

AND

4.2.2 The prescriber attests that the patient remains at or has returned to having a high risk for fracture

Product Name: Forteo, Teriparatide	
Diagnosis	Osteoporosis, Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TERIPARATIDE	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 620 MCG/2.48ML	3004407000D221	Brand
FORTEO	TERIPARATIDE (RECOMBINANT) SOLN PEN-INJ 600 MCG/2.4ML	3004407000D220	Brand

Approval Criteria

1 - Treatment duration of parathyroid hormones (e.g., teriparatide injection, Forteo, Tymlos) has not exceeded a total of 24 months during the patient's lifetime

OR

2 - The patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones (e.g., teriparatide injection, Forteo, Tymlos)

Fotivda

Prior Authorization Guideline

Guideline ID	GL-146527
Guideline Name	Fotivda
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Fotivda	
Diagnosis	Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FOTIVDA	TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT)	21533076250120	Brand
FOTIVDA	TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT)	21533076250130	Brand

Approval Criteria

1 - Diagnosis of advanced renal cell carcinoma (RCC)

AND

2 - ONE of the following:

- Disease has relapsed
- Disease is refractory

AND

3 - Patient has received two or more prior systemic therapies

Product Name: Fotivda	
Diagnosis	Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FOTIVDA	TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT)	21533076250120	Brand
FOTIVDA	TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT)	21533076250130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Fotivda therapy

Product Name: Fotivda	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FOTIVDA	TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT)	21533076250120	Brand
FOTIVDA	TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT)	21533076250130	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Fotivda	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FOTIVDA	TIVOZANIB HCL CAP 0.89 MG (BASE EQUIVALENT)	21533076250120	Brand
FOTIVDA	TIVOZANIB HCL CAP 1.34 MG (BASE EQUIVALENT)	21533076250130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Fotivda therapy

Fruzaqla

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146528
Guideline Name	Fruzaqla
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Fruzaqla	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FRUZAQLA	FRUQUINTINIB CAP 1 MG	21335035000120	Brand
FRUZAQLA	FRUQUINTINIB CAP 5 MG	21335035000140	Brand

Approval Criteria

1 - Diagnosis of colorectal cancer

AND

2 - Disease of ONE of the following:

- Advanced
- Metastatic

AND

3 - Patient has been previously treated with ALL of the following:

- Fluoropyrimidine-based chemotherapy (e.g., capecitabine, 5-FU)
- Oxaliplatin-based chemotherapy (e.g., CAPEOX, FOLFOX)
- Irinotecan-based chemotherapy (e.g., FOLFIRI, FOLFIRINOX)
- Anti-VEGF therapy (e.g., aflibercept, bevacizumab, ramucirumab)

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Disease is RAS wild-type

AND

4.1.2 Patient has been previously treated with an anti-EGFR therapy (e.g., cetuximab, panitumumab)

OR

4.2 Disease is not RAS wild-type

Product Name: Fruzaqla	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FRUZAQLA	FRUQUINTINIB CAP 1 MG	21335035000120	Brand
FRUZAQLA	FRUQUINTINIB CAP 5 MG	21335035000140	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Fruzaqla therapy

Product Name: Fruzaqla	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FRUZAQLA	FRUQUINTINIB CAP 1 MG	21335035000120	Brand
FRUZAQLA	FRUQUINTINIB CAP 5 MG	21335035000140	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Fruzaqla	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FRUZAQLA	FRUQUINTINIB CAP 1 MG	21335035000120	Brand
FRUZAQLA	FRUQUINTINIB CAP 5 MG	21335035000140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Fruzaqla therapy

Furoscix

Prior Authorization Guideline

Guideline ID	GL-146334
Guideline Name	Furoscix
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Furoscix	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FUROSCIX	FUROSEMIDE SUBCUTANEOUS CARTRIDGE KIT 80 MG/10ML	3720003000F720	Brand

Approval Criteria

1 - Diagnosis of chronic heart failure

AND

2 - Heart failure is classified as ONE of the following:

2.1 New York Heart Association (NYHA) class II heart failure

OR

2.2 New York Heart Association (NYHA) class III heart failure

AND

3 - Patient has signs or symptoms of congestion due to fluid overload

AND

4 - Patient is established on background loop diuretic therapy (e.g., furosemide, torsemide, bumetanide)

AND

5 - Both of the following:

5.1 Patient does not require ongoing emergency care or hospitalization for heart failure, acute pulmonary edema, or other conditions

AND

5.2 Patient is currently a candidate for parenteral diuresis outside of the hospital

AND

6 - Patient has an estimated creatine clearance greater than 30ml/min

AND

7 - Furoscix is prescribed by or in consultation with a cardiologist

Galafold

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146529
Guideline Name	Galafold
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Galafold	
Diagnosis	Fabry Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GALAFOLD	MIGALASTAT HCL CAP 123 MG (BASE EQUIVALENT)	30903650100120	Brand

Approval Criteria

1 - Diagnosis of Fabry disease

AND

2 - Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data

AND

3 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta) or Elfabrio (pegunigalsidase alfa-iwxj)

Product Name: Galafold	
Diagnosis	Fabry Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GALAFOLD	MIGALASTAT HCL CAP 123 MG (BASE EQUIVALENT)	30903650100120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Galafold therapy

AND

2 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta) or Elfabrio (pegunigalsidase alfa-iwxj)

Gattex

Prior Authorization Guideline

Guideline ID	GL-146530
Guideline Name	Gattex
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Gattex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GATTEX	TEDUGLUTIDE (RDNA) FOR INJ KIT 5 MG	52533070006420	Brand

Approval Criteria

1 - Diagnosis of Short Bowel Syndrome (SBS)

AND

2 - Dependent on parenteral support

Product Name: Gattex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GATTEX	TEDUGLUTIDE (RDNA) FOR INJ KIT 5 MG	52533070006420	Brand

Approval Criteria

1 - Documentation of positive clinical response to Gattex therapy

Gavreto

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146531
Guideline Name	Gavreto
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Gavreto	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GAVRETO	PRALSETINIB CAP 100 MG	21535750000120	Brand

Approval Criteria

1 - Patient has a diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

3 - There is presence of RET rearrangement positive tumors

Product Name: Gavreto	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GAVRETO	PRALSETINIB CAP 100 MG	21535750000120	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.3 Disease is RET gene fusion positive

AND

1.4 Disease is not amenable to radioactive iodine therapy

OR

2 - ALL of the following:

2.1 Diagnosis of medullary carcinoma

AND

2.2 ONE of the following:

- Disease is recurrent, persistent, or progressive
- Disease is symptomatic with distant metastases

AND

2.3 Disease is RET-mutation positive

OR

3 - ALL of the following:

3.1 Diagnosis of anaplastic carcinoma

AND

3.2 ONE of the following:

- Disease is stage IVA or IVB (locoregional)
- Disease is metastatic

AND

3.3 Disease is RET gene fusion positive

Product Name: Gavreto	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GAVRETO	PRALSETINIB CAP 100 MG	21535750000120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic cholangiocarcinoma
- Intrahepatic cholangiocarcinoma

AND

2 - Disease is ONE of the following:

- Unresectable
- Resected gross residual (R2)

- Metastatic

AND

3 - Disease is RET gene fusion positive

Product Name: Gavreto	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Thyroid Carcinoma, Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GAVRETO	PRALSETINIB CAP 100 MG	21535750000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Gavreto therapy

Product Name: Gavreto	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GAVRETO	PRALSETINIB CAP 100 MG	21535750000120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Gavreto	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GAVRETO	PRALSETINIB CAP 100 MG	21535750000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Gavreto therapy

Genvoya and Stribild

Prior Authorization Guideline

Guideline ID	GL-146335
Guideline Name	Genvoya and Stribild
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Genvoya, Stribild	
Diagnosis	Human Immunodeficiency Virus (HIV)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GENVOYA	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOV AF TAB 150-150-200-10 MG	12109904290315	Brand
STRIBILD	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOVDF TAB 150-150-200-300 MG	12109904300320	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)

AND

2 - ONE of the following:

2.1 Patient is not an appropriate candidate for ALL of the following (please specify why patient is not a candidate):

- efavirenz/emtricitabine/tenofovir disoproxil (generic Atripla)
- Triumeq (abacavir/dolutegravir/lamivudine)
- Juluca (dolutegravir/rilpivirine)
- Dovato (dolutegravir/lamivudine)

OR

2.2 Patient is currently on Genvoya or Stribild therapy

Product Name: Genvoya, Stribild	
Diagnosis	Post-Exposure Prophylaxis
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GENVOYA	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOV AF TAB 150-150-200-10 MG	12109904290315	Brand
STRIBILD	ELVITEGRAV-COBIC-EMTRICITAB-TENOFOVDF TAB 150-150-200-300 MG	12109904300320	Brand

Approval Criteria

1 - Diagnosis of post-exposure prophylaxis

Gilotrif

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146532
Guideline Name	Gilotrif
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Gilotrif	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GILOTRIF	AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT)	21360006100320	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT)	21360006100330	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT)	21360006100340	Brand

Approval Criteria

1 - Diagnosis of metastatic non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

- Squamous disease progressing after previous platinum-based chemotherapy
- Tumors are positive for non-resistant epidermal growth factor receptor (EGFR) mutations

Product Name: Gilotrif	
Diagnosis	Advanced Non-Nasopharyngeal Head and Neck Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GILOTRIF	AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT)	21360006100320	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT)	21360006100330	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT)	21360006100340	Brand

Approval Criteria

1 - Diagnosis of advanced, non-nasopharyngeal head and neck cancer

AND

2 - Disease has progressed on or after platinum-containing chemotherapy

Product Name: Gilotrif	
Diagnosis	Brain Metastases
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GILOTRIF	AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT)	21360006100320	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT)	21360006100330	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT)	21360006100340	Brand

Approval Criteria

1 - Diagnosis of brain metastasis due to EGFR (epidermal growth factor receptor)-sensitizing mutation positive non-small cell lung cancer

Product Name: Gilotrif	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Advanced Non-Nasopharyngeal Head and Neck Cancer, Brain Metastases
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GILOTRIF	AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT)	21360006100320	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT)	21360006100330	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT)	21360006100340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Gilotrif therapy

Product Name: Gilotrif	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GILOTRIF	AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT)	21360006100320	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT)	21360006100330	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT)	21360006100340	Brand

Approval Criteria

1 - Gilotrif will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Gilotrif	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GILOTRIF	AFATINIB DIMALEATE TAB 20 MG (BASE EQUIVALENT)	21360006100320	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 30 MG (BASE EQUIVALENT)	21360006100330	Brand
GILOTRIF	AFATINIB DIMALEATE TAB 40 MG (BASE EQUIVALENT)	21360006100340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Gilotrif therapy

Gleevec

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146533
Guideline Name	Gleevec
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Chronic Myelogenous/Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic

GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of chronic myelogenous/myeloid leukemia (CML)

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Myelodysplastic Disease (MDS)/Myeloproliferative Disease (MPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD)

AND

2 - Platelet-derived growth factor receptor (PDGFR) gene re-arrangements

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Aggressive Systemic Mastocytosis (ASM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of aggressive systemic mastocytosis (ASM)

AND

2 - ONE of the following:

- Kit D816V mutation negative or unknown
- Well-differentiated SM [WDSM]
- Eosinophilia is present with FIP1L1-PDGFRA fusion gene

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Hypereosinophilic Syndrome (HES)/Chronic Eosinophilic Leukemia (CEL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of at least ONE of the following:

- Hypereosinophilic syndrome (HES)
- Chronic eosinophilic leukemia (CEL)

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Dermatofibrosarcoma Protuberans (DFSP)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of dermatofibrosarcoma protuberans (DFSP)

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gastrointestinal stromal tumors (GIST)
- Desmoid tumors/aggressive fibromatosis
- Pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT)

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of chordoma

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand

IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of melanoma

AND

2 - Patient has C-KIT (gene) mutation

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	AIDS-Related Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi Sarcoma

AND

2 - Not used as first line therapy

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Steroid-Refractory Chronic Graft-Versus-Host Disease (GVHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of chronic graft-versus-host disease

AND

2 - Patient is being treated with systemic corticosteroids

AND

3 - Patient had no response to first-line therapy options

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - ONE of the following:

- FIP1L1-PDGFRA rearrangement
- PDGFRB rearrangement
- ABL1 rearrangement

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	All Indications except NCCN
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand

IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Gleevec therapy

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Gleevec, generic imatinib	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Generic
GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21531835100320	Brand
IMATINIB MESYLATE	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Generic
GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21531835100340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Gleevec therapy

GLP-1 & Dual GIP/GLP-1 Receptor Agonists

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156323
Guideline Name	GLP-1 & Dual GIP/GLP-1 Receptor Agonists
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Victoza 1.2mg per day (2 Pen Pack), liraglutide 1.2mg per day (2 Pen Pack), Mounjaro, Ozempic, Rybelsus	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 2.5 MG/0.5ML	2717308000D510	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML	2717308000D515	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML	2717308000D520	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML	2717308000D525	Brand

MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML	2717308000D530	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML	2717308000D535	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/3ML)	2717007000D221	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 1 MG/DOSE (4 MG/3ML)	2717007000D222	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 2 MG/DOSE (8 MG/3ML)	2717007000D225	Brand
RYBELSUS	SEMAGLUTIDE TAB 3 MG	27170070000310	Brand
RYBELSUS	SEMAGLUTIDE TAB 7 MG	27170070000320	Brand
RYBELSUS	SEMAGLUTIDE TAB 14 MG	27170070000330	Brand
LIRAGLUTIDE	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Generic
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Generic
MOUNJARO	TIRZEPATIDE SOLN AUTO-INJECTOR 2.5 MG/0.5ML	2717308000D510	Brand
MOUNJARO	TIRZEPATIDE SOLN AUTO-INJECTOR 5 MG/0.5ML	2717308000D515	Brand
MOUNJARO	TIRZEPATIDE SOLN AUTO-INJECTOR 7.5 MG/0.5ML	2717308000D520	Brand
MOUNJARO	TIRZEPATIDE SOLN AUTO-INJECTOR 10 MG/0.5ML	2717308000D525	Brand
MOUNJARO	TIRZEPATIDE SOLN AUTO-INJECTOR 12.5 MG/0.5ML	2717308000D530	Brand
MOUNJARO	TIRZEPATIDE SOLN AUTO-INJECTOR 15 MG/0.5ML	2717308000D535	Brand

Approval Criteria

1 - Confirmation of type 2 diabetes mellitus via medical records (i.e., medical documentation confirming type 2 diabetes mellitus, medical claims history) or prescriber attestation

AND

2 - ONE of the following:

2.1 Suboptimal response (i.e., suboptimal glycemic control) to one product, or a combination thereof, from ONE of the following drugs/classes for 90 days in the past 365 days, as confirmed by claims history or submission of medical records

- Metformin
- Metformin combinations
- DPP-4 inhibitors
- DPP-4 inhibitor combinations
- SGLT2 inhibitors
- SGLT2 inhibitor combinations
- Sulfonylureas

OR

2.2 History of contraindication or intolerance to ONE product from any of the following drugs/classes: (please specify contraindication or intolerance)

- Metformin
- Metformin combinations
- DPP-4 inhibitors
- DPP-4 inhibitor combinations
- SGLT2 inhibitors
- SGLT2 inhibitor combinations
- Sulfonylureas

Product Name: Victoza 1.8mg per day (3 Pen Pack), liraglutide 1.8mg per day (3 Pen Pack)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Brand
LIRAGLUTIDE	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Generic
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Generic

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to metformin (please specify contraindication or intolerance)

AND

3 - History of failure to achieve acceptable glycemic control with Victoza 1.2mg per day for 90 days (2 Pen Pack), as confirmed by claims history or submission of medical records

Product Name: Bydureon BCise, Byetta, Trulicity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BYDUREON BCISE	EXENATIDE EXTENDED RELEASE SUSP AUTO-INJECTOR 2 MG/0.85ML	2717002000D420	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML	2717002000D220	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML	2717002000D240	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 0.75 MG/0.5ML	2717001500D520	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML	2717001500D530	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML	2717001500D540	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML	2717001500D550	Brand
TRULICITY	DULAGLUTIDE SOLN AUTO-INJECTOR 0.75 MG/0.5ML	2717001500D520	Brand
TRULICITY	DULAGLUTIDE SOLN AUTO-INJECTOR 1.5 MG/0.5ML	2717001500D530	Brand
TRULICITY	DULAGLUTIDE SOLN AUTO-INJECTOR 3 MG/0.5ML	2717001500D540	Brand

TRULICITY	DULAGLUTIDE SOLN AUTO-INJECTOR 4.5 MG/0.5ML	2717001500D550	Brand

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus confirmed by submission of medical records (i.e., chart notes, medical claims history)

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin (i.e., suboptimal glycemic control) at a minimum dose of 1500mg daily for 90 days, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to metformin (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Suboptimal response (i.e., suboptimal glycemic control) to both of the following, each for a minimum of 90 days, as confirmed by claims history or submission of medical records:

- A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus)
- Mounjaro

OR

3.2 History of contraindication or intolerance to both of the following (please specify contraindication or intolerance)

- A commercially available semaglutide product indicated for type 2 diabetes mellitus (e.g., Ozempic, Rybelsus)

• Mounjaro

2 . Revision History

Date	Notes
9/26/2024	Added liraglutide

Gonadotropin-Releasing Hormone Agonists

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152546
Guideline Name	Gonadotropin-Releasing Hormone Agonists
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: leuprolide acetate inj kit 5 mg/mL, Lupron Depot-Ped, Triptodur, Fensolvi	
Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand

LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - Diagnosis of central precocious puberty (idiopathic or neurogenic)

AND

2 - Onset of secondary sexual characteristics in ONE of the following:

2.1 Females less than or equal to 8 years of age

OR

2.2 Males less than or equal to 9 years of age

AND

3 - Confirmation of diagnosis as defined by ONE of the following:

3.1 Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)

OR

3.2 A pubertal luteinizing hormone response to a gonadotropin releasing hormone (GnRH) stimulation test

OR

3.3 Bone age advanced one year beyond the chronological age

AND

4 - If the request is for Triptodur or Fensolvi, ONE of the following:

4.1 Failure to Lupron-Depot Ped as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Lupron-Depot Ped (please specify intolerance or contraindication)

Product Name: leuprolide acetate inj kit 5 mg/mL, Lupron Depot-Ped, Triptodur, Fensolvi	
Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand

LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - Patient is currently receiving therapy for central precocious puberty

AND

2 - Documentation of positive clinical response to therapy (e.g., decrease in height velocity, cessation of menses, arrest pubertal progression, reduction in bone age advancement)

AND

3 - Patient is currently younger than the appropriate time point for the onset of puberty, as ONE of the following:

3.1 Female younger than 11 years of age

OR

3.2 Male younger than 12 years of age

Product Name: Lupron Depot 3.75 mg and 3-month 11.25 mg

Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand

Approval Criteria

1 - Diagnosis of endometriosis or endometriosis is suspected

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following classes as confirmed by claims history or submission of medical records:

- Oral contraceptives or depot medroxyprogesterone (e.g., Depo-Provera)
- Non-steroidal anti-inflammatory drugs (NSAIDs)

OR

2.2 History of intolerance or contraindication to BOTH of the following classes (please specify intolerance or contraindication):

- Oral contraceptives or depot medroxyprogesterone (e.g., Depo-Provera)
- Non-steroidal anti-inflammatory drugs (NSAIDs)

OR

2.3 Patient has had surgical ablation to prevent recurrence

Product Name: Lupron Depot 3.75 mg and 3-month 11.25 mg	
Diagnosis	Endometriosis
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand

Approval Criteria

1 - Diagnosis of endometriosis or endometriosis is suspected

AND

2 - Recurrence of symptoms following an initial course of therapy

AND

3 - Concurrently to be used with add-back therapy (e.g., progestin, estrogen, or bone sparing agents)

AND

4 - Treatment duration has not exceeded a total of 12 months, as confirmed by claims history or submission of medical records

Notes	Approval Length - Authorization will be issued for 6 months. Duration of both the initial and recurrent course of therapies is no longer than 1 2 months total.

Product Name: Lupron Depot 3.75 mg and 3-month 11.25 mg	
Diagnosis	Uterine Leiomyomata (Fibroids)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand

Approval Criteria

1 - ALL of the following:

1.1 For the treatment of uterine leiomyomata-related anemia

AND

1.2 Patient did not respond to iron therapy of 1 month duration

AND

1.3 For use prior to surgery

OR

2 - For use prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)

Product Name: Lupron Depot 7.5 mg, 22.5 mg, 30 mg, and 45 mg, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Prostate Cancer
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand
LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand

Approval Criteria

1 - For a diagnosis of advanced or metastatic prostate cancer, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

Product Name: Lupron Depot, Lupron Depot-Ped, Fensolvi, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Gender Dysphoria in Adolescents*
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand

LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand
LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional with expertise in child and adolescent psychiatry

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient has experienced puberty development to at least Tanner stage 2

AND

4 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following laboratory tests, based upon the laboratory reference range, confirming:

- Pubertal levels of estradiol in a female
- Pubertal levels of testosterone in a male
- Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)
- A pubertal luteinizing hormone response to a gonadotropin-releasing hormone (GnRH) stimulation test

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting a letter from the prescriber and/or formal documentation stating ALL of the following:

5.1 Patient has experienced pubertal changes that have resulted in an increase of their gender dysphoria that has significantly impaired psychological or social functioning

AND

5.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed

AND

5.3 BOTH of the following:

5.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

5.3.2 Patient will continue enrollment, attendance, and active participation in psychological and social support throughout the course of treatment

AND

5.4 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

Notes	*Please verify gender dysphoria is a coverable benefit for the patient.

Product Name: Lupron Depot, Lupron Depot-Ped, Fensolvi, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Gender Dysphoria in Adolescents*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand

LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following within the last 6 months:

- LH (luteinizing hormone) suppression assessing for appropriate suppression
- Change in dosing

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional with expertise in child and adolescent psychiatry

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in gender dysphoria hormone therapy

AND

4 - Submission of medical records (e.g., chart notes, laboratory values) documenting a letter from the prescriber and/or formal documentation stating ALL of the following:

4.1 Patient continues to meet their individual goals of therapy for gender dysphoria

AND

4.2 Patient continues to have a strong affinity for the desired (opposite of natal) gender

AND

4.3 Discontinuation of treatment and subsequent pubertal development would interfere with or impair psychological functioning and well-being

AND

4.4 Coexisting psychiatric and medical comorbidities or social problems that may interfere with treatment continue to be addressed or removed

AND

4.5 BOTH of the following:

4.5.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

4.5.2 Patient will continue enrollment, attendance, and active participation in psychological and social support throughout the course of treatment

AND

4.6 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

Notes	*Please verify gender dysphoria is a coverable benefit for the patient.

Product Name: Lupron Depot, Lupron Depot-Ped, Fensolvi, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults*
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand
LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand

LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting the

gonads (i.e., testes, ovaries) have not been removed and are functional (e.g., hormone producing)

AND

4 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

6 - Submission of medical records (e.g., chart notes, laboratory values) documenting a letter from the prescriber and/or formal documentation stating ALL of the following:

6.1 Transgender patient has identified goals of gender-affirming hormone therapy

AND

6.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed

AND

6.3 BOTH of the following:

6.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

6.3.2 Patient will continue enrollment, attendance, and active participation in psychological and social support throughout the course of treatment **AND** **6.4** Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

Notes	*Please verify gender dysphoria is a coverable benefit for the patient

Product Name: Lupron Depot, Lupron Depot-Ped, Fensolvi, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand
LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand

LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following within the last 6 months:

- Luteinizing hormone (LH) suppression assessing for appropriate suppression
- Change in dosing

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting the medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy

AND

4 - Submission of medical records (e.g., chart notes, laboratory values) documenting the gonads (i.e., testes, ovaries) are intact

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender

AND

6 - Submission of medical records (e.g., chart notes, laboratory values) documenting inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

7 - Submission of medical records (e.g., chart notes, laboratory values) documenting a letter from the prescriber and/or formal documentation stating ALL of the following:

7.1 Transgender patient continues to meet goals of gender-affirming hormone therapy

AND

7.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment continue to be addressed or removed

AND

7.3 BOTH of the following:

7.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

7.3.2 Patient will continue enrollment, attendance, and active participation in psychological and social support throughout the course of treatment

AND

7.4 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

Notes	*Please verify gender dysphoria is a coverable benefit for the patient

Product Name: Lupron Depot, Lupron Depot-Ped, Fensolvi, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Fertility Preservation
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand
LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand

LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - For use in pre-menopausal women

AND

2 - Patient is receiving a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

Product Name: Lupron Depot, Lupron Depot-Ped, Fensolvi, Triptodur, leuprolide acetate inj kit 5 mg/mL, leuprolide acetate (3 month) 22.5 mg inj	
Diagnosis	Fertility Preservation
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand
LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
FENSOLVI	LEUPROLIDE ACET (6 MONTH) FOR INJ PEDIATRIC KIT 45 MG	30080050256450	Brand
TRIPTODUR	TRIPTORELIN PAMOATE FOR IM ER SUSP 22.5 MG (BASE EQUIV)	3008007040G240	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE (3 MONTH) FOR INJ 22.5 MG	21405010152230	Brand
LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - Patient is currently receiving gonadotropin-releasing hormone (GnRH) analog therapy for the purpose of fertility preservation

AND

2 - Patient continues to receive a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

Product Name: leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Salivary Gland Tumors
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic

Approval Criteria

1 - For a diagnosis of salivary gland tumors, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

Product Name: leuprolide acetate inj kit 5 mg/mL	
Diagnosis	Uterine Sarcoma
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic

Approval Criteria

1 - For a diagnosis of uterine sarcoma, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

Product Name: Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL	
Diagnosis	NCCN Recommended Regimens
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	Brand
LUPRON DEPOT (1-MONTH)	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	Brand
LUPRON DEPOT (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	Brand
LUPRON DEPOT (4-MONTH)	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	Brand
LUPRON DEPOT (6-MONTH)	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	Brand
LUPRON DEPOT-PED (1-MONTH)	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 11.25 MG	30080050156420	Brand
LUPRON DEPOT-PED (3-MONTH)	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	Brand
LEUPROLIDE ACETATE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	Generic

LUPRON DEPOT-PED	LEUPROLIDE ACET (6 MONTH) FOR IM INJ PEDIATRIC KIT 45 MG	30080050256460	Brand

Approval Criteria

1 - For uses supported by the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, the requested medication is not delegated to OptumRx for review and should be processed as a medical benefit

2 . Revision History

Date	Notes
8/23/2024	Updated reauthorization criteria for CPP. Added uterine sarcoma.

Growth Hormone, Growth Stimulating Agents - Managed Medicaid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155812
Guideline Name	Growth Hormone, Growth Stimulating Agents - Managed Medicaid
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)*
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand

SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand

GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 ONE of the following:

1.1.1.1 All of the following:

- Infant is less than 4 months of age
- Infant has growth deficiency
- Prescribed by an endocrinologist

OR

1.1.1.2 BOTH of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Prescribed by an endocrinologist

OR

1.1.1.3 BOTH of the following:

- Diagnosis of panhypopituitarism
- Prescribed by an endocrinologist

AND

1.1.2 If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of pediatric growth hormone (GH) deficiency as confirmed by ONE of the following:

1.2.1.1 Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height

OR

1.2.1.2 Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

OR

1.2.1.3 Growth velocity is greater than 2 SD below mean for age and gender

OR

1.2.1.4 Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

1.2.2.2 Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

1.2.3 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.2.3.1 BOTH of the following:

1.2.3.1.1 Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

AND

1.2.3.1.2 BOTH GH response values are less than 10 micrograms per liter

OR

1.2.3.2 BOTH of the following:

1.2.3.2.1 Patient is less than 1 year of age

AND

1.2.3.2.2 ONE of the following is below the age and gender adjusted normal range as provided by the physician's lab:

- Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C)
- Insulin Growth Factor Binding Protein-3 (IGFBP-3)

AND

1.2.4 ONE of the following:

1.2.4.1 Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

OR

1.2.4.2 BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week

AND

1.2.5 Prescribed by an endocrinologist

AND

1.2.6 If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Notes	*Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH de ficiency, utilize criteria for Transition Phase Adolescent or Adult GH D eficiency.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand

OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:**

- Previous height and date obtained
- Current height and date obtained

AND

2 - BOTH of the following:**

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Calculated height (growth) velocity over the past 12 months

AND

4 - ONE of the following:

4.1 Patient is a male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

4.2 Patient is a female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

5 - ONE of the following:

5.1 Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

OR

5.2 BOTH of the following:

- Tanner Stage 3 or greater

• Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week **AND** **6** - Prescribed by an endocrinologist

Notes	*Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH de ficiency, utilize criteria for Transition Phase Adolescent or Adult GH D eficiency. **Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Skytrofa	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3 MG	3010000380E110	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3.6 MG	3010000380E115	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 4.3 MG	3010000380E120	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 5.2 MG	3010000380E125	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 6.3 MG	3010000380E130	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 7.6 MG	3010000380E135	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 9.1 MG	3010000380E140	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 11 MG	3010000380E145	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CART 13.3 MG	3010000380E150	Brand

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 ONE of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Diagnosis of panhypopituitarism

AND

1.1.2 Prescribed by an endocrinologist

AND

1.1.3 ONE of the following:

1.1.3.1 Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

1.1.3.2 History of intolerance or contraindication to TWO of the following (please specify intolerance or contraindication):

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of pediatric GH (growth hormone) deficiency as confirmed by ONE of the following:

1.2.1.1 Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height

OR

1.2.1.2 Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

OR

1.2.1.3 Growth velocity is greater than 2 SD below mean for age and gender

OR

1.2.1.4 Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

1.2.2.2 Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

1.2.3 Submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:

1.2.3.1 Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

AND

1.2.3.2 Both GH response values are less than 10 micrograms per liter

AND

1.2.4 One of the following:

1.2.4.1 Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

1.2.4.2 History of intolerance or contraindication to TWO of the following (please specify intolerance or contraindication):

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

AND

1.2.5 Prescribed by an endocrinologist

Product Name: Skytrofa	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3 MG	3010000380E110	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 3.6 MG	3010000380E115	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 4.3 MG	3010000380E120	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 5.2 MG	3010000380E125	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 6.3 MG	3010000380E130	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 7.6 MG	3010000380E135	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 9.1 MG	3010000380E140	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CARTRIDGE 11 MG	3010000380E145	Brand
SKYTROFA	LONAPEGSOMATROPIN-TCGD FOR SUBCUTANEOUS INJ CART 13.3 MG	3010000380E150	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - BOTH of the following:*

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Calculated height (growth) velocity over the past 12 months

AND

4 - ONE of the following:

4.1 Patient is a male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

4.2 Patient is a female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

5 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Sogroya, Ngenla	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010000720D210	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010000720D220	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010000720D230	Brand
NGENLA	SOMATROGON-GHLA SOLUTION PEN-INJECTOR 24 MG/1.2ML (20 MG/ML)	3010001500D220	Brand
NGENLA	SOMATROGON-GHLA SOLUTION PEN-INJECTOR 60 MG/1.2ML (50 MG/ML)	3010001500D240	Brand

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of panhypopituitarism

AND

1.1.2 Prescribed by an endocrinologist

AND

1.1.3 ONE of the following:

1.1.3.1 Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

1.1.3.2 History of intolerance or contraindication to TWO of the following (please specify intolerance or contraindication):

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of pediatric GH (growth hormone) deficiency as confirmed by ONE of the following:

1.2.1.1 Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height

OR

1.2.1.2 Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

OR

1.2.1.3 Growth velocity is greater than 2 SD below mean for age and gender

OR

1.2.1.4 Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

1.2.2.2 Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

1.2.3 Submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:

1.2.3.1 Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

AND

1.2.3.2 Both GH response values are less than 10 micrograms per liter

AND

1.2.4 ONE of the following:

1.2.4.1 If the request is for Sogroya, the patient is 2.5 years of age or older

OR

1.2.4.2 If the request is for Ngenla, the patient is 3 years of age or older

AND

1.2.5 ONE of the following:

1.2.5.1 Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

1.2.5.2 History of intolerance or contraindication to TWO of the following (please specify intolerance or contraindication):

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

AND

1.2.6 Prescribed by an endocrinologist

Product Name: Sogroya, Ngenla	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010000720D210	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010000720D220	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010000720D230	Brand

NGENLA	SOMATROGON-GHLA SOLUTION PEN-INJECTOR 24 MG/1.2ML (20 MG/ML)	3010001500D220	Brand
NGENLA	SOMATROGON-GHLA SOLUTION PEN-INJECTOR 60 MG/1.2ML (50 MG/ML)	3010001500D240	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - BOTH of the following:*

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Calculated height (growth) velocity over the past 12 months

AND

4 - ONE of the following:

4.1 Patient is a male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

4.2 Patient is a female and ONE of the following:

- Tanner stage less than 4

• Bone age less than 14 years measured in the past 12 months **AND** **5** - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand

NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Diagnosis of Prader-Willi Syndrome

AND

2 - Prescribed by an endocrinologist

AND

3 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand

SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand

HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - ONE of the following criteria:

1.1 BOTH of the following:

1.1.1 Evidence of positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)

AND

1.1.2 Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

1.2.2 BOTH of the following:

- Expected adult height not attained
- Documentation of expected adult height goal

AND

1.2.3 Prescribed by an endocrinologist

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand

OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Diagnosis of SGA (small for gestational age) based on demonstration of catch up growth failure in the first 24 months of life using a birth to 36 month growth chart as confirmed by BOTH of the following:

1.1 Documentation that ONE of the following is below the third percentile for gestational age (greater than or equal to 2 standard deviations [SD] below population mean):

- Birth weight

- Birth length

AND

1.2 Patient has demonstrated failure of catch up growth in the first 24 months of life

AND

2 - Documentation that height remains less than or equal to third percentile (greater than or equal to 2 SD below population mean)

AND

3 - Prescribed by an endocrinologist

AND

4 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand

SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand

GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand

OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Diagnosis of pediatric growth failure associated with ONE of the following:

1.1 BOTH of the following:

1.1.1 Turner Syndrome (Gonadal Dysgenesis)

AND

1.1.2 Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

OR

1.2 BOTH of the following:

1.2.1 Noonan Syndrome

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

1.2.2.2 Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

2 - Height is below the fifth percentile on growth charts for age and gender

AND

3 - Prescribed by an endocrinologist

AND

4 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand

NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand

ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand

GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Diagnosis of pediatric growth failure with short-stature homeobox (SHOX) gene deficiency as confirmed by genetic testing

AND

2 - ONE of the following:

2.1 Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

2.2 Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

3 - Prescribed by an endocrinologist

AND

4 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand

NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand

SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand

HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Diagnosis of pediatric growth failure associated with chronic renal insufficiency

AND

2 - ONE of the following:

2.1 Patient is male and ONE of the following:

- Tanner stage less than 4
- Bone age less than 16 years measured in the past 12 months

OR

2.2 Patient is female and ONE of the following:

- Tanner stage less than 4
- Bone age less than 14 years measured in the past 12 months

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

AND

4 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document

reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand

NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained

- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand

SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand

GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Diagnosis of adult growth hormone deficiency (GHD) as a result of ONE of the following:

1.1 Clinical records supporting a diagnosis of childhood-onset GHD

OR

1.2 BOTH of the following:

1.2.1 Adult-onset GHD

AND

1.2.2 Clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has undergone ONE of the following GH (growth hormone) stimulation tests to confirm adult GH deficiency:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- Glucagon

- ARG
- Macrilen (macimorelin)

AND

2.1.2 ONE of the following peak GH values:

2.1.2.1 ITT less than or equal to 5 micrograms per liter

OR

2.1.2.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

OR

2.1.2.3 Glucagon less than or equal to 3 micrograms per liter

OR

2.1.2.4 ARG less than or equal to 0.4 micrograms per liter

OR

2.1.2.5 Macimorelin less than 2.8 nanograms per milliliter 30, 45, 60 and 90 minutes following macimorelin administration

OR

2.2 BOTH of the following:

2.2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of THREE of the following anterior pituitary hormones:

- Prolactin
- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

AND

2.2.2 Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

AND

3 - ONE of the following:

3.1 Diagnosis of panhypopituitarism

OR

3.2 Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole),Femara (letrazole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

4 - Prescribed by an endocrinologist

AND

5 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand

OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
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GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Documentation of Insulin-like Growth Factor 1 (IGF-1)/Somatomedin C level within the past 12 months

AND

2 - ONE of the following:

2.1 Diagnosis of panhypopituitarism

OR

2.2 Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

3 - Prescribed by an endocrinologist

Product Name: Sogroya	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010000720D210	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010000720D220	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010000720D230	Brand

Approval Criteria

1 - Diagnosis of adult growth hormone deficiency (GHD) as a result of ONE of the following:

1.1 Clinical records supporting a diagnosis of childhood-onset GHD

OR

1.2 BOTH of the following:

1.2.1 Adult-onset GHD

AND

1.2.2 Clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has undergone ONE of the following GH (growth hormone) stimulation tests to confirm adult GH deficiency:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- Glucagon
- ARG
- Macrilen (macimorelin)

AND

2.1.2 ONE of the following peak GH values:

2.1.2.1 ITT less than or equal to 5 micrograms per liter

OR

2.1.2.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared

- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

OR

2.1.2.3 Glucagon less than or equal to 3 micrograms per liter

OR

2.1.2.4 ARG less than or equal to 0.4 micrograms per liter

OR

2.1.2.5 Macimorelin less than 2.8 nanograms per milliliter 30, 45, 60 and 90 minutes following macimorelin administration

OR

2.2 BOTH of the following:

2.2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of THREE of the following anterior pituitary hormones:

- Prolactin
- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

AND

2.2.2 Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

AND

3 - ONE of the following:

3.1 Diagnosis of panhypopituitarism

OR

3.2 Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole),Femara (letrazole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

4 - Prescribed by an endocrinologist

AND

5 - ONE of the following:

5.1 Failure to ONE of the following, confirmed by claims history or submission of medical records:

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

OR

5.2 History of intolerance or contraindication to TWO of the following (please specify intolerance or contraindication):

- Somatropin (Nutropin AQ)
- Somatropin (Norditropin)
- Somatropin (Omnitrope)

Product Name: Sogroya	
Diagnosis	Adult Growth Hormone Deficiency

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010000720D210	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010000720D220	Brand
SOGROYA	SOMAPACITAN-BECO SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010000720D230	Brand

Approval Criteria

1 - Documentation of Insulin-like Growth Factor 1 (IGF-1)/Somatomedin C level within the past 12 months

AND

2 - ONE of the following:

2.1 Diagnosis of panhypopituitarism

OR

2.2 Other diagnosis and not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

3 - Prescribed by an endocrinologist

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim

Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand

GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

2 - Documentation of ONE of the following:

- Attained expected adult height
- Closed epiphyses on bone radiograph

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

3.1 BOTH of the following:

3.1.1 Documentation of high risk of growth hormone (GH) deficiency due to GH deficiency in childhood from ONE of the following:

3.1.1.1 Embryopathic/congenital defects

OR

3.1.1.2 Genetic mutations

OR

3.1.1.3 Irreversible structural hypothalamic-pituitary disease

OR

3.1.1.4 Panhypopituitarism

OR

3.1.1.5 Deficiency of THREE of the following anterior pituitary hormones:

- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- Prolactin
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

AND

3.1.2 ONE of the following:

3.1.2.1 Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

OR

3.1.2.2 ALL of the following:

3.1.2.2.1 Patient does not have a low IGF-1/Somatomedin C level

AND

3.1.2.2.2 Discontinued GH therapy for at least 1 month

AND

3.1.2.2.3 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- ARG
- Glucagon

AND

3.1.2.2.4 ONE of the following peak GH values:

3.1.2.2.4.1 ITT less than or equal to 5 micrograms per liter

OR

3.1.2.2.4.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

OR

3.1.2.2.4.3 Glucagon less than or equal to 3 micrograms per liter

OR

3.1.2.2.4.4 ARG less than or equal to 0.4 micrograms per liter

OR

3.2 ALL of the following:

3.2.1 At low risk of severe GH deficiency (e.g., due to isolated and/or idiopathic GH deficiency)

AND

3.2.2 Discontinued GH therapy for at least 1 month

AND

3.2.3 BOTH of the following:

3.2.3.1 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- ITT
- GHRH and ARG
- ARG
- Glucagon

AND

3.2.3.2 ONE of the following peak GH values:

3.2.3.2.1 ITT less than or equal to 5 micrograms per liter

OR

3.2.3.2.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

OR

3.2.3.2.3 Glucagon less than or equal to 3 micrograms per liter

OR

3.2.3.2.4 ARG less than or equal to 0.4 micrograms per liter

AND

4 - Prescribed by an endocrinologist

AND

5 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (document reason or special circumstance) (See Table 1 in Background section for non-preferred products)

Product Name: Genotropin, Genotropin Miniquick, Humatrope, Norditropin Flexpro, Nutropin AQ, NuSpin, Omnitrope, Saizen, Zomacton, Zorbtive, Serostim

Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOMACTON	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	Brand
OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	Brand
SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
SAIZENPREP RECONSTITUTIONKIT	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	Brand
ZOMACTON	SOMATROPIN FOR INJ 10 MG	30100020002140	Brand
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand
NUTROPIN AQ NUSPIN 5	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/2ML	3010002000D207	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 5 MG/1.5ML	3010002000D212	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/1.5ML	3010002000D230	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 15 MG/1.5ML	3010002000D240	Brand
NUTROPIN AQ NUSPIN 10	SOMATROPIN SOLUTION PEN-INJECTOR 10 MG/2ML	3010002000D220	Brand
NUTROPIN AQ NUSPIN 20	SOMATROPIN SOLUTION PEN-INJECTOR 20 MG/2ML	3010002000D250	Brand
NORDITROPIN FLEXPRO	SOMATROPIN SOLUTION PEN-INJECTOR 30 MG/3ML	3010002000D260	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 5 MG/1.5ML	3010002000E210	Brand
OMNITROPE	SOMATROPIN SOLUTION CARTRIDGE 10 MG/1.5ML	3010002000E213	Brand
GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 5 MG	3010002000E159	Brand

GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E188	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.2 MG	3010002000E404	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.4 MG	3010002000E407	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.6 MG	3010002000E410	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 0.8 MG	3010002000E413	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1 MG	3010002000E416	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.2 MG	3010002000E419	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.4 MG	3010002000E422	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.6 MG	3010002000E425	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 1.8 MG	3010002000E428	Brand
GENOTROPIN MINIQUICK	SOMATROPIN FOR SUBCUTANEOUS INJ PREFILLED SYR 2 MG	3010002000E431	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 6 MG (18 UNIT)	3010002000E120	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 12 MG (36 UNIT)	3010002000E130	Brand
HUMATROPE	SOMATROPIN FOR INJ CARTRIDGE 24 MG	3010002000E140	Brand

Approval Criteria

1 - Documentation of positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 [Insulin-like Growth Factor 1] and IGFBP-3 [Insulin-like growth factor binding protein 3] levels)

AND

2 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

3 - Prescribed by an endocrinologist

Product Name: Serostim	
Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)-associated wasting syndrome or cachexia

AND

2 - Documentation of ONE of the following:

2.1 Unintentional weight loss of greater than 10 percent over the last 12 months

OR

2.2 Unintentional weight loss of greater than 7.5 percent over the last 6 months

OR

2.3 Loss of 5 percent body cell mass (BCM) within 6 months

OR

2.4 Body mass index (BMI) less than 20 kilograms per meter squared

OR

2.5 ONE of the following:

2.5.1 ALL of the following:

- Patient is male
- BCM less than 35 percent of total body weight
- BMI less than 27 kilograms per meter squared

OR

2.5.2 ALL of the following:

- Patient is female
- BCM less than 23 percent of total body weight
- BMI less than 27 kilograms per meter squared

AND

3 - A nutritional evaluation has been completed since onset of wasting first occurred

AND

4 - Patient has not had weight loss as a result of other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)

AND

5 - Patient's anti-retroviral therapy has been optimized to decrease the viral load

Product Name: Serostim	
Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	Brand
SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	Brand

Approval Criteria

1 - Evidence of positive response to therapy (i.e., greater than or equal to 2 percent increase in body weight and/or body cell mass [BCM])

AND

2 - ONE of the following targets or goals has not been achieved:

- Weight
- BCM
- Body Mass Index (BMI)

Product Name: Zorbtive	
Diagnosis	Short Bowel Syndrome
Approval Length	*4 weeks
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	Brand

Approval Criteria

1 - Diagnosis of Short Bowel Syndrome

AND

2 - Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements)

AND

3 - Patient has not previously received 4 weeks of treatment with Zorbtive*

Notes	*Treatment with Zorbtive will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied.

Product Name: Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INCRELEX	MECASERMIN INJ 40 MG/4ML (10 MG/ML)	30160045002020	Brand

Approval Criteria

1 - ONE of the following criteria:

1.1 Documentation of ALL of the following:

1.1.1 Diagnosis of severe primary Insulin-like Growth Factor 1 (IGF-1) deficiency

AND

1.1.2 Height standard deviation score less than or equal to -3.0

AND

1.1.3 Basal IGF-1 standard deviation score less than or equal to -3.0

AND

1.1.4 Normal or elevated growth hormone levels

AND

1.1.5 Documentation of open epiphyses on last bone radiograph

AND

1.1.6 The patient will not be treated with concurrent growth hormone therapy

AND

1.1.7 Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Diagnosis of growth hormone gene deletion and has developed neutralizing antibodies to growth hormone

AND

1.2.2 Documentation of open epiphyses on last bone radiograph

AND

1.2.3 The patient will not be treated with concurrent growth hormone therapy

AND

1.2.4 Prescribed by an endocrinologist

Product Name: Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INCRELEX	MECASERMIN INJ 40 MG/4ML (10 MG/ML)	30160045002020	Brand

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

• Expected adult height not obtained • Expected adult height goal **AND** **3** - Patient is not treated with concurrent growth hormone therapy **AND** **4** - Prescribed by an endocrinologist	
Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

2 . Background

Benefit/Coverage/Program Information
Table 1: Human Growth Hormone: **Preferred Agents:** Somatropin (Nutropin AQ®), Somatropin (Norditropin®), Somatropin (Omnitrope®) **Nonpreferred Agents:** Somatropin (Genotropin®, Humatrope®, NordiFlex®, NuSpin™, Saizen®, Zorbtive®, Serostim®, and Zomacton®), Skytrofa™ (lonapegsomatropin-tcgd), Ngenla (somatrogon), Sogroya (somapacitan)

Growth Stimulating Products : Mecasermin (Increlex®)

3 . Revision History

Date	Notes
9/24/2024	Omnitrope moved to preferred agent. Updated step therapy criteria.

Haegarda

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147287
Guideline Name	Haegarda
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Haegarda	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HAEGARDA	C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 2000 UNIT	85802022002130	Brand
HAEGARDA	C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 3000 UNIT	85802022002140	Brand

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

1.2.1 Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6

OR

1.2.2 Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

OR

1.2.3 Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - Prescribed for the prophylaxis of HAE attacks

AND

3 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Orladeyo, Takhzyro)

AND

4 - Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Haegarda

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name: Haegarda	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HAEGARDA	C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 2000 UNIT	85802022002130	Brand
HAEGARDA	C1 ESTERASE INHIBITOR (HUMAN) FOR SUBCUTANEOUS INJ 3000 UNIT	85802022002140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Haegarda therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Haegarda therapy

AND

3 - Prescribed for the prophylaxis of HAE attacks

AND

4 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Orladeyo, Takhzyro)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
5/13/2024	Copy core; New

HCG

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146536
Guideline Name	HCG
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Prepubertal Cryptorchidism
Approval Length	6 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVAREL	CHORIONIC GONADOTROPIN FOR IM INJ 5000 UNIT	30062020002130	Brand
NOVAREL	CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT	30062020002140	Brand
CHORIONIC GONADOTROPIN	CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT	30062020002140	Brand
OVIDREL	CHORIOGONADOTROPIN ALFA INJ 250 MCG/0.5ML	3006202205E520	Brand

PREGNYL W/DILUENT BENZYL ALCOHOL/NACL	CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT	30062020002140	Brand
PREGNYL	CHORIONIC GONADOTROPIN FOR IM INJ 10000 UNIT	30062020002140	Brand

Approval Criteria

1 - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction

Hemangeol

Prior Authorization Guideline

Guideline ID	GL-146337
Guideline Name	Hemangeol
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Hemangeol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HEMANGEOL	PROPRANOLOL HCL ORAL SOLN 4.28 MG/ML (3.75 MG/ML BASE EQUIV)	33100040102080	Brand

Approval Criteria

1 - Diagnosis of proliferating infantile hemangioma

AND

2 - Prescriber provides a reason or special circumstance the patient cannot use generic propranolol oral solution

Hemlibra

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146537
Guideline Name	Hemlibra
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Hemlibra	
Diagnosis	Hemophilia A with Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML	85105030202010	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML)	85105030202020	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML)	85105030202030	Brand

HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML	85105030202040	Brand

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - Patient has developed high-titer factor VIII inhibitors [greater than 5 Bethesda units (BU)]

AND

3 - Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name: Hemlibra	
Diagnosis	Hemophilia A with Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML	85105030202010	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML)	85105030202020	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML)	85105030202030	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML	85105030202040	Brand

Approval Criteria

1 - Documentation of positive clinical response to Hemlibra therapy

Product Name: Hemlibra	
Diagnosis	Hemophilia A without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML	85105030202010	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML)	85105030202020	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML)	85105030202030	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML	85105030202040	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of severe hemophilia A

AND

1.1.2 Documentation of endogenous factor VIII levels less than 1% of normal factor VIII [less than 0.01 international units/milliliter (IU/mL)]

OR

1.2 BOTH of the following:

1.2.1 ONE of the following:

1.2.1.1 BOTH of the following:

1.2.1.1.1 Diagnosis of moderate hemophilia A

AND

1.2.1.1.2 Documentation of endogenous factor VIII level greater than or equal to 1% and less than 5% (greater than or equal to 0.01 IU/mL to less than 0.05 IU/mL)

OR

1.2.1.2 BOTH of the following:

1.2.1.2.1 Diagnosis of mild hemophilia A

AND

1.2.1.2.2 Documentation of endogenous factor VIII level greater than or equal to 5% (greater than or equal to 0.05 IU/mL)

AND

1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting a failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of prophylactic factor VIII replacement products

OR

1.3 BOTH of the following:

1.3.1 Patient is currently on Hemlibra therapy as confirmed by claims history or submission of medical records

AND

1.3.2 Diagnosis of hemophilia A

AND

2 - Hemlibra is prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

AND

3 - Prescriber attestation that the patient is not to receive extended half-life factor VIII replacement products (e.g., Eloctate, Adynovate, Afstyla, Jivi) for the treatment of breakthrough bleeding episodes

Product Name: Hemlibra	
Diagnosis	Hemophilia A without Inhibitors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 30 MG/ML	85105030202010	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 60 MG/0.4ML (150 MG/ML)	85105030202020	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 105 MG/0.7ML (150 MG/ML)	85105030202030	Brand
HEMLIBRA	EMICIZUMAB-KXWH SUBCUTANEOUS SOLN 150 MG/ML	85105030202040	Brand

Approval Criteria

1 - Documentation of positive clinical response to Hemlibra therapy

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Hemlibra in combination with an extended half-life factor VIII

replacement product (e.g., Eloctate, Adynovate, Afstyla, Jivi) for the treatment of breakthrough bleeding episodes (Prescription claim history that does not show any concomitant extended half-life factor VIII replacement product claim within 60 days of reauthorization request may be used as documentation)

Hepatitis C Criteria

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148186
Guideline Name	Hepatitis C Criteria
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Harvoni, ledipasvir/sofosbuvir (authorized generic of Harvoni)	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HARVONI	LEDIPASVIR-SOFOSBUVIR TAB 45-200 MG	12359902400310	Brand
HARVONI	LEDIPASVIR-SOFOSBUVIR TAB 90-400 MG	12359902400320	Generic
LEDIPASVIR/SOFOSBUVIR	LEDIPASVIR-SOFOSBUVIR TAB 90-400 MG	12359902400320	Generic
HARVONI	LEDIPASVIR-SOFOSBUVIR PELLET PACK 33.75-150 MG	12359902403006	Brand
HARVONI	LEDIPASVIR-SOFOSBUVIR PELLET PACK 45-200 MG	12359902403010	Brand

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 4, 5, or 6 infection

AND

2 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

3 - ONE of the following:

3.1 Patient is genotype 1 or 4 and has a history of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret
- Zepatier

OR

3.2 Patient is genotype 5 or 6 and has a history of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret

OR

3.3 Patient is currently on Harvoni (ledipasvir/sofosbuvir) therapy

AND

4 - Patient is NOT receiving the requested medication in combination with another HCV

(hepatitis C virus) direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

5 - The requested regimen is an approvable regimen based on patient genotype and characteristics (See Table 1 in Background section)

AND

6 - If brand is requested, the provider must submit explanation of medical necessity for brand versus authorized generic

Notes	Approval length is by regimen based on patient genotype and charact eristics in Table 1.

Product Name: Sovaldi	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOVALDI	SOFOSBUVIR TAB 200 MG	12353080000310	Brand
SOVALDI	SOFOSBUVIR TAB 400 MG	12353080000320	Brand
SOVALDI	SOFOSBUVIR PELLET PACK 150 MG	12353080003015	Brand
SOVALDI	SOFOSBUVIR PELLET PACK 200 MG	12353080003020	Brand

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 infection

AND

2 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

3 - ONE of the following:

3.1 Patient is genotype 1 or 4 and has a history of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret
- Zepatier

OR

3.2 Patient is genotype 2 or 3 and has a history of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Sofosbuvir/velpatasvir (authorized generic of Epclusa)
- Mavyret

OR

3.3 Patient is currently on Sovaldi therapy

AND

4 - Patient is NOT receiving the requested medication in combination with another HCV (hepatitis C virus) direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Zepatier (elbasvir/grazoprevir)]

AND

5 - The requested regimen is an approvable regimen based on patient genotype and characteristics (see Table 2 in Background section)

Notes	Approval length is by regimen based on patient genotype and charact eristics in Table 2.

Product Name: Vosevi	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOSEVI	SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR TAB 400-100-100 MG	12359903800330	Brand

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

3 - The patient is without cirrhosis or has compensated cirrhosis (Child-Pugh A)

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Patient is genotype 1, 2, 3, 4, 5, or 6 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV (hepatitis C virus) regimen containing an NS5A (nonstructural protein 5A) inhibitor as confirmed by claims history or submission of medical records

AND

4.1.2 If the patient is genotype 1 and has NOT been previously treated with an NS3/4A (nonstructural protein 3/4A) inhibitor, history of intolerance or contraindication to Mavyret (please specify intolerance or contraindication)

OR

4.2 ALL of the following:

4.2.1 Patient is genotype 1a or 3 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofosbuvir without an NS5A inhibitor as confirmed by claims history or submission of medical records

AND

4.2.2 If patient is genotype 1a and has been treated with or without an NS3/4A inhibitor, history of intolerance or contraindication to Mavyret (please specify intolerance or contraindication)

AND

4.2.3 If patient is genotype 3 and has NOT been treated with an NS3/4A inhibitor, history of intolerance or contraindication to Mavyret (please specify intolerance or contraindication)

OR

4.3 Patient is currently on Vosevi therapy

AND

5 - Patient is NOT receiving the requested medication in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

6 - The requested regimen is an approvable regimen based on patient genotype and characteristics (See Table 3 in Background section)

Notes	Approval length is by regimen based on patient genotype and charact eristics in Table 3.

Product Name: Zepatier	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEPATIER	ELBASVIR-GRAZOPREVIR TAB 50-100 MG	12359902300320	Brand

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1 or 4 infection

AND

2 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

3 - Patient is NOT receiving the requested medication in combination with another HCV (hepatitis C virus) direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir)]

AND

4 - The requested regimen is an approvable regimen based on patient genotype and characteristics (See Table 4 in Background section)

Notes	Approval length is by regimen based on patient genotype and charact eristics in Table 4.

2 . Background

Benefit/Coverage/Program Information

Table 1. Harvoni or ledipasvir/sofosbuvir (authorized generic of Harvoni)

Recommended treatment regimen and duration:

Genotype	Patient Population	Regimen and Duration
Genotype 1	Treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A)	HARVONI 12 weeks*
	Treatment-experienced** without cirrhosis	HARVONI 12 weeks
	Treatment-experienced** with compensated cirrhosis (Child-Pugh A)	HARVONI 24 weeks+
	Treatment-naïve and treatment-experienced** with decompensated cirrhosis (Child-Pugh B or C)	HARVONI + ribavirin 12 weeks
Genotype 1 or 4	Treatment-naïve and treatment-experienced** liver transplant recipients without cirrhosis, or with compensated cirrhosis (Child-Pugh A)	HARVONI + ribavirin 12 weeks
Genotype 4, 5, or 6	Treatment-naïve and treatment-experienced** without cirrhosis or with compensated cirrhosis (Child-Pugh A)	HARVONI 12 weeks

*HARVONI for 8 weeks can be considered in treatment-naïve genotype 1 patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL

**Treatment-experienced adult and pediatric patients have failed a peginterferon alfa +/- ribavirin based regimen with or without an HCV protease inhibitor

+HARVONI + ribavirin for 12 weeks can be considered in treatment-experienced genotype 1 patients with cirrhosis who are eligible for ribavirin

Table 2. Sovaldi

Recommended Adult Treatment Regimen and Duration

	Adult Patient Population	Regimen and Duration
Genotype 1 or 4	Treatment naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + peginterferon alfa + ribavirin 12 weeks
Genotype 2	Treatment naïve and treatment experienced* without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + ribavirin 12 weeks
Genotype 3	Treatment naïve and treatment experienced* without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + ribavirin 24 weeks

SOVALDI in combination with ribavirin for 24 weeks can be considered for adult patients with genotype 1 infection who are interferon ineligible.

SOVALDI should be used in combination with ribavirin for treatment of HCV in adult patients with hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first.

*Treatment-experienced patients have failed an interferon based regimen with or without ribavirin

Recommended Treatment Regimen and Duration for Pediatric Patients 3 Years of Age and Older

	Pediatric Patient Population 3 Years of Age and Older	Regimen and Duration
Genotype 2	Treatment naïve and treatment experienced* without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + ribavirin 12 weeks
Genotype 3	Treatment naïve and treatment experienced* without cirrhosis or with	SOVALDI + ribavirin 24 weeks

	compensated cirrhosis (Child-Pugh A)	

*Treatment experienced patients have failed an interferon based regimen with or without ribavirin

Table 3. Vosevi

Genotype	Patients previously treated with an HCV regimen containing:	VOSEVI Duration
1, 2, 3, 4, 5, or 6	An NS5A inhibitor[1]	12 weeks
1a or 3	Sofosbuvir without an NS5A inhibitor[2]	12 weeks

1. In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir.

2. In clinical trials, prior treatment experience included sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir).

Table 4. Zepatier

Dosage Regimens and Durations for ZEPATIER in Patients with Genotype 1 or 4 HCV with or without Cirrhosis

Patient Population	Treatment	Duration
Genotype 1a: treatment naïve or PegIFN/RBV experienced* without baseline NS5A polymorphisms+	ZEPATIER	12 weeks
Genotype 1a: treatment naïve or PegIFN/RBV experienced* with baseline NS5A polymorphisms+	ZEPATIER + ribavirin	16 weeks

Genotype 1b: treatment naïve or PegIFN/RBV experienced*	ZEPATIER	12 weeks
Genotype 1a or 1b: PegIFN/RBV/PI experienced++	ZEPATIER + ribavirin	12 weeks
Genotype 4: treatment naïve	ZEPATIER	12 weeks
Genotype 4: PegIFN/RBV experienced*	ZEPATIER + ribavirin	16 weeks

*Peginterferon alfa + ribavirin

+Polymorphisms at amino acid positions 28, 30, 31, or 93

++Peginterferon alfa + ribavirin + HCV NS3/4 A protease inhibitor

3 . Revision History

Date	Notes
6/13/2024	New guideline specific to NM

Hetlioz

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146538
Guideline Name	Hetlioz
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Hetlioz, generic tasimelteon, Hetlioz LQ	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIMELTEON	TASIMELTEON CAPSULE 20 MG	60250070000130	Generic
HETLIOZ	TASIMELTEON CAPSULE 20 MG	60250070000130	Brand
HETLIOZ LQ	TASIMELTEON ORAL SUSP 4 MG/ML	60250070001820	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of non-24-hour sleep wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome)

AND

1.1.2 Patient is totally blind (has no light perception)

OR

1.2 Diagnosis of nighttime sleep disturbances in Smith-Magenis-Syndrome (SMS)

AND

2 - ONE of the following:

2.1 History of contraindication or intolerance to melatonin therapy (please specify contraindication or intolerance)

OR

2.2 BOTH of the following:

2.2.1 Failure of at least 6 months of continuous therapy (i.e., uninterrupted daily treatment) with melatonin, as confirmed by claims history or submission of medical records

AND

2.2.2 Continuous trial of melatonin was done under the guidance of a specialist in sleep disorders

AND

3 - Prescribed by or in consultation with a specialist in sleep disorders

Product Name: Brand Hetlioz, generic tasimelteon, Hetlioz LQ	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIMELTEON	TASIMELTEON CAPSULE 20 MG	60250070000130	Generic
HETLIOZ	TASIMELTEON CAPSULE 20 MG	60250070000130	Brand
HETLIOZ LQ	TASIMELTEON ORAL SUSP 4 MG/ML	60250070001820	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

HIV

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150995
Guideline Name	HIV
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	8/7/2024

1 . Criteria

Product Name: Brand Viread, generic tenofovir disoproxil fumarate	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 150 MG	12108570100305	Brand
VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 200 MG	12108570100310	Brand
VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 250 MG	12108570100315	Brand
TENOFOVIR DISOPROXIL FUMARATE	TENOFOVIR DISOPROXIL FUMARATE TAB 300 MG	12108570100320	Generic
VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 300 MG	12108570100320	Brand
VIREAD	TENOFOVIR DISOPROXIL FUMARATE ORAL POWDER 40 MG/GM	12108570102920	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- HIV (human immunodeficiency virus)
- Hepatitis B
- HIV post-exposure prophylaxis (PEP)

Notes	Approval Duration: 12 months for HIV and hepatitis B; 4 weeks for PEP.

Product Name: Brand Truvada, generic emtricitabine/tenofovir disoproxil	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 100-150 MG	12109902300308	Generic
TRUVADA	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 100-150 MG	12109902300308	Brand
EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 133-200 MG	12109902300312	Generic
TRUVADA	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 133-200 MG	12109902300312	Brand
EMTRICITABINE/TENOFOVIR DISOPROXIL	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 167-250 MG	12109902300316	Generic
TRUVADA	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 167-250 MG	12109902300316	Brand
EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300 MG	12109902300320	Generic
TRUVADA	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300 MG	12109902300320	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- HIV (human immunodeficiency virus)
- Pre-exposure prophylaxis (PrEP)
- HIV post-exposure prophylaxis (PEP)

Notes	Approval Duration: 12 months for HIV and PrEP; 4 weeks for PEP.

Product Name: Aptivus, Viracept, nevirapine, nevirapine ER	
Diagnosis	HIV
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEVIRAPINE	NEVIRAPINE TAB 200 MG	12109050000320	Generic
NEVIRAPINE	NEVIRAPINE SUSP 50 MG/5ML	12109050001820	Generic
APTIVUS	TIPRANAVIR CAP 250 MG	12104585000120	Brand
VIRACEPT	NELFINAVIR MESYLATE TAB 250 MG	12104545200320	Brand
VIRACEPT	NELFINAVIR MESYLATE TAB 625 MG	12104545200340	Brand
NEVIRAPINE ER	NEVIRAPINE TAB ER 24HR 400 MG	12109050007520	Generic

Approval Criteria

1 - Diagnosis of HIV (human immunodeficiency virus)

Product Name: (All other HIV medications which do not have criteria above) brand Selzentry, generic maraviroc, Fuzeon, Tivicay, Tivicay PD, Isentress, Isentress HD, brand Reyataz, generic atazanavir, Brand Prezista, generic darunavir, brand Lexiva, generic fosamprenavir, brand Norvir, generic ritonavir, Brand Ziagen, generic abacavir, Brand Emtriva, generic emtricitabine, Brand Epivir, generic lamivudine, stavudine, Brand Retrovir, generic zidovudine, Pifeltro, Brand Sustiva, generic efavirenz, brand Intelence, generic etravirine, Edurant, Tybost, Brand Epzicom, generic abacavir/lamivudine, Evotaz, Dovato, Prezcobix, Cimduo, Brand Combivir, generic lamivudine/zidovudine, Brand Kaletra, generic lopinavir/ritonavir, Triumeq, Triumeq PD, Trizivir, Delstrigo, Brand Atripla, generic efavirenz/emtricitabine/tenofovir, Brand Symfi Lo, Brand Symfi, generic efavirenz/lamivudine/tenofovir, Odefsey, Symtuza, Juluca

Diagnosis	Human Immunodeficiency Virus (HIV), HIV post-exposure prophylaxis (PEP)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SELZENTRY	MARAVIROC TAB 25 MG	12102060000305	Brand
SELZENTRY	MARAVIROC TAB 75 MG	12102060000310	Brand
MARAVIROC	MARAVIROC TAB 150 MG	12102060000320	Generic
SELZENTRY	MARAVIROC TAB 150 MG	12102060000320	Brand
MARAVIROC	MARAVIROC TAB 300 MG	12102060000330	Generic
SELZENTRY	MARAVIROC TAB 300 MG	12102060000330	Brand
SELZENTRY	MARAVIROC ORAL SOLN 20 MG/ML	12102060002020	Brand
FUZEON	ENFUVIRTIDE FOR INJ 90 MG	12102530002120	Brand
TIVICAY	DOLUTEGRAVIR SODIUM TAB 10 MG (BASE EQUIV)	12103015100305	Brand
TIVICAY	DOLUTEGRAVIR SODIUM TAB 25 MG (BASE EQUIV)	12103015100310	Brand
TIVICAY	DOLUTEGRAVIR SODIUM TAB 50 MG (BASE EQUIV)	12103015100320	Brand
TIVICAY PD	DOLUTEGRAVIR SODIUM TAB FOR ORAL SUSP 5 MG (BASE EQUIV)	12103015107320	Brand
ISENTRESS	RALTEGRAVIR POTASSIUM TAB 400 MG (BASE EQUIV)	12103060100320	Brand
ISENTRESS HD	RALTEGRAVIR POTASSIUM TAB 600 MG (BASE EQUIV)	12103060100330	Brand
ISENTRESS	RALTEGRAVIR POTASSIUM CHEW TAB 25 MG (BASE EQUIV)	12103060100510	Brand
ISENTRESS	RALTEGRAVIR POTASSIUM CHEW TAB 100 MG (BASE EQUIV)	12103060100540	Brand

ISENTRESS	RALTEGRAVIR POTASSIUM PACKET FOR SUSP 100 MG (BASE EQUIV)	12103060103020	Brand
ATAZANAVIR	ATAZANAVIR SULFATE CAP 150 MG (BASE EQUIV)	12104515200130	Generic
ATAZANAVIR SULFATE	ATAZANAVIR SULFATE CAP 150 MG (BASE EQUIV)	12104515200130	Generic
ATAZANAVIR	ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV)	12104515200140	Generic
ATAZANAVIR SULFATE	ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV)	12104515200140	Generic
REYATAZ	ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV)	12104515200140	Brand
ATAZANAVIR SULFATE	ATAZANAVIR SULFATE CAP 300 MG (BASE EQUIV)	12104515200150	Generic
REYATAZ	ATAZANAVIR SULFATE CAP 300 MG (BASE EQUIV)	12104515200150	Brand
REYATAZ	ATAZANAVIR SULFATE ORAL POWDER PACKET 50 MG (BASE EQUIV)	12104515203020	Brand
PREZISTA	DARUNAVIR TAB 75 MG	12104520000305	Brand
PREZISTA	DARUNAVIR TAB 150 MG	12104520000310	Brand
PREZISTA	DARUNAVIR TAB 600 MG	12104520000325	Brand
PREZISTA	DARUNAVIR TAB 800 MG	12104520000350	Brand
PREZISTA	DARUNAVIR ORAL SUSP 100 MG/ML	12104520001820	Brand
FOSAMPRENAVIR CALCIUM	FOSAMPRENAVIR CALCIUM TAB 700 MG (BASE EQUIV)	12104525100330	Generic
LEXIVA	FOSAMPRENAVIR CALCIUM TAB 700 MG (BASE EQUIV)	12104525100330	Brand
LEXIVA	FOSAMPRENAVIR CALCIUM SUSP 50 MG/ML (BASE EQUIV)	12104525101820	Brand

NORVIR	RITONAVIR TAB 100 MG	12104560000320	Brand
RITONAVIR	RITONAVIR TAB 100 MG	12104560000320	Generic
NORVIR	RITONAVIR POWDER PACKET 100 MG	12104560003020	Brand
ABACAVIR	ABACAVIR SULFATE TAB 300 MG (BASE EQUIV)	12105005100320	Generic
ABACAVIR SULFATE	ABACAVIR SULFATE TAB 300 MG (BASE EQUIV)	12105005100320	Generic
ZIAGEN	ABACAVIR SULFATE TAB 300 MG (BASE EQUIV)	12105005100320	Brand
ABACAVIR	ABACAVIR SULFATE SOLN 20 MG/ML (BASE EQUIV)	12105005102020	Generic
ZIAGEN	ABACAVIR SULFATE SOLN 20 MG/ML (BASE EQUIV)	12105005102020	Brand
EMTRICITABINE	EMTRICITABINE CAPS 200 MG	12106030000120	Generic
EMTRIVA	EMTRICITABINE CAPS 200 MG	12106030000120	Brand
EMTRIVA	EMTRICITABINE SOLN 10 MG/ML	12106030002010	Brand
EPIVIR	LAMIVUDINE TAB 150 MG	12106060000320	Brand
LAMIVUDINE	LAMIVUDINE TAB 150 MG	12106060000320	Generic
EPIVIR	LAMIVUDINE TAB 300 MG	12106060000330	Brand
LAMIVUDINE	LAMIVUDINE TAB 300 MG	12106060000330	Generic
EPIVIR	LAMIVUDINE ORAL SOLN 10 MG/ML	12106060002020	Brand
LAMIVUDINE	LAMIVUDINE ORAL SOLN 10 MG/ML	12106060002020	Generic
STAVUDINE	STAVUDINE CAP 15 MG	12108070000115	Generic
STAVUDINE	STAVUDINE CAP 20 MG	12108070000120	Generic
STAVUDINE	STAVUDINE CAP 30 MG	12108070000130	Generic
STAVUDINE	STAVUDINE CAP 40 MG	12108070000140	Generic

RETROVIR	ZIDOVUDINE CAP 100 MG	12108085000110	Brand
ZIDOVUDINE	ZIDOVUDINE CAP 100 MG	12108085000110	Generic
ZIDOVUDINE	ZIDOVUDINE TAB 300 MG	12108085000330	Generic
RETROVIR	ZIDOVUDINE SYRUP 10 MG/ML	12108085001210	Brand
ZIDOVUDINE	ZIDOVUDINE SYRUP 10 MG/ML	12108085001210	Generic
PIFELTRO	DORAVIRINE TAB 100 MG	12109025000320	Brand
EFAVIRENZ	EFAVIRENZ CAP 50 MG	12109030000110	Generic
SUSTIVA	EFAVIRENZ CAP 50 MG	12109030000110	Brand
EFAVIRENZ	EFAVIRENZ CAP 200 MG	12109030000140	Generic
SUSTIVA	EFAVIRENZ CAP 200 MG	12109030000140	Brand
EFAVIRENZ	EFAVIRENZ TAB 600 MG	12109030000330	Generic
SUSTIVA	EFAVIRENZ TAB 600 MG	12109030000330	Brand
INTELENCE	ETRAVIRINE TAB 25 MG	12109035000310	Brand
ETRAVIRINE	ETRAVIRINE TAB 100 MG	12109035000320	Generic
INTELENCE	ETRAVIRINE TAB 100 MG	12109035000320	Brand
ETRAVIRINE	ETRAVIRINE TAB 200 MG	12109035000340	Generic
INTELENCE	ETRAVIRINE TAB 200 MG	12109035000340	Brand
EDURANT	RILPIVIRINE HCL TAB 25 MG (BASE EQUIVALENT)	12109080100320	Brand
TYBOST	COBICISTAT TAB 150 MG	12109530000320	Brand
ABACAVIR SULFATE/LAMIVUDINE	ABACAVIR SULFATE-LAMIVUDINE TAB 600-300 MG	12109902200340	Generic
EPZICOM	ABACAVIR SULFATE-LAMIVUDINE TAB 600-300 MG	12109902200340	Brand

EVOTAZ	ATAZANAVIR SULFATE-COBICISTAT TAB 300-150 MG (BASE EQUIV)	12109902220330	Brand
DOVATO	DOLUTEGRAVIR SODIUM-LAMIVUDINE TAB 50-300 MG (BASE EQ)	12109902260320	Brand
PREZCOBIX	DARUNAVIR-COBICISTAT TAB 800-150 MG	12109902270320	Brand
JULUCA	DOLUTEGRAVIR SODIUM-RILPIVIRINE HCL TAB 50-25 MG (BASE EQ)	12109902280320	Brand
CIMDUO	LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE TAB 300-300 MG	12109902470330	Brand
COMBIVIR	LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG	12109902500320	Brand
LAMIVUDINE/ZIDOVUDINE	LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG	12109902500320	Generic
KALETRA	LOPINAVIR-RITONAVIR TAB 100-25 MG	12109902550310	Brand
LOPINAVIR/RITONAVIR	LOPINAVIR-RITONAVIR TAB 100-25 MG	12109902550310	Generic
KALETRA	LOPINAVIR-RITONAVIR TAB 200-50 MG	12109902550320	Brand
LOPINAVIR/RITONAVIR	LOPINAVIR-RITONAVIR TAB 200-50 MG	12109902550320	Generic
KALETRA	LOPINAVIR-RITONAVIR SOLN 400-100 MG/5ML (80-20 MG/ML)	12109902552020	Brand
LOPINAVIR/RITONAVIR	LOPINAVIR-RITONAVIR SOLN 400-100 MG/5ML (80-20 MG/ML)	12109902552020	Generic
TRIUMEQ	ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TAB 600-50-300 MG	12109903150320	Brand
TRIUMEQ PD	ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TAB FOR ORAL SUS 60-5-30 MG	12109903157320	Brand
TRIZIVIR	ABACAVIR SULFATE-LAMIVUDINE-	12109903200320	Brand

	ZIDOVUDINE TAB 300-150-300 MG		
DELSTRIGO	DORAVIRINE-LAMIVUDINE-TENOFOVIR DF TAB 100-300-300 MG	12109903270320	Brand
ATRIPLA	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300 MG	12109903300320	Brand
EFAVIRENZ/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300 MG	12109903300320	Generic
EFAVIRENZ/LAMIVUDINE/TENOFOVIR DISOPROXIL FUMARATE	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 400-300-300 MG	12109903330330	Generic
SYMFI LO	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 400-300-300 MG	12109903330330	Brand
EFAVIRENZ/LAMIVUDINE/TENOFOVIR DISOPROXIL FUMARATE	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 600-300-300 MG	12109903330340	Generic
SYMFI	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 600-300-300 MG	12109903330340	Brand
ODEFSEY	EMTRICITABINE-RILPIVIRINE-TENOFOVIR AF TAB 200-25-25 MG	12109903390320	Brand
SYMTUZA	DARUNAVIR-COBIC-EMTRICITAB-TENOFOV AF TAB 800-150-200-10 MG	12109904200320	Brand
DARUNAVIR	DARUNAVIR TAB 600 MG	12104520000325	Generic
DARUNAVIR	DARUNAVIR TAB 800 MG	12104520000350	Generic

Approval Criteria

1 - ONE of the following diagnoses:

- HIV (human immunodeficiency virus)

• HIV post-exposure prophylaxis (PEP) **AND** **2** - If the request is non-preferred*, ONE of the following: **2.1** History of contraindication or intolerance to THREE preferred* products **OR** **2.2** Continuation of current therapy	
Notes	This guideline does NOT include Biktarvy, Complera, Descovy, Genvoya, Rukobia, and Stribild. These medications have drug specific guidelines. Approval Duration: 12 months for HIV; 4 weeks for PEP. *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
8/6/2024	Copy Core

Hycamtin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146539
Guideline Name	Hycamtin
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Hycamtin, generic topotecan	
Diagnosis	Small Cell Lung Cancer (SCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYCAMTIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	Brand
HYCAMTIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	Brand
HYCAMTIN	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Brand

TOPOTECAN HCL	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Generic

Approval Criteria

1 - Diagnosis of small cell lung cancer (SCLC)

AND

2 - Patient has experienced a relapse of disease after initial first-line chemotherapy (e.g., cisplatin with etoposide)

Product Name: Brand Hycamtin, generic topotecan	
Diagnosis	Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYCAMTIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	Brand
HYCAMTIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	Brand
HYCAMTIN	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Brand
TOPOTECAN HCL	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Generic

Approval Criteria

1 - Diagnosis of Merkel cell carcinoma

AND

2 - Disease is M1 disseminated

AND

3 - Patient has a contraindication to or disease has progressed on anti-PD-L1 or anti-PD-1 therapy

Product Name: Brand Hycamtin, generic topotecan	
Diagnosis	Small Cell Lung Cancer (SCLC), Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYCAMTIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	Brand
HYCAMTIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	Brand
HYCAMTIN	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Brand
TOPOTECAN HCL	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Hycamtin (topotecan) therapy

Product Name: Brand Hycamtin, generic topotecan	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYCAMTIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	Brand
HYCAMTIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	Brand

HYCAMTIN	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Brand
TOPOTECAN HCL	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Hycamtin, generic topotecan	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYCAMTIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	Brand
HYCAMTIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	Brand
HYCAMTIN	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Brand
TOPOTECAN HCL	TOPOTECAN HCL FOR INJ 4 MG (BASE EQUIV)	21550080102120	Generic

Approval Criteria

1 - Documentation of positive clinical response to Hycamtin (topotecan) therapy

Hyftor

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146338
Guideline Name	Hyftor
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Hyftor	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYFTOR	SIROLIMUS GEL 0.2%	90784070004020	Brand

Approval Criteria

1 - Diagnosis of tuberous sclerosis

AND

2 - One of the following:

2.1 One or more of the following major features:

- Hypomelanotic macules (At least 3; at least 5 mm diameter)
- Angiofibroma (At least 3) or fibrous cephalic plaque
- Ungual fibromas (At least 2)
- Shagreen patch
- Multiple retinal hamartomas
- Multiple cortical tubers and/or radial migration lines
- Subependymal nodule (At least 2)
- Subependymal giant cell astrocytoma
- Cardiac rhabdomyoma
- Lymphangiomyomatosis (LAM)
- Angiomyolipomas (At least 2)

OR

2.2 Two or more of the following minor features:

- “Confetti” skin lesions
- Dental enamel pits (At least 3)
- Intraoral fibromas (At least 2)
- Retinal achromic patch
- Multiple renal cysts
- Nonrenal hamartomas
- Sclerotic bone lesions

OR

2.3 Confirmed presence of a mutation in the TSC1 or TSC2 gene

AND

3 - Patient has facial angiofibroma associated with tuberous sclerosis

AND

4 - Patient is not receiving Hyftor in combination with a systemic mTOR (mechanistic target of rapamycin) inhibitor [e.g., Rapamune (sirolimus), Afinitor (everolimus)]

AND

5 - Hyftor is being prescribed by, or in consultation, with a dermatologist, neurologist, or oncologist

Product Name: Hyftor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HYFTOR	SIROLIMUS GEL 0.2%	90784070004020	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improvement in skin lesions)

AND

2 - Patient is not receiving Hyftor in combination with a systemic mTOR inhibitor [e.g., Rapamune (sirolimus), Afinitor (everolimus)]

AND

3 - Hyftor is being prescribed by, or in consultation, with a dermatologist, neurologist, or oncologist

Ibrance

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146540
Guideline Name	Ibrance
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ibrance	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBRANCE	PALBOCICLIB CAP 75 MG	21531060000120	Brand
IBRANCE	PALBOCICLIB CAP 100 MG	21531060000130	Brand
IBRANCE	PALBOCICLIB CAP 125 MG	21531060000140	Brand
IBRANCE	PALBOCICLIB TAB 75 MG	21531060000320	Brand

IBRANCE	PALBOCICLIB TAB 100 MG	21531060000330	Brand
IBRANCE	PALBOCICLIB TAB 125 MG	21531060000340	Brand

Approval Criteria

1 - Diagnosis of advanced, recurrent, or metastatic breast cancer

AND

2 - Disease is hormone-receptor (HR)-positive

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

4 - ONE of the following:

- Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane)
- Used in combination with Faslodex (fulvestrant)

Product Name: Ibrance	
Diagnosis	Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBRANCE	PALBOCICLIB CAP 75 MG	21531060000120	Brand
IBRANCE	PALBOCICLIB CAP 100 MG	21531060000130	Brand

IBRANCE	PALBOCICLIB CAP 125 MG	21531060000140	Brand
IBRANCE	PALBOCICLIB TAB 75 MG	21531060000320	Brand
IBRANCE	PALBOCICLIB TAB 100 MG	21531060000330	Brand
IBRANCE	PALBOCICLIB TAB 125 MG	21531060000340	Brand

Approval Criteria

1 - Diagnosis of unresectable retroperitoneal WD-DDLS (well-differentiated/dedifferentiated liposarcoma)

Product Name: Ibrance	
Diagnosis	Breast Cancer, Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBRANCE	PALBOCICLIB CAP 75 MG	21531060000120	Brand
IBRANCE	PALBOCICLIB CAP 100 MG	21531060000130	Brand
IBRANCE	PALBOCICLIB CAP 125 MG	21531060000140	Brand
IBRANCE	PALBOCICLIB TAB 75 MG	21531060000320	Brand
IBRANCE	PALBOCICLIB TAB 100 MG	21531060000330	Brand
IBRANCE	PALBOCICLIB TAB 125 MG	21531060000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Ibrance therapy

Product Name: Ibrance	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBRANCE	PALBOCICLIB CAP 75 MG	21531060000120	Brand
IBRANCE	PALBOCICLIB CAP 100 MG	21531060000130	Brand
IBRANCE	PALBOCICLIB CAP 125 MG	21531060000140	Brand
IBRANCE	PALBOCICLIB TAB 75 MG	21531060000320	Brand
IBRANCE	PALBOCICLIB TAB 100 MG	21531060000330	Brand
IBRANCE	PALBOCICLIB TAB 125 MG	21531060000340	Brand

Approval Criteria

1 - Ibrance will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Ibrance	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IBRANCE	PALBOCICLIB CAP 75 MG	21531060000120	Brand
IBRANCE	PALBOCICLIB CAP 100 MG	21531060000130	Brand
IBRANCE	PALBOCICLIB CAP 125 MG	21531060000140	Brand
IBRANCE	PALBOCICLIB TAB 75 MG	21531060000320	Brand
IBRANCE	PALBOCICLIB TAB 100 MG	21531060000330	Brand
IBRANCE	PALBOCICLIB TAB 125 MG	21531060000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ibrance therapy

Iclusig

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146541
Guideline Name	Iclusig
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Iclusig	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia (CML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ICLUSIG	PONATINIB HCL TAB 10 MG (BASE EQUIV)	21531875100315	Brand
ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21531875100320	Brand
ICLUSIG	PONATINIB HCL TAB 30 MG (BASE EQUIV)	21531875100330	Brand
ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21531875100340	Brand

Approval Criteria

1 - Diagnosis of chronic myelogenous/ myeloid leukemia (CML)

AND

2 - One of the following:

2.1 BOTH of the following:

- Disease is in the chronic phase
- Patient has resistance or intolerance to two or more tyrosine kinase inhibitor (TKI) therapies [e.g., imatinib mesylate, Sprycel (dasatinib), or Tasigna (nilotinib)]

OR

2.2 Confirmed documentation of T315I mutation

OR

2.3 BOTH of the following:

- Disease is in the accelerated or blast phase
- No other kinase inhibitors are indicated

Product Name: Iclusig	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ICLUSIG	PONATINIB HCL TAB 10 MG (BASE EQUIV)	21531875100315	Brand
ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21531875100320	Brand
ICLUSIG	PONATINIB HCL TAB 30 MG (BASE EQUIV)	21531875100330	Brand
ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21531875100340	Brand

Approval Criteria

1 - Diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL)

Product Name: Iclusig	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ICLUSIG	PONATINIB HCL TAB 10 MG (BASE EQUIV)	21531875100315	Brand
ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21531875100320	Brand
ICLUSIG	PONATINIB HCL TAB 30 MG (BASE EQUIV)	21531875100330	Brand
ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21531875100340	Brand

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - One of the following:

2.1 Patient has a FGFR1 (fibroblast growth factor receptor 1) rearrangement

OR

2.2 Patient has an ABL1 (gene) rearrangement

Product Name: Iclusig	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ICLUSIG	PONATINIB HCL TAB 10 MG (BASE EQUIV)	21531875100315	Brand
ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21531875100320	Brand
ICLUSIG	PONATINIB HCL TAB 30 MG (BASE EQUIV)	21531875100330	Brand
ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21531875100340	Brand

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST)

AND

2 - Disease is ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Recurrent/metastatic disease after progression on approved therapies (e.g. imatinib, sunitinib, regorafenib, and standard dose ripretinib)

Product Name: Iclusig	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia (CML), Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL), Myeloid/Lymphoid Neoplasms, Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ICLUSIG	PONATINIB HCL TAB 10 MG (BASE EQUIV)	21531875100315	Brand
ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21531875100320	Brand
ICLUSIG	PONATINIB HCL TAB 30 MG (BASE EQUIV)	21531875100330	Brand
ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21531875100340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Iclusig therapy

Product Name: Iclusig	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ICLUSIG	PONATINIB HCL TAB 10 MG (BASE EQUIV)	21531875100315	Brand
ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21531875100320	Brand
ICLUSIG	PONATINIB HCL TAB 30 MG (BASE EQUIV)	21531875100330	Brand
ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21531875100340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Iclusig	
Diagnosis	NCCN Recommended Regimen

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ICLUSIG	PONATINIB HCL TAB 10 MG (BASE EQUIV)	21531875100315	Brand
ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21531875100320	Brand
ICLUSIG	PONATINIB HCL TAB 30 MG (BASE EQUIV)	21531875100330	Brand
ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21531875100340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Iclusig therapy

ICS.LABA Combination Products

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146339
Guideline Name	ICS.LABA Combination Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic budesonide/formoterol, generic Breyna	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic
BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic

BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic

Approval Criteria

1 - One of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of COPD

AND

1.1.2 ONE of the following:

1.1.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of asthma

AND

1.2.2 ONE of the following:

1.2.2.1 Patient is less than 12 years of age

OR

1.2.2.2 ONE of the following:

1.2.2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.2.2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

Product Name: fluticasone/vilanterol (authorized generic of Breo Ellipta)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of asthma

AND

1.2 BOTH of the following:

1.2.1 ONE of the following:

1.2.1.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2 ONE of the following:

1.2.2.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

1.2.2.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

OR

2 - ALL of the following:

2.1 Diagnosis of COPD

AND

2.2 ONE of the following:

2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

2.3.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

Product Name: Advair HFA, fluticasone-salmeterol (authorized generic of Advair HFA), Dulera, AirDuo Digihaler, AirDuo Respiclick *	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 50-5 MCG/ACT	44209902903210	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 100-5 MCG/ACT	44209902903220	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 200-5 MCG/ACT	44209902903240	Brand
AIRDUO RESPICLICK 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT	44209902708010	Generic
AIRDUO RESPICLICK 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT	44209902708015	Generic
AIRDUO RESPICLICK 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT	44209902708025	Generic
AIRDUO DIGIHALER 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT W/ SENSOR	44209902718020	Brand
AIRDUO DIGIHALER 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT W/SENSOR	44209902718030	Brand
AIRDUO DIGIHALER 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT W/SENSOR	44209902718040	Brand
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

Notes	*Policy applies to Brand Necessary requests

Product Name: Brand Symbicort, Brand Advair Diskus*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Brand
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Brand
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Brand
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Brand
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of asthma

AND

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient is less than 12 years of age

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure of Breyna or budesonide/formoterol (generic of Symbicort) confirmed by claims history or submitted medical records

OR

1.2.1.2.2 History of intolerance or contraindication to Breyna or budesonide/formoterol (generic of Symbicort) (please specify intolerance or contraindication)

OR

1.2.2 BOTH of the following:

1.2.2.1 ONE of the following:

1.2.2.1.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2.2 ONE of the following:

1.2.2.2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

1.2.2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2 - All of the following:

2.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2.2 ONE of the following:

2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

Notes	*Policy applies to Brand Necessary requests

Product Name: Breo Ellipta*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of asthma

AND

1.2 BOTH of the following:

1.2.1 ONE of the following:

1.2.1.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

1.2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

1.2.2 ONE of the following:

1.2.2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

1.2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort))
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2 - ALL of the following:

2.1 Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2.2 ONE of the following:

2.2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

AND

2.3 ONE of the following:

2.3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Breyna or budesonide/formoterol (generic of Symbicort)
- fluticasone/vilanterol (authorized generic of Breo Ellipta)

Notes	*Policy applies to Brand Necessary requests

Idhifa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146542
Guideline Name	Idhifa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Idhifa	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IDHIFA	ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT)	21535030200320	Brand
IDHIFA	ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21535030200340	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - AML is IDH2 (isocitrate dehydrogenase 2) mutation-positive

AND

3 - ONE of the following:

3.1 Disease is relapsed or refractory

OR

3.2 Used as low-intensity treatment induction when not a candidate for intensive induction therapy

OR

3.3 Used for consolidation therapy as continuation of low-intensity regimen used for induction

Product Name: Idhifa	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IDHIFA	ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT)	21535030200320	Brand

IDHIFA	ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21535030200340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Idhifa therapy

Product Name: Idhifa	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IDHIFA	ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT)	21535030200320	Brand
IDHIFA	ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21535030200340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Idhifa	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IDHIFA	ENASIDENIB MESYLATE TAB 50 MG (BASE EQUIVALENT)	21535030200320	Brand
IDHIFA	ENASIDENIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21535030200340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Idhifa therapy

Ilaris

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146836
Guideline Name	Ilaris
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ilaris	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Familial cold autoinflammatory syndrome (FCAS)
- Muckle-Wells Syndrome (MWS)

AND

2 - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of FCAS and MWS

Product Name: Ilaris	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Patient is currently on Ilaris therapy for ONE of the following:

- Familial cold autoinflammatory syndrome (FCAS)
- Muckle-Wells Syndrome (MWS)

AND

2 - Documentation of positive clinical response to Ilaris therapy

Product Name: Ilaris	
Diagnosis	Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Diagnosis of tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS)

AND

2 - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of TRAPS

Product Name: Ilaris	
Diagnosis	Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Patient is currently on Ilaris therapy for tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS)

AND

2 - Documentation of positive clinical response to Ilaris therapy, defined as a decrease in frequency or severity of attacks

Product Name: Ilaris	
Diagnosis	Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Diagnosis of ONE of the following

- Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)
- Mevalonate Kinase Deficiency (MKD)

AND

2 - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of HIDS or MKD

Product Name: Ilaris	
Diagnosis	Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Patient is currently on Ilaris therapy for ONE of the following:

- Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)
- Mevalonate Kinase Deficiency (MKD)

AND

2 - Documentation of positive clinical response to Ilaris therapy, defined as a decrease in frequency or severity of attacks

Product Name: Ilaris	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Diagnosis of Familial Mediterranean Fever (FMF)

AND

2 - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of FMF

AND

3 - ONE of the following:

3.1 Failure to colchicine as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to colchicine (please specify contraindication or intolerance)

Product Name: Ilaris	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Patient is currently on Ilaris therapy for Familial Mediterranean Fever (FMF)

AND

2 - Documentation of positive clinical response to Ilaris therapy, defined by a decrease in index disease flare or normalization of CRP (C-reactive protein)

Product Name: Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Diagnosis of systemic juvenile idiopathic arthritis (SJIA)

AND

2 - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of SJIA

AND

3 - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

Product Name: Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Patient is currently on Ilaris therapy for systemic juvenile idiopathic arthritis (SJIA)

AND

2 - Documentation of positive clinical response to Ilaris therapy

AND

3 - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

Product Name: Ilaris	
Diagnosis	Still's Disease [Adult-Onset Still's Disease (AOSD)]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Diagnosis of Adult Onset Still's Disease (AOSD)

AND

2 - Diagnosis is made by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of Still's Disease

AND

3 - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

Product Name: Ilaris	
Diagnosis	Still's Disease [Adult-Onset Still's Disease (AOSD)]
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Patient is currently on Ilaris therapy for Adult Onset Still's Disease (AOSD)

AND

2 - Documentation of positive clinical response to Ilaris therapy

AND

3 - Patient is not receiving Ilaris in combination with another biologic (e.g., Actemra)

Product Name: Ilaris	
Diagnosis	Gout Flare
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand

Approval Criteria

1 - Diagnosis of a gout flare

AND

2 - ONE of the following:

2.1 History of failure to BOTH of the following confirmed by claims history or submission of medical records:

- Colchicine
- Non-steroidal anti-inflammatory drugs (NSAIDs)

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Colchicine
- Non-steroidal anti-inflammatory drugs (NSAIDs)

AND

3 - Provider attests that the patient is not an appropriate candidate for systemic corticosteroids

AND

4 - Prescribed by one of the following:

- Rheumatologist
- Nephrologist

AND

5 - The patient has not received Ilaris in the past 12 weeks

2 . Revision History

Date	Notes
4/30/2024	Removed "-NY CHIP" from GL name

Ilumya

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146544
Guideline Name	Ilumya
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ilumya	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILUMYA	TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML	9025058010E520	Brand

Approval Criteria

1 - Diagnosis of chronic moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

AND

3 - Prescribed by, or in consultation with, a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Ilumya therapy as confirmed by claims history or submission of medical records

OR

4.2 One of the following:

4.2.1 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Enbrel (etanercept)]

OR

4.2.2 All of the following:

4.2.2.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

4.2.2.2 One of the following:

- Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.2.3 One of the following:

- Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

Product Name: Ilumya	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ILUMYA	TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML	9025058010E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ilumya therapy

AND

2 - Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Imbruvica

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146545
Guideline Name	Imbruvica
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Imbruvica	
Diagnosis	B-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand

IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of mantle cell lymphoma (MCL)

AND

1.2 ONE of the following:

1.2.1 Patient has received at least one prior therapy for MCL

OR

1.2.2 Used in pre-treatment therapy in combination with Rituxan (rituximab) to limit the number of cycles with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen

OR

2 - Diagnosis of ONE of the following:

- Chronic Lymphocytic Leukemia (CLL)
- Small Lymphocytic Lymphoma (SLL)

OR

3 - BOTH of the following:

3.1 Diagnosis of ONE of the following:

- Diffuse large B-cell lymphoma [non-GCB DLBCL (non-germinal center B-cell diffuse large B-cell) and non-candidate for transplant]

- Human Immunodeficiency Virus (HIV)-related B-cell lymphoma
- Post-transplant lymphoproliferative disorders
- Histologic transformation to diffuse large B-cell lymphoma
- Hairy cell leukemia
- Nodal or splenic marginal zone lymphoma (MZL)
- Extranodal marginal zone lymphoma (EMZL) of the stomach
- Extranodal Marginal Zone Lymphoma of Nongastric Sites (Noncutaneous)
- High grade B-cell lymphoma

AND

3.2 Used as second-line or a subsequent therapy

Product Name: Imbruvica	
Diagnosis	Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand
IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - Diagnosis of Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma

Product Name: Imbruvica	
Diagnosis	Primary CNS Lymphoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand
IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - Diagnosis of primary central nervous system (CNS) lymphoma

AND

2 - ONE of the following:

2.1 Used as second-line or a subsequent therapy

OR

2.2 Used as induction therapy if the patient is unsuitable or intolerant to high-dose methotrexate

Product Name: Imbruvica	
Diagnosis	B-Cell Lymphoma, Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma, Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand
IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Imbruvica therapy

Product Name: Imbruvica	
Diagnosis	Chronic Graft Versus Host Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand
IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - Diagnosis of chronic graft versus host disease

AND

2 - History of failure of at least one other systemic therapy [e.g., corticosteroids, mycophenolate, etc.] as confirmed by claims history or submission of medical records

Product Name: Imbruvica	
Diagnosis	Chronic Graft Versus Host Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand
IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - Patient shows evidence of positive clinical response while on Imbruvica therapy

Product Name: Imbruvica	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand
IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Imbruvica	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMBRUVICA	IBRUTINIB CAP 70 MG	21532133000110	Brand
IMBRUVICA	IBRUTINIB CAP 140 MG	21532133000120	Brand
IMBRUVICA	IBRUTINIB TAB 140 MG	21532133000320	Brand
IMBRUVICA	IBRUTINIB TAB 280 MG	21532133000330	Brand
IMBRUVICA	IBRUTINIB TAB 420 MG	21532133000340	Brand
IMBRUVICA	IBRUTINIB TAB 560 MG	21532133000350	Brand
IMBRUVICA	IBRUTINIB ORAL SUSP 70 MG/ML	21532133001820	Brand

Approval Criteria

1 - Documentation of positive clinical response to Imbruvica therapy

Impavido

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146340
Guideline Name	Impavido
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Impavido	
Approval Length	28 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IMPAVIDO	MILTEFOSINE CAP 50 MG	16000036000120	Brand

Approval Criteria

1 - Patient has a diagnosis of ONE of the following:

- Visceral leishmaniasis due to Leishmania donovani
- Cutaneous leishmaniasis due to Leishmania braziliensis, Leishmania guyanensis, or Leishmania panamensis
- Mucosal leishmaniasis due to Leishmania braziliensis
- Primary Amebic Meningoencephalitis (PAM)
- Keratitis due to Acanthamoeba
- Amebic encephalitis due to Balamuthia mandrillaris

Inbrija

Prior Authorization Guideline

Guideline ID	GL-146342
Guideline Name	Inbrija
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Inbrija	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INBRIJA	LEVODOPA INHAL POWDER CAP 42 MG	73200040000160	Brand

Approval Criteria

1 - Diagnosis of Parkinson’s disease

AND

2 - Inbrija will be used as intermittent treatment for OFF episodes

AND

3 - Prescribed by, or in consultation with, a neurologist or specialist in the treatment of Parkinson's disease

AND

4 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

5 - Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa/levodopa therapy including BOTH of the following:

- Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet
- Dose and dosing interval optimization

AND

6 - ONE of the following:

6.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes confirmed by claims history or submission of medical records (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

OR

6.2 History of contraindication or intolerance to ALL anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (please specify intolerance or contraindication):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

Product Name: Inbrija	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INBRIJA	LEVODOPA INHAL POWDER CAP 42 MG	73200040000160	Brand

Approval Criteria

1 - Documentation of positive clinical response to Inbrija therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Ingrezza

Prior Authorization Guideline

Guideline ID	GL-146546
Guideline Name	Ingrezza
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ingrezza	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INGREZZA	VALBENAZINE TOSYLATE CAP THERAPY PACK 40 MG (7) & 80 MG (21)	6238008020B220	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 40 MG (BASE EQUIV)	62380080200120	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV)	62380080200130	Brand

INGREZZA	VALBENAZINE TOSYLATE CAP 80 MG (BASE EQUIV)	62380080200140	Brand

Approval Criteria

1 - Diagnosis of moderate to severe tardive dyskinesia

AND

2 - ONE of the following:

2.1 Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

OR

2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

AND

3 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Psychiatrist

Product Name: Ingrezza	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INGREZZA	VALBENAZINE TOSYLATE CAP THERAPY PACK 40 MG (7) & 80 MG (21)	6238008020B220	Brand

INGREZZA	VALBENAZINE TOSYLATE CAP 40 MG (BASE EQUIV)	62380080200120	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV)	62380080200130	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 80 MG (BASE EQUIV)	62380080200140	Brand

Approval Criteria

1 - Diagnosis of chorea associated with Huntington's disease

AND

2 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Psychiatrist

Product Name: Ingrezza	
Diagnosis	Tardive Dyskinesia, Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INGREZZA	VALBENAZINE TOSYLATE CAP THERAPY PACK 40 MG (7) & 80 MG (21)	6238008020B220	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 40 MG (BASE EQUIV)	62380080200120	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 60 MG (BASE EQUIV)	62380080200130	Brand
INGREZZA	VALBENAZINE TOSYLATE CAP 80 MG (BASE EQUIV)	62380080200140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ingrezza therapy

Inhaled Corticosteroids

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149518
Guideline Name	Inhaled Corticosteroids
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/4/2024

1 . Criteria

Product Name: Asmanex HFA, Asmanex Twisthaler	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 100 MCG/ACT	44400036203220	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 200 MCG/ACT	44400036203230	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 50 MCG/ACT	44400036203210	Brand
ASMANEX TWISTHALER	MOMETASONE FUROATE INHAL POWD 110 MCG/ACT (BREATH ACTIVATED)	44400036208010	Brand

30 METERED DOSES			
ASMANEX TWISTHALER 14 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 60 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 120 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 30 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure of Brand Fluticasone propionate HFA confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to Brand Fluticasone propionate HFA (please specify intolerance or contraindication)

Product Name: Alvesco, ArmonAir Digihaler, Arnuity Ellipta, Flovent Diskus, Brand Flovent HFA, Pulmicort Flexhaler, Qvar RediHaler	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 50 MCG/BLISTER	44400033208010	Brand
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 100 MCG/BLISTER	44400033208020	Brand
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 250 MCG/BLISTER	44400033208030	Brand
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 90 MCG/ACT (BREATH ACTIVATED)	44400015008009	Brand
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 180 MCG/ACT (BREATH ACTIVATED)	44400015008018	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 80 MCG/ACT	44400017003420	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 160 MCG/ACT	44400017003440	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 55 MCG/ACT WITH SENSOR	44400033218020	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 113 MCG/ACT WITH SENSOR	44400033218030	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 232 MCG/ACT WITH SENSOR	44400033218040	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50 MCG/ACT	44400033108010	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100 MCG/ACT	44400033108020	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200 MCG/ACT	44400033108030	Brand
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE)	44400033223220	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE)	44400033223230	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE)	44400033223240	Generic
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 40 MCG/ACT	44400010128120	Brand
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 80 MCG/ACT	44400010128140	Brand

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Brand Fluticasone propionate HFA
- Asmanex HFA or Asmanex Twisthaler

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Brand Fluticasone propionate HFA
- Asmanex HFA or Asmanex Twisthaler

Inlyta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146547
Guideline Name	Inlyta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Inlyta	
Diagnosis	Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INLYTA	AXITINIB TAB 1 MG	21335013000320	Brand
INLYTA	AXITINIB TAB 5 MG	21335013000340	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of advanced renal cell carcinoma

AND

1.2 ONE of the following:

- Patient has failed one prior systemic therapy
- The requested medication will be used in combination with Bavencio (avelumab) or Keytruda (pembrolizumab)

OR

2 - Diagnosis of stage IV renal cell carcinoma

Product Name: Inlyta	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INLYTA	AXITINIB TAB 1 MG	21335013000320	Brand
INLYTA	AXITINIB TAB 5 MG	21335013000340	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Follicular Carcinoma
- Oncocytic Carcinoma
- Papillary Carcinoma

AND

2 - Patient's disease is ONE of the following:

- Recurrent and unresectable
- Persistent
- Metastatic

AND

3 - Disease is not amenable to radioactive iodine treatment

Product Name: Inlyta	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INLYTA	AXITINIB TAB 1 MG	21335013000320	Brand
INLYTA	AXITINIB TAB 5 MG	21335013000340	Brand

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Patient's disease is ONE of the following:

- Recurrent and unresectable
- Metastatic

Product Name: Inlyta	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INLYTA	AXITINIB TAB 1 MG	21335013000320	Brand
INLYTA	AXITINIB TAB 5 MG	21335013000340	Brand

Approval Criteria

1 - Diagnosis of alveolar soft part sarcoma (ASPS)

AND

2 - The requested medication will be used in combination with Keytruda (pembrolizumab)

Product Name: Inlyta	
Diagnosis	Advanced Renal Cell Carcinoma, Thyroid Carcinoma, Salivary Gland Tumor, Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INLYTA	AXITINIB TAB 1 MG	21335013000320	Brand
INLYTA	AXITINIB TAB 5 MG	21335013000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Inlyta therapy

Product Name: Inlyta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INLYTA	AXITINIB TAB 1 MG	21335013000320	Brand
INLYTA	AXITINIB TAB 5 MG	21335013000340	Brand

Approval Criteria

1 - Inlyta will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Inlyta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INLYTA	AXITINIB TAB 1 MG	21335013000320	Brand
INLYTA	AXITINIB TAB 5 MG	21335013000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Inlyta therapy

Inqovi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146548
Guideline Name	Inqovi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Inqovi	
Diagnosis	Myelodysplastic Syndrome (MDS), Chronic Myelomonocytic Leukemia (CMML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INQOVI	DECITABINE-CEDAZURIDINE TAB 35-100 MG	21990002250320	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of myelodysplastic syndrome (MDS)

AND

1.2 Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS)

OR

2 - Diagnosis of chronic myelomonocytic leukemia (CMML)

Product Name: Inqovi	
Diagnosis	Myelodysplastic Syndrome (MDS), Chronic Myelomonocytic Leukemia (CMML)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INQOVI	DECITABINE-CEDAZURIDINE TAB 35-100 MG	21990002250320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Inqovi therapy

Product Name: Inqovi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INQOVI	DECITABINE-CEDAZURIDINE TAB 35-100 MG	21990002250320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Inqovi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INQOVI	DECITABINE-CEDAZURIDINE TAB 35-100 MG	21990002250320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Inqovi therapy

Inrebic

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146549
Guideline Name	Inrebic
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Inrebic	
Diagnosis	Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INREBIC	FEDRATINIB HCL CAP 100 MG	21537520200120	Brand

Approval Criteria

1 - Diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis

AND

2 - One of the following:

2.1 Failure to Jakafi (ruxolitinib) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to Jakafi (ruxolitinib) (please specify intolerance or contraindication)

OR

2.3 Patient is currently on Inrebic therapy

Product Name: Inrebic	
Diagnosis	Myelofibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INREBIC	FEDRATINIB HCL CAP 100 MG	21537520200120	Brand

Approval Criteria

1 - Documentation that the patient has evidence of symptom improvement or reduction in spleen volume while on Inrebic

Product Name: Inrebic

Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INREBIC	FEDRATINIB HCL CAP 100 MG	21537520200120	Brand

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - Patient has a JAK2 (Janus kinase 2) rearrangement

AND

3 - ONE of the following:

3.1 Failure to Jakafi (ruxolitinib) confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to Jakafi (ruxolitinib) (please specify intolerance or contraindication)

OR

3.3 Patient is currently on Inrebic therapy

Product Name: Inrebic	
Diagnosis	Myeloid/Lymphoid Neoplasms

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INREBIC	FEDRATINIB HCL CAP 100 MG	21537520200120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Inrebic therapy

Product Name: Inrebic	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INREBIC	FEDRATINIB HCL CAP 100 MG	21537520200120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Inrebic	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

INREBIC	FEDRATINIB HCL CAP 100 MG	21537520200120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Inrebic therapy

Insulin Pen Needles and Syringes

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146888
Guideline Name	Insulin Pen Needles and Syringes
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Non-preferred insulin pen needles and insulin syringes	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
EASY TOUCH SAFETY PEN NEEDLES/29G X 5MM	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 3/16"	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand
EASY TOUCH SAFETY PEN NEEDLES/29G X 8MM	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 5/16"	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand

DROPLET PEN NEEDLES 29GX10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
TECHLITE PEN NEEDLES 29G X 10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
AURORA PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREFINE PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CARETOUCH PEN NEEDLE 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29G X1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DRUG MART UNIFINE PENTIPS29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EASY TOUCH PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
GLOBAL EASE INJECT PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
H-E-B INCONTROL PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHWISE PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
INSUPEN 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
KROGER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MARATHON MEDICAL PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEIJER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PC UNIFINE PENTIPS 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand

PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PEN NEEDLES/29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PX PEN NEEDLE 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
QC PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RAYA SURE PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RELION PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/REMOVER/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TECHLITE PEN NEEDLES 29G X 12 MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TODAYS HEALTH ORIGINAL PEN NEEDLES 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TRUEPLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ULTRA FLO INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS PLUS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VALUMARK PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VIDA MIA UNIFINE PENTIPS ORIGINAL 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS PLUS/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ADVOCATE INSULIN PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand

BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
LITETOUCH PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
SURE COMFORT PEN NEEDLES 29GX1/2" 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE ORIGINAL PEN NEEDLES ULTI-FINE	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE PEN NEEDLES/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTIGUARD SAFEPACK PEN NEEDLE/29G X 1/2"/SHARPS CONTAINER	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTILET PEN NEEDLE 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTRA-THIN II PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
BD AUTOSHIELD DUO 30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH PEN NEEDLE/30 G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
PEN NEEDLES 30GX5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
SAFETY PEN NEEDLES/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
ULTICARE MINI SAFETY PEN NEEDLES 30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS PLUS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4"	INSULIN PEN NEEDLE 30 G X 6 MM (1/4" OR 15/64")	97051050146341	Brand
ABOUTTIME PEN NEEDLES 30GX 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ASSURE ID SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
CAREFINE PEN NEEDLES 30GX5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
DROPLET PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

EASY TOUCH PEN NEEDLE 30 G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
INSUPEN ULTRAFIN 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
PEN NEEDLES 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SECURESAFE SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SURE COMFORT PEN NEEDLES 30GX5/16" SHORT	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ULTICARE SHORT SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM SAFETY PEN NEEDLE/31 G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT TOUCH PEN NEEDLES/31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
RAYA SURE PEN NEEDLE 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
ABOUTTIME PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM SAFETY PEN NEEDLE/31 G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
BD PEN NEEDLE/MINI/ULTRA-FINE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CARETOUCH PEN NEEDLES 31GX 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLICKFINE PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

COMFORT EZ/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT TOUCH PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DIATHRIVE PEN NEEDLE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31G X3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPSAFE SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DRUG MART UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY COMFORT PEN NEEDLES 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY TOUCH PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31G X3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FREDS PHARMACY UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GLOBAL EASE INJECT PEN NEEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTICARE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE CLICKFINE SAFETY PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLE 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HM ULTICARE MINI PEN NEEDLES/31G X 5MM (3/16")	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
INSUPEN 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
KROGER PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS PLUS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31 G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MARATHON MEDICAL PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MM PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PC UNIFINE PENTIPS 31G X 5MM MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PREFERRED PLUS UNIFINE PENTIPS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PX MINI PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RA PEN NEEDLES 31G X 5MM 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RAYA SURE PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/MINI/REMOVER/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

SURE COMFORT PEN NEEDLES 31GX3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTICARE PEN NEEDLES 31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET SHORT PEN NEEDLES31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA FLO INSULIN PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA-THIN II MINI PEN NEEEDLES/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRACARE PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE ULTRA PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
WEGMANS UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ZEVRX PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
1ST TIER UNIFINE PENTIPS /MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

1ST TIER UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREFINE PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CARETOUCH PEN NEEDLES 31 G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT EZ/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT TOUCH PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DIATHRIVE PEN NEEDLE/31 G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPLET PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPSAFE SAFTEY PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DRUG MART UNIFINE PENTIPS31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY COMFORT PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY TOUCH PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHWISE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

INCONTROL ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
INSUPEN ULTRAFIN 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM/ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MAXICOMFORT II PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEIJER PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MICRODOT PEN NEEDLE/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MM PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PC UNIFINE PENTIPS 31G X 6MM ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31GX6MM (1/4")	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
BD INSULIN SYRINGE/U-500/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-500 0.5 ML 31G X 6MM (15/64")	97051030956330	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE/0.3ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
DROPLET INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
EQL INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand

EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GNP INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
KROGER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LEADER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTICARE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
VP INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand

DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EQL INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INSULIN SYRINGES/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGES/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
KROGER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LEADER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MEDIC INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MM INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
PRECISION SURE-DOSE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand

PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CAREONE INSULIN SYRINGES/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand

SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
INSULIN SYRINGES/0.5ML/27GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CAREONE INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CARETOUCH INSULIN SYRINGE/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
COMFORT EZ INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EQL INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GNP INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KROGER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LEADER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LONGS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MM INSULIN SYRINGE/U-100/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRODIGY INSULIN SYRINGE/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

RELION INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTIGUARD SAFEPACK/SYRINGE/NEEDLE/31G X 5/16"/SHARPS CONTAIN	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD LO-DOSE INSULIN SYRINGE MICROFINE IV/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GNP INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand

INSULIN SYRINGES/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LEADER INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ULTICARE INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE/0.5ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETY-GLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
DROPLET INSULIN SYRINGE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

EASY TOUCH INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EQL INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGES/1/2ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGES/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KINRAY INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KROGER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LEADER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RA INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RELION INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SB INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SAFETY SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
BD SAFETYGLIDE INSULIN SYSYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CARETOUCH INSULIN SYRINGE0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EQL INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G	INSULIN SYRINGE (DISP) U-100 0.3 ML	97051030056305	Brand

KMART VALU PLUS INSULIN SYRINGE/0.5ML/29G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
KMART VALU PLUS INSULIN SYRINGE/0.5ML/30G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
BD INSULIN SYRINGE LUER-LOK/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
BD INSULIN SYRINGE SLIP TIP/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/29G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/30G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE REGULAR LUER TIP/SOFTPACK/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
VERIFINE INSULIN SYRINGE 0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VERIFINE INSULIN SYRINGE 0.5ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
AQ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GNP INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGES/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KROGER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

LEADER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MEDIC INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MM INSULIN SYRINGE/U-100/1/2ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
RA INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SB INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ZEVRX INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CAREONE INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PX INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1/2ML 30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.5ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand

ZEVRX INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/25G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 25 X 5/8"	97051030906330	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
INSULIN SYRINGES 0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31GX1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/HALF UNIT/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
INSULIN SYRINGES 0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
SURE COMFORT INSULIN SYRINGES/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand

ULTICARE U-100 INSULIN SYRINGES/0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
INSULIN SYRINGE 1ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
SURE COMFORT INSULIN SYRINGES/U-100/1ML/31GX6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
ULTICARE U-100 INSULIN SYRINGES/1ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 3/16" (5 MM)	97051030906338	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/2"	97051030906341	Brand
EASY COMFORT INSULIN SYRINGES/0.5ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/32G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
EASY COMFORT INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
INSULIN SYRINGES/U-100/1ML/27GX/1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 3/16" (5 MM)	97051030906355	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 15/64"	97051030906359	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 15/64"	97051030906361	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 15/64"	97051030906362	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/28G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 5/16"	97051030906368	Brand

BD INSULIN SYRINGE MICROFINE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP INSULIN SYRINGES/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
INSULIN SYRINGES/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LEADER INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PRODIGY INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
REALITY INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ULTICARE INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
AQ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

DROPLET INSULIN SYRINGE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 29GX12.5MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EQL INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGES/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/NEEDLE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
KROGER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LEADER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

RA INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
REALITY INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SB INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TRUEPLUS INSULIN SYRINGE /U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SAFETY SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA FLO INSULIN SYRINGE 1M/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VERIFINE INSULIN SYRINGE 1ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CARETOUCH INSULIN SYRINGE/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EQL INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGES/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/NEEDLE 1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
KROGER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LEADER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MM INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
RA INSULIN SYRINGE/U-100/1 ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

SB INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
BD INSULIN SYRINGE ULTRA FINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRAFINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CAREONE INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1.0ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand

EASY TOUCH INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH SHEATHLOCK SAFETY SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
HM ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
INSULIN SYRINGES/U-100/1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 30G X 1/2"/SHARPS CON	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
AQ INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CAREONE INSULIN SYRINGES/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CARETOUCH INSULIN SYRINGE/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
COMFORT EZ INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EQL INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GNP INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/NEEDLE 1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGES/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KROGER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
LEADER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

LITETOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MM INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MONOJECT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MS INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
PRO COMFORT INSULIN SYRINGES/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SB INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 31G X 5/16"/SHARPS CO	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA FLO INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
VERIFINE INSULIN SYRINGE 1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

CAREONE INSULIN SYRINGES/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CARETOUCH INSULIN SYRINGE/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
COMFORT ASSIST INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE U-100/0.3/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EQL INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL EASY GLIDE INSULINSYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGES/3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HM ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

KINRAY INSULIN SYRINGE PREFERRED PLUS/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
KROGER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LEADER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MM INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MS INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
PRODIGY INSULIN SYRING/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/31G X 5/16"/SHARPS	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
VERIFINE INSULIN SYRINGE 0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ASSURE ID INSULIN SAFETY SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
RELION INSULIN SYRINGE 0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
ASSURE ID INSULIN SAFETY SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE 1ML/31GX15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
EMBRACE PEN NEEDLES/29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VERIFINE INSULIN PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EMBRACE PEN NEEDLES/30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EMBRACE PEN NEEDLES/30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

PEN NEEDLES	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
AQINJECT PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PIP PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PX EXTRA SHORT PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
QC PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RAYA SURE PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

RELION MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TECHLITE PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MICRO PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 6MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTRACARE PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS PLUS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

UNIFINE ULTRA PEN NEEDLE/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
WEGMANS UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ZEVRX PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ABOUTTIME PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
AURORA PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREFINE PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CARETOUCH PEN NEEDLES 31GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT EZ SHORT/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT TOUCH PEN NEEDLES/31G X 8 MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DIATHRIVE PEN NEEDLE/31 GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31G X5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPSAFE SAFETY PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

DRUG MART UNIFINE PENTIPS31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY COMFORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY TOUCH PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EMBRACE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES 31G X5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GLOBAL EASE INJECT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTICARE PEN NEEDLES /31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HM ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN ULTRAFIN 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LEADER UNIFINE PENTIPS PLUS/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LITETOUCH PEN NEEDLES 31GX8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

LITETOUCH PEN NEEDLES/31G X 8MM/SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MARATHON MEDICAL PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEIJER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MM PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PC UNIFINE PENTIPS 31G X 8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM (5/16")	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PRO COMFORT PEN NEEDLES/ 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX SHORTLENGTH PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
QC PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RA PEN NEEDLES 31G X 8MM 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RAYA SURE PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

RELION PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
SURE COMFORT PEN NEEDLES 31GX5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TECHLITE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TODAYS HEALTH SHORT PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 5/16"/SHARPS CONTA	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 8MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET SHORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA FLO INSULIN PEN NEELE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA-THIN II PEN NEEDLES/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRACARE PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE ULTRA PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
WEGMANS UNIFINE PENTIPS PLUS/SHORT/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ZEVRX PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ABOUTTIME PEN NEEDLE 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AQINJECT PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM READYGARD DUO SAFETY PEN NEEDLE/32GX4MM/DUAL AUTO PROTEC	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREFINE PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CARETOUCH PEN NEEDLES 32GX 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLE 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT EZ MICRO/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT TOUCH PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DIATHRIVE PEN NEEDLE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

DROPLET PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DROPLET PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPSPLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPS32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY TOUCH PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EMBRACE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
FIFTY50 PEN NEEDLES/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASE INJECT PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASY GLIDE PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTICARE PEN NEEDLES/32GX 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL PEN NEEDLES/NANO/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
HEALTHWISE MICRON PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN PEN NEEDLES 32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
KROGER PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LEADER UNIFINE PENTIPS/NANO/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

LEADER UNIFINE PENTIPS/PLUS/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LITETOUCH INSULIN PEN NEEDLES/32G X 4MM/MINI	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MARATHON MEDICAL PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MICRODOT PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MM PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
NOVOFINE PLUS PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PIP PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PRO COMFORT PEN NEEDLES/ 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT PEN NEEDLE/32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT SAFETY PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
QC UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32" (4MM)	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TECHLITE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

TRUE COMFORT PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT SAFETY PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CNTR	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CONTA	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM/SHORT	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA FLO INSULIN PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA THIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRACARE PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE SAFECONTROL PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE ULTRA PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

VERIFINE INSULIN PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
VERIFINE PLUS INSULIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
WEGMANS UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ZEVRX PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CAREFINE PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CARETOUCH PEN NEEDLES 32GX 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
COMFORT TOUCH PEN NEEDLES/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH PEN NEEDLES 32GX3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PRO COMFORT PEN NEEDLES/ 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PURE COMFORT PEN NEEDLE/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
ULTRACARE PEN NEEDLES/32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM MINI INSULIN PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

CAREFINE PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
COMFORT TOUCH PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH PEN NEEDLES 32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
FIFTY50 PEN NEEDLES/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTICARE PEN NEEDLES/32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
INSUPEN SENSITIVE 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
NOVOFINE PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PRO COMFORT PEN NEEDLES/ 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PURE COMFORT PEN NEEDLE 32G X6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
SURE COMFORT PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TECHLITE PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTICARE MINI PEN NEEDLES/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

ULTRACARE PEN NEEDLES/32G X 1/14"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
VERIFINE INSULIN PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
BD PEN NEEDLE/MICRO/ULTRA-FINE/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
1ST TIER UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM MINI INSULIN PEN NEEDLE/32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
COMFORT TOUCH PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32G X 5/16"	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
INSUPEN SENSITIVE 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
PURE COMFORT PEN NEEDLE 32G X8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
TECHLITE PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
ADVOCATE INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CARETOUCH PEN NEEDLE 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
COMFORT TOUCH PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY COMFORT PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY GLIDE PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand

H-E-B IN CONTROL UNIFINE PENTIPS PLUS 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
INSUPEN 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
KROGER PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
MICRODOT PEN NEEDLE/33G X 4 MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRA FLO INSULIN PEN NEEDLE 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRACARE PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
COMFORT TOUCH PEN NEEDLES/33GX 3/16"	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
EASY COMFORT PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM MINI INSULIN PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
AUM PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
COMFORT TOUCH PEN NEEDLES/33GX1/4"	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand

EASY COMFORT PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX8MM	INSULIN PEN NEEDLE 33 G X 8 MM (1/3" OR 5/16")	97051050146380	Brand
DROPLET MICRON 34G X 9/64"	INSULIN PEN NEEDLE 34 G X 3.5 MM (9/64")	97051050146385	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE HALF-UNIT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE/1ML/27G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE MICROFINE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/1ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/U-100/2ML/27.5G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 2 ML 27.5 X 5/8"	97051030906390	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD VEO INSULIN SYRINGE ULTR-FINE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand

BD VEO INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD SAFETYGLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD PEN NEEDLE/SHORT/ULTRA-FINE/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO/ULTRA - FINE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

Approval Criteria

1 - If the request is non-preferred*, history of failure to a preferred* BD (Becton Dickinson) insulin pen needle or syringe as confirmed by claims history or submission of medical records

OR

2 - If the request is non-preferred*, physician has provided documentation as to why the patient is unable to use a preferred* BD product (document rationale)

Notes	*PDL links are listed in Background.

Product Name: All insulin pen needles and insulin syringes	
Diagnosis	Requests exceeding 6 pen needles or syringes per day*
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
EASY TOUCH SAFETY PEN NEEDLES/29G X 5MM	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 3/16"	INSULIN PEN NEEDLE 29 G X 5 MM (1/5" OR 3/16")	97051050146318	Brand

EASY TOUCH SAFETY PEN NEEDLES/29G X 8MM	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand
MAXI-COMFORT SAFETY PEN NEEDLE/29G X 5/16"	INSULIN PEN NEEDLE 29 G X 8 MM (1/3" OR 5/16")	97051050146322	Brand
DROPLET PEN NEEDLES 29GX10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
TECHLITE PEN NEEDLES 29G X 10MM	INSULIN PEN NEEDLE 29 G X 10 MM	97051050146326	Brand
AURORA PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREFINE PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CAREONE UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CARETOUCH PEN NEEDLE 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29G X1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DROPLET PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
DRUG MART UNIFINE PENTIPS29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EASY TOUCH PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
GLOBAL EASE INJECT PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
H-E-B INCONTROL PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHWISE PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
INSUPEN 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
KROGER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MARATHON MEDICAL PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand

MEIJER PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PC UNIFINE PENTIPS 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PEN NEEDLES/29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
PX PEN NEEDLE 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
QC PEN NEEDLES 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RAYA SURE PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
RELION PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/REMOVER/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TECHLITE PEN NEEDLES 29G X 12 MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TODAYS HEALTH ORIGINAL PEN NEEDLES 29G X 1/2"	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
TRUEPLUS PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ULTRA FLO INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS PLUS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VALUMARK PEN NEEDLES 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VIDA MIA UNIFINE PENTIPS ORIGINAL 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
1ST TIER UNIFINE PENTIPS PLUS/ORIGINAL/29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand

1ST TIER UNIFINE PENTIPS 29GX12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
ADVOCATE INSULIN PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
LITETOUCH PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
SURE COMFORT PEN NEEDLES 29GX1/2" 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE ORIGINAL PEN NEEDLES ULTI-FINE	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTICARE PEN NEEDLES/29G X 12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTIGUARD SAFEPACK PEN NEEDLE/29G X 1/2"/SHARPS CONTAINER	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTILET PEN NEEDLE 29GX12.7MM	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
ULTRA-THIN II PEN NEEDLES 29GX1/2"	INSULIN PEN NEEDLE 29 G X 12.7 MM (1/2")	97051050146331	Brand
BD AUTOSHIELD DUO 30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH PEN NEEDLE/30 G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
PEN NEEDLES 30GX5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
SAFETY PEN NEEDLES/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
ULTICARE MINI SAFETY PEN NEEDLES 30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS PLUS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE PENTIPS/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 3/16"	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4"	INSULIN PEN NEEDLE 30 G X 6 MM (1/4" OR 15/64")	97051050146341	Brand
ABOUTTIME PEN NEEDLES 30GX 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ASSURE ID SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

CAREFINE PEN NEEDLES 30GX5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
DROPLET PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EASY TOUCH PEN NEEDLE 30 G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
EASY TOUCH SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
INSUPEN ULTRAFIN 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
PEN NEEDLES 30GX8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SECURESAFE SAFETY PEN NEEDLES/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
SURE COMFORT PEN NEEDLES 30GX5/16" SHORT	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
ULTICARE SHORT SAFETY PEN NEEDLES 30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
UNIFINE SAFECONTROL PEN NEEDLE/30G X 5/16"	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM SAFETY PEN NEEDLE/31 G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT TOUCH PEN NEEDLES/31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
RAYA SURE PEN NEEDLE 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
ABOUTTIME PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM SAFETY PEN NEEDLE/31 G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
BD PEN NEEDLE/MINI/ULTRA-FINE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CAREONE UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CARETOUCH PEN NEEDLES 31GX 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
CLICKFINE PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT EZ/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT TOUCH PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DIATHRIVE PEN NEEDLE/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31G X3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPLET PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DROPSAFE SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
DRUG MART UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY COMFORT PEN NEEDLES 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EASY TOUCH PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31G X3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FIFTY50 PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
FREDS PHARMACY UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GLOBAL EASE INJECT PEN NEEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTICARE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE CLICKFINE SAFETY PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLE 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
HM ULTICARE MINI PEN NEEDLES/31G X 5MM (3/16")	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
INSUPEN 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
KROGER PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS PLUS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LEADER UNIFINE PENTIPS/MINI/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31 G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
LITETOUCH PEN NEEDLES/31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MARATHON MEDICAL PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
MM PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PC UNIFINE PENTIPS 31G X 5MM MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PREFERRED PLUS UNIFINE PENTIPS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PX MINI PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RA PEN NEEDLES 31G X 5MM 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
RAYA SURE PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SHOPKO UNIFINE PENTIPS PEN NEEDLES/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

SHOPKO UNIFINE PENTIPS PLUS PEN NEEDLES/MINI/REMOVER/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
SURE COMFORT PEN NEEDLES 31GX3/16" (5MM)	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TECHLITE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTICARE PEN NEEDLES 31G X 5MM/MINI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 3/16"/SHARPS CONTAI	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTILET SHORT PEN NEEDLES31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA FLO INSULIN PEN NEEDLE 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRA-THIN II MINI PEN NEEEDLES/31GX3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
ULTRACARE PEN NEEDLES/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS PLUS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE PENTIPS 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
UNIFINE ULTRA PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
WEGMANS UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand

ZEVRX PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
1ST TIER UNIFINE PENTIPS /MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
1ST TIER UNIFINE PENTIPS PLUS/MINI/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AURORA PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREFINE PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CAREONE UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CARETOUCH PEN NEEDLES 31 G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
CLICKFINE PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT EZ/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
COMFORT TOUCH PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DIATHRIVE PEN NEEDLE/31 G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPLET PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DROPSAFE SAFTEY PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
DRUG MART UNIFINE PENTIPS31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY COMFORT PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EASY TOUCH PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
EXEL COMFORT POINT INSULIN PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

HEALTHWISE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
HEALTHY ACCENTS UNIFINE PENTIPS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
INSUPEN ULTRAFIN 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
KROGER PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
LITETOUCH PEN NEEDLES 31G X 6MM/ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MAXICOMFORT II PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MEIJER PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MICRODOT PEN NEEDLE/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
MM PEN NEEDLES 31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PC UNIFINE PENTIPS 31G X 6MM ULTRA SHORT	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES 31GX6MM (1/4")	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
BD INSULIN SYRINGE/U-500/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-500 0.5 ML 31G X 6MM (15/64")	97051030956330	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD INSULIN SYRINGE/0.3ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand

DROPLET INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
EQL INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
GNP INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
KROGER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LEADER INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.3ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTICARE INSULIN SYRINGE/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand
VP INSULIN SYRINGE/U-100/0.3ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 29 X 1/2"	97051030906305	Brand

ADVOCATE INSULIN SYRINGE/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EQL INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLOBAL INSULIN SYRINGES/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
GNP INSULIN SYRINGES/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
KROGER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LEADER INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MEDIC INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MM INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
MONOJECT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand

MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
PRECISION SURE-DOSE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 5/16"	97051030906307	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CAREONE INSULIN SYRINGES/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand

GLOBAL INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTICARE INSULIN SYRINGE/0.3ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 1/2"	97051030906308	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
INSULIN SYRINGES/0.5ML/27GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 27 X 1/2"	97051030906310	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CAREONE INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CARETOUCH INSULIN SYRINGE/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
COMFORT EZ INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
EQL INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
GNP INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
KROGER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LEADER INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
LONGS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MM INSULIN SYRINGE/U-100/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
MS INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand

PRO COMFORT INSULIN SYRINGES/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
PRODIGY INSULIN SYRINGE/1/2ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
RELION INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTIGUARD SAFEPACK/SYRINGE/NEEDLE/31G X 5/16"/SHARPS CONTAIN	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
BD LO-DOSE INSULIN SYRINGE MICROFINE IV/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand

GNP INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGES/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LEADER INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ULTICARE INSULIN SYRINGE/0.5ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD INSULIN SYRINGE/0.5ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETY-GLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
DROPLET INSULIN SYRINGE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EASY TOUCH INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EQL INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
GNP INSULIN SYRINGES/1/2ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
INSULIN SYRINGES/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KINRAY INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
KROGER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LEADER INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RA INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
REALITY INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
RELION INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand

SB INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SAFETY SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTICARE INSULIN SYRINGE/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/0.5ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
ADVOCATE INSULIN SYRINGE/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
BD SAFETYGLIDE INSULIN SYSYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CARETOUCH INSULIN SYRINGE0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EASY TOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EQL INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
EXEL COMFORT POINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KMART VALU PLUS INSULIN SYRINGE/0.3ML/30G	INSULIN SYRINGE (DISP) U-100 0.3 ML	97051030056305	Brand
KMART VALU PLUS INSULIN SYRINGE/0.5ML/29G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
KMART VALU PLUS INSULIN SYRINGE/0.5ML/30G	INSULIN SYRINGE (DISP) U-100 1/2 ML	97051030056310	Brand
BD INSULIN SYRINGE LUER-LOK/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
BD INSULIN SYRINGE SLIP TIP/U-100/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/29G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
KMART VALU PLUS INSULIN SYRINGE/1ML/30G	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE REGULAR LUER TIP/SOFTPACK/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
MONOJECT INSULIN SYRINGE/1ML	INSULIN SYRINGE (DISP) U-100 1 ML	97051030056320	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
VERIFINE INSULIN SYRINGE 0.5ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 5/16"	97051030906318	Brand
INSULIN SYRINGES/U-100/0.5ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 28 X 1/2"	97051030906320	Brand
INSULIN SYRINGES/U-100/0.5ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
VERIFINE INSULIN SYRINGE 0.5ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 29 X 1/2"	97051030906327	Brand
AQ INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
GNP INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/NEEDLE 0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

INSULIN SYRINGES/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
KROGER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LEADER INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
LITETOUCH INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MEDIC INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MM INSULIN SYRINGE/U-100/1/2ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
RA INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SB INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand

ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.5ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
ZEVRX INSULIN SYRINGE/0.5ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 5/16"	97051030906328	Brand
CAREONE INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
EASY TOUCH INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PRO COMFORT INSULIN SYRINGES/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
PX INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTICARE INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1/2ML 30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.5ML/30G X 1/2"/SHARPS C	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ULTRA FLO INSULIN SYRINGE 0.5ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand

ULTRACARE INSULIN SYRINGE/U-100/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
ZEVRX INSULIN SYRINGE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/25G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 25 X 5/8"	97051030906330	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 15/64"	97051030906333	Brand
INSULIN SYRINGES 0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31GX1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/HALF UNIT/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
ULTICARE U-100 INSULIN SYRINGES/0.3ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/4" (6 MM)	97051030906334	Brand
INSULIN SYRINGES 0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand

SURE COMFORT INSULIN SYRINGES/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
ULTICARE U-100 INSULIN SYRINGES/0.5ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 31 X 1/4" (6 MM)	97051030906336	Brand
INSULIN SYRINGE 1ML/31G X1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
SURE COMFORT INSULIN SYRINGES/U-100/1ML/31GX6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
ULTICARE U-100 INSULIN SYRINGES/1ML/31G X 1/4"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 1/4" (6 MM)	97051030906337	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 3/16" (5 MM)	97051030906338	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 1/2"	97051030906341	Brand
EASY COMFORT INSULIN SYRINGES/0.5ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
TRUE COMFORT PRO INSULIN SYRINGE/0.5ML/32G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 32 X 5/16"	97051030906343	Brand
EASY COMFORT INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/32GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 32 X 5/16"	97051030906344	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
INSULIN SYRINGES/U-100/1ML/27GX/1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MAXICOMFORT INSULIN SYRINGES 27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/DETACH NEEDLE/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
MONOJECT INSULIN SYRINGE/SOFTPACK/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
VANISHPOINT INSULIN SYRINGE/0.5ML/30G X 3/16"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 3/16" (5 MM)	97051030906355	Brand
DROPLET INSULIN SYRINGE U-100/0.3ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 30 X 15/64"	97051030906359	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
DROPLET INSULIN SYRINGE U-100/0.5ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 0.5 ML 30 X 15/64"	97051030906361	Brand

DROPLET INSULIN SYRINGE U-100/1ML/30G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 15/64"	97051030906362	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/28G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 5/16"	97051030906368	Brand
BD INSULIN SYRINGE MICROFINE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP INSULIN SYRINGES/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
GNP ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
INSULIN SYRINGES/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LEADER INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MAXI-COMFORT INSULIN SYRINGE/U-100/1ML/28GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/PERM NEEDLE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
PRODIGY INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
REALITY INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ULTICARE INSULIN SYRINGE/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

AQ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
DROPLET INSULIN SYRINGE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 29GX12.5MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
EQL INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
GNP INSULIN SYRINGES/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/NEEDLE 1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
KROGER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LEADER INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
MONOJECT INSULIN SYRINGE/SAFETY/PERM NEEDLE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand

MONOJECT ULTRA COMFORT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
RA INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
REALITY INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SB INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SECURESAFE SAFETY INSULIN SYRINGES/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
TRUEPLUS INSULIN SYRINGE /U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SAFETY SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTICARE INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA FLO INSULIN SYRINGE 1M/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
ULTRA-THIN II INSULIN SYRINGE/U-100/1ML/29GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VALUE HEALTH INSULIN SYRINGE/U-100/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
VERIFINE INSULIN SYRINGE 1ML/29G X 12MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
CARETOUCH INSULIN SYRINGE/U-100/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
VANISHPOINT INSULIN SYRINGE/1ML/29G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 5/16"	97051030906382	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CARETOUCH INSULIN SYRINGE/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

DROPLET INSULIN SYRINGE U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
EQL INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
GNP INSULIN SYRINGES/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/NEEDLE 1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
KROGER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LEADER INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
LITETOUCH INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MAGELLAN INSULIN SAFETY SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MM INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
MONOJECT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
PREFERRED PLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand

PRO COMFORT INSULIN SYRINGES/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
RA INSULIN SYRINGE/U-100/1 ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
SB INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/30GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
VANISHPOINT INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 5/16"	97051030906384	Brand
BD INSULIN SYRINGE ULTRA FINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
BD INSULIN SYRINGE ULTRAFINE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CAREONE INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/1.0ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand

EASY TOUCH INSULIN SYRINGE/SAFETY/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
EASY TOUCH SHEATHLOCK SAFETY SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
HM ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
INSULIN SYRINGES/U-100/1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
PRO COMFORT INSULIN SYRINGES/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
TRUE COMFORT PRO INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTICARE INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 30G X 1/2"/SHARPS CON	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRA FLO INSULIN SYRINGE 1ML/30GX1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ZEVRX INSULIN SYRINGE/1ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 30 X 1/2"	97051030906386	Brand
ADVOCATE INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
AQ INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
BD INSULIN SYRINGE ULTRAFINE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CAREONE INSULIN SYRINGES/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

CARETOUCH INSULIN SYRINGE/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
COMFORT EZ INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH FLIPLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EASY TOUCH SHEATHLOCK SAFETY INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
EQL INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GLUCOPRO INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
GNP INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
HEALTHWISE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/NEEDLE 1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
INSULIN SYRINGES/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
KROGER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

LEADER INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
LITETOUCH INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MM INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MONOJECT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
MS INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
PRO COMFORT INSULIN SYRINGES/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SB INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
SURE COMFORT INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUE COMFORT PRO INSULIN SYRINGE/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
TRUEPLUS INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/SHORT/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTICARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE 1ML 31G X 5/16"/SHARPS CO	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA FLO INSULIN SYRINGE 1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/1ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
ULTRACARE INSULIN SYRINGE/U-100/1ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand
VERIFINE INSULIN SYRINGE 1ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 5/16"	97051030906387	Brand

ADVOCATE INSULIN SYRINGE/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CAREONE INSULIN SYRINGES/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CARETOUCH INSULIN SYRINGE/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
CLEVER CHOICE COMFORT EZ INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
COMFORT ASSIST INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE U-100/0.3/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPLET INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX8MM 0.3ML	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EASY TOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
EQL INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
FIFTY50 SUPERIOR COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL EASY GLIDE INSULINSYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLOBAL INJECT EASE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GLUCOPRO INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
GNP INSULIN SYRINGES/3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HEALTHWISE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
HM ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/NEEDLE 0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
INSULIN SYRINGE/U-100/1ML/30G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
KINRAY INSULIN SYRINGE PREFERRED PLUS/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
KROGER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LEADER INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
LITETOUCH INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MM INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MONOJECT ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
MS INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
PRODIGY INSULIN SYRING/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
RELION INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
SURE COMFORT INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TECHLITE INSULIN SYRINGE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TOPCARE ULTRA COMFORT INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
TRUEPLUS INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE ULTRAFINE U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/SHORT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTICARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTIGUARD SAFEPACK INSULIN SYRINGE/0.3ML/31G X 5/16"/SHARPS	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA FLO INSULIN SYRINGE 0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand

ULTRA FLO INSULIN SYRINGE 1/2 UNIT/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRA-THIN II INSULIN SYRINGE SHORT/U-100/0.3ML/31GX5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ULTRACARE INSULIN SYRINGE/U-100/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
VERIFINE INSULIN SYRINGE 0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
ASSURE ID INSULIN SAFETY SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPLET INSULIN SYRINGE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 0.5ML	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
RELION INSULIN SYRINGE 0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
TECHLITE INSULIN SYRINGE U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
ASSURE ID INSULIN SAFETY SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPLET INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
DROPSAFE INSULIN SAFETY SYRINGE/FIXED NEEDLE 31GX6MM 1ML	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
GLOBAL EASY GLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE 1ML/31GX15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
RELION INSULIN SYRINGE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
TECHLITE INSULIN SYRINGE U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
EMBRACE PEN NEEDLES/29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
VERIFINE INSULIN PEN NEEDLE 29G X 12MM	INSULIN PEN NEEDLE 29 G X 12 MM (1/2")	97051050146330	Brand
EMBRACE PEN NEEDLES/30G X 5MM	INSULIN PEN NEEDLE 30 G X 5 MM (1/5" OR 3/16")	97051050146340	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand

EMBRACE PEN NEEDLES/30G X 8MM	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
PEN NEEDLES	INSULIN PEN NEEDLE 30 G X 8 MM (1/3" OR 5/16")	97051050146344	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 4MM	INSULIN PEN NEEDLE 31 G X 4 MM (1/6" OR 5/32")	97051050146354	Brand
AQINJECT PEN NEEDLE/31G X 3/16"	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
AUM INSULIN SAFETY PEN NEEDLE/31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
COMFORT EZ PRO SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PEN NEEDLES 31GX5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PIP PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 5MM	INSULIN PEN NEEDLE 31 G X 5 MM (1/5" OR 3/16")	97051050146358	Brand
EMBRACE PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PREVENT SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PURE COMFORT SAFETY PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
PX EXTRA SHORT PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
QC PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

RAYA SURE PEN NEEDLE 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
RELION PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TECHLITE PEN NEEDLES/31G X 6 MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUE COMFORT SAFETY PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MICRO PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES/31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTICARE MINI PEN NEEDLES31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTIGUARD SAFEPACK/MINI PEN NEEDLE/31G X 6MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ULTRACARE PEN NEEDLES/31G X 1/4"	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE PENTIPS PLUS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand

UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
UNIFINE ULTRA PEN NEEDLE/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
WEGMANS UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ZEVRX PEN NEEDLES 31G X 6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS PLUS/ULTRA SHORT/31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
1ST TIER UNIFINE PENTIPS 31GX6MM	INSULIN PEN NEEDLE 31 G X 6 MM (1/4" OR 15/64")	97051050146361	Brand
ABOUTTIME PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ADVOCATE INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
AURORA PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREFINE PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CARETOUCH PEN NEEDLES 31GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLE UNIVERSAL/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT EZ SHORT/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
COMFORT TOUCH PEN NEEDLES/31G X 8 MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DIATHRIVE PEN NEEDLE/31 GX 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31G X5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DROPLET PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

DROPSAFE SAFETY PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
DRUG MART UNIFINE PENTIPS31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY COMFORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EASY TOUCH PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
EMBRACE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES 31G X5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
FIFTY50 PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GLOBAL EASE INJECT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP CLICKFINE UNIVERSAL PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTICARE PEN NEEDLES /31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GNP ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HEALTHWISE SHORT PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
HM ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN ULTRAFIN 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
INSUPEN 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
KROGER PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LEADER UNIFINE PENTIPS PLUS/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

LITETOUCH PEN NEEDLES 31GX8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
LITETOUCH PEN NEEDLES/31G X 8MM/SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MARATHON MEDICAL PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEDICINE SHOPPE PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MEIJER PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
MM PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PC UNIFINE PENTIPS 31G X 8MM SHORT	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES 31GX8MM (5/16")	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT DROPSAFE SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PREVENT SAFETY PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PRO COMFORT PEN NEEDLES/ 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
PX SHORTLENGTH PEN NEEDLES/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
QC PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RA PEN NEEDLES 31G X 8MM 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RAYA SURE PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

RELION PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
RELION SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
SURE COMFORT PEN NEEDLES 31GX5/16" (8MM)	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TECHLITE PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TODAYS HEALTH SHORT PEN NEEDLES 31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TOPCARE CLICKFINE UNIVERSAL PEN EEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUE COMFORT PRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE MICRO PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES ULTI-FINE IV	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTICARE SHORT PEN NEEDLES/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 5/16"/SHARPS CONTA	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTIGUARD SAFEPACK/SHORT PEN NEEDLE/31G X 8MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET PEN NEEDLE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTILET SHORT PEN NEEDLES 31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA FLO INSULIN PEN NEELE 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRA-THIN II PEN NEEDLES/SHORT/31GX5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ULTRACARE PEN NEEDLES/31G X 5/16"	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand

UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
UNIFINE ULTRA PEN NEEDLE/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
VERIFINE PLUS INSULIN PEN NEEDLE 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
WEGMANS UNIFINE PENTIPS PLUS/SHORT/31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ZEVRX PEN NEEDLES 31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS PLUS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
1ST TIER UNIFINE PENTIPS 31GX8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
ABOUTTIME PEN NEEDLE 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AQINJECT PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM READYGARD DUO SAFETY PEN NEEDLE/32GX4MM/DUAL AUTO PROTEC	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREFINE PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CARETOUCH PEN NEEDLES 32GX 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLE 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
CLICKFINE PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT EZ MICRO/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
COMFORT TOUCH PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

DIATHRIVE PEN NEEDLE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DROPLET PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DROPLET PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPSPLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
DRUG MART UNIFINE PENTIPS32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EASY TOUCH PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
EMBRACE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
FIFTY50 PEN NEEDLES/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASE INJECT PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GLOBAL EASY GLIDE PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTICARE PEN NEEDLES/32GX 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GNP ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL PEN NEEDLES/NANO/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
HEALTHWISE MICRON PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INCONTROL ULTICARE MINI PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN PEN NEEDLES 32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
INSUPEN 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
KROGER PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

LEADER UNIFINE PENTIPS/NANO/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LEADER UNIFINE PENTIPS/PLUS/32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
LITETOUCH INSULIN PEN NEEDLES/32G X 4MM/MINI	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MARATHON MEDICAL PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MICRODOT PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
MM PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
NOVOFINE PLUS PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PIP PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PRO COMFORT PEN NEEDLES/ 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT PEN NEEDLE/32G X4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
PURE COMFORT SAFETY PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
QC UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
RELION PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT AUTOKEEPER SAFETY PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
SURE COMFORT PEN NEEDLES 32GX5/32" (4MM)	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

TECHLITE PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUE COMFORT SAFETY PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
TRUEPLUS 5-BEVEL PEN NEEDLES 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTICARE MICRO PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4 MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 4MM/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CNTR	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTIGUARD SAFEPACK/MICRO PEN NEEDLE/32G X 5/32"/SHARPS CONTA	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTILET PEN NEEDLE 32GX4MM/SHORT	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA FLO INSULIN PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRA THIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ULTRACARE PEN NEEDLES/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
UNIFINE SAFECONTROL PEN NEEDLE 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

UNIFINE ULTRA PEN NEEDLE/32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
VERIFINE INSULIN PEN NEEDLE 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
VERIFINE PLUS INSULIN PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
WEGMANS UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
ZEVRX PEN NEEDLES 32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS PLUS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
1ST TIER UNIFINE PENTIPS 32GX4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
AUM MINI INSULIN PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM PEN NEEDLE/32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CAREFINE PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CARETOUCH PEN NEEDLES 32GX 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
COMFORT TOUCH PEN NEEDLES/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
DROPLET PEN NEEDLES 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH PEN NEEDLES 32GX3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
EASY TOUCH 32GX5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PRO COMFORT PEN NEEDLES/ 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
PURE COMFORT PEN NEEDLE/32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 5MM	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
ULTRACARE PEN NEEDLES/32G X 3/16"	INSULIN PEN NEEDLE 32 G X 5 MM (1/5" OR 3/16")	97051050146367	Brand
AUM MINI INSULIN PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

AUM PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
CAREFINE PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
COMFORT TOUCH PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
DROPLET PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH PEN NEEDLES 32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
EASY TOUCH 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
FIFTY50 PEN NEEDLES/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTICARE PEN NEEDLES/32GX1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GNP ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
GOODSENSE PEN NEEDLE/PENFINE CLASSIC/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
INSUPEN SENSITIVE 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
NOVOFINE PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PRO COMFORT PEN NEEDLES/ 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
PURE COMFORT PEN NEEDLE 32G X6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
SURE COMFORT PEN NEEDLES 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TECHLITE PEN NEEDLES/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
TRUE COMFORT PRO PEN NEEDLES 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTICARE MINI PEN NEEDLES/32G X 1/4"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand

ULTIGUARD SAFEPACK/MINI PEN NEEDLE/32G X 1/4"/SHARPS CONTAIN	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
ULTRACARE PEN NEEDLES/32G X 1/14"	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
VERIFINE INSULIN PEN NEEDLE 32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
BD PEN NEEDLE/MICRO/ULTRA-FINE/32G X 6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
1ST TIER UNIFINE PENTIPS 32GX6MM	INSULIN PEN NEEDLE 32 G X 6 MM (1/4" OR 15/64")	97051050146368	Brand
AUM MINI INSULIN PEN NEEDLE/32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
COMFORT TOUCH PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32G X 5/16"	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
DROPLET PEN NEEDLES 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
INSUPEN SENSITIVE 32GX8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
PURE COMFORT PEN NEEDLE 32G X8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
TECHLITE PEN NEEDLES/32G X 8MM	INSULIN PEN NEEDLE 32 G X 8 MM (1/3" OR 5/16")	97051050146372	Brand
ADVOCATE INSULIN PEN NEEDLES	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM PEN NEEDLE/33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CAREONE UNIFINE PENTIPS PLUS PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CARETOUCH PEN NEEDLE 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ INSULIN PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
COMFORT TOUCH PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand

EASY COMFORT PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
EASY GLIDE PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
H-E-B IN CONTROL UNIFINE PENTIPS PLUS 33GX5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
INSUPEN 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
KROGER PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
MICRODOT PEN NEEDLE/33G X 4 MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
PEN NEEDLES 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRA FLO INSULIN PEN NEEDLE 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
ULTRACARE PEN NEEDLES/33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33G X 5/32"	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS PLUS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
1ST TIER UNIFINE PENTIPS 33GX4MM	INSULIN PEN NEEDLE 33 G X 4 MM (1/6" OR 5/32")	97051050146376	Brand
AUM MINI INSULIN PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM PEN NEEDLE/33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
COMFORT TOUCH PEN NEEDLES/33GX 3/16"	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
EASY COMFORT PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 5MM	INSULIN PEN NEEDLE 33 G X 5 MM (1/5" OR 3/16")	97051050146377	Brand
AUM MINI INSULIN PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
AUM PEN NEEDLE/33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand

CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
COMFORT TOUCH PEN NEEDLES/33GX1/4"	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
EASY COMFORT PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
TRUE COMFORT PRO PEN NEEDLES 33G X 6MM	INSULIN PEN NEEDLE 33 G X 6 MM (1/4" OR 15/64")	97051050146378	Brand
CLEVER CHOICE COMFORT EZ PEN NEEDLES 33GX8MM	INSULIN PEN NEEDLE 33 G X 8 MM (1/3" OR 5/16")	97051050146380	Brand
DROPLET MICRON 34G X 9/64"	INSULIN PEN NEEDLE 34 G X 3.5 MM (9/64")	97051050146385	Brand
B-D INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/30G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE ULTRAFINE/0.5ML/30G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 30 X 1/2"	97051030906329	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/28G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 28 X 1/2"	97051030906370	Brand
B-D INSULIN SYRINGE ULTRAFINE II/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRA-FINE/1/2 UNIT/0.3ML/31G X 8MM	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE HALF-UNIT/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE ULTRAFINE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD SAFETYGLIDE INSULIN SYRINGE/0.3ML/31G X 5/16"	INSULIN SYRINGE/NEEDLE U-100 0.3 ML 31 X 5/16"	97051030906388	Brand
BD INSULIN SYRINGE/U-100/1ML/27G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE/1ML/27G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 1/2"	97051030906350	Brand
BD INSULIN SYRINGE MICROFINE IV/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE MICROFINE/U-100/1ML/27G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 1 ML 27 X 5/8"	97051030906360	Brand
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/1ML/29G X 12.7MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 29 X 1/2"	97051030906380	Brand
BD INSULIN SYRINGE/U-100/2ML/27.5G X 5/8"	INSULIN SYRINGE/NEEDLE U-100 2 ML 27.5 X 5/8"	97051030906390	Brand

BD SAFETYGLIDE INSULIN SYRINGE/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD VEO INSULIN SYRINGE ULTR-FINE/U-100/0.5ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/0.5ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1/2 ML 31 X 15/64"	97051030906391	Brand
BD SAFETYGLIDE INSULIN SYRINGE/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/U-100/1ML/31G X 15/64"	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD VEO INSULIN SYRINGE ULTRA-FINE/1ML/31G X 6MM	INSULIN SYRINGE/NEEDLE U-100 1 ML 31 X 15/64"	97051030906399	Brand
BD PEN NEEDLE/SHORT/ULTRA-FINE/31G X 8MM	INSULIN PEN NEEDLE 31 G X 8 MM (1/3" OR 5/16")	97051050146364	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO 2ND GEN/32G X 5/32"	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand
BD PEN NEEDLE/NANO/ULTRA - FINE/32G X 4MM	INSULIN PEN NEEDLE 32 G X 4 MM (1/6" OR 5/32")	97051050146366	Brand

Approval Criteria

1 - Physician confirmation that the patient requires a greater quantity because of more frequent delivery of insulin

Notes	*The quantity limit for both pen needles and syringes is 6 of each per day.

2 . Background

Benefit/Coverage/Program Information
PDL links NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Updated PDL links

Insulins

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146815
Guideline Name	Insulins
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Admelog vial, Apidra vial, Humalog 100U/ml vial, Insulin Aspart vial, Lyumjev vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APIDRA	INSULIN GLULISINE INJ 100 UNIT/ML	27104004002022	Brand
INSULIN ASPART	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
ADMELOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
HUMALOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
LYUMJEV	INSULIN LISPRO-AABC INJ 100 UNIT/ML	27104005052020	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

Product Name: Novolog vial, Fiasp vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
FIASP	INSULIN ASPART (WITH NIACINAMIDE) INJ 100 UNIT/ML	27104002202020	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- insulin lispro vial
- Insulin Aspart vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- insulin lispro vial
- Insulin Aspart vial

Product Name: Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG MIX 70/30	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand
NOVOLOG MIX 70/30 RELION	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to Insulin Aspart mix vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Insulin Aspart mix vial (please specify intolerance or contraindication)

Product Name: Humalog Mix 75/25 vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG MIX 75/25	INSULIN LISPRO PROT & LISPRO INJ 100 UNIT/ML (75-25)	27104080001820	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)

Product Name: Humulin R U-500 vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMULIN R U-500 (CONCENTRATED)	INSULIN REGULAR (HUMAN) INJ 500 UNIT/ML	27104010002015	Brand

Approval Criteria

1 - Patient requires more than 200 units of insulin per day

Product Name: Insulin Lispro Kwikpen, Insulin Lispro Junior Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INSULIN LISPRO JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
INSULIN LISPRO KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand

Approval Criteria

1 - ONE of the following:

1.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

1.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

1.3 History of failure to insulin lispro vial as demonstrated by poorly controlled diabetes based on hemoglobin A1c

OR

1.4 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Apidra Solostar pen, Humalog cartridge, Humalog Kwikpen, Humalog Junior Kwikpen, Insulin Aspart Penfill, Insulin Aspart Flexpen, Admelog Solostar pen, Lyumjev Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
APIDRA SOLOSTAR	INSULIN GLULISINE SOLN PEN-INJECTOR INJ 100 UNIT/ML	2710400400D220	Brand
INSULIN ASPART FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand

INSULIN ASPART PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
ADMELOG SOLOSTAR	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 200 UNIT/ML	2710400500D230	Brand
HUMALOG	INSULIN LISPRO SOLN CARTRIDGE 100 UNIT/ML	2710400500E220	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJ 100 UNIT/ML (1 UNIT DIAL)	2710400505D222	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJECTOR 200 UNIT/ML	2710400505D230	Brand

Approval Criteria

1 - ONE of the following:

1.1 One of the following:

1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

1.2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

1.2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

1.2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - ONE of the following:

2.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication)

Product Name: Humalog Tempo Pen, Lyumjev Tempo Pen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG TEMPO PEN	INSULIN LISPRO SOLN PEN-INJ W/TRANSMITTER PORT 100 UNIT/ML	2710400500D224	Brand
LYUMJEV TEMPO PEN	INSULIN LISPRO-AABC SOLN PEN-INJ W/TRANSMIT PORT 100 UNIT/ML	2710400505D224	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to insulin lispro Kwikpen confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance to insulin lispro Kwikpen (please specify intolerance or contraindication)

AND

1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product

Product Name: Novolog Penfill, Novolog Flexpen, Fiasp Penfill, Fiasp Pumpcart, Fiasp FlexTouch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
NOVOLOG PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
FIASP FLEXTOUCH	INSULIN ASPART (WITH NIACINAMIDE) SOL PEN-INJ 100 UNIT/ML	2710400220D220	Brand
FIASP PENFILL	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand
FIASP PUMPCART	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand

Approval Criteria

1 - One of the following:

1.1 One of the following:

1.1.1 Failure to insulin lispro vial confirmed by claims history or submission of medical records

OR

1.1.2 History of contraindication or intolerance to insulin lispro vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - One of the following:

2.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Insulin lispro Kwikpen
- Insulin aspart pen or cartridge

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Insulin lispro Kwikpen
- Insulin aspart pen or cartridge

Product Name: Novolin R Flexpen, Novolin R Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLIN R FLEXPEN RELION	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand
NOVOLIN R FLEXPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Humulin R U-100 vial
- Novolin R U-100 vial

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Humulin R U-500 Kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMULIN R U-500 KWIKPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 500 UNIT/ML	2710401000D250	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Patient requires more than 200 units of insulin per day

AND

1.2 ONE of the following:

1.2.1 Failure to Humulin R U-500 vial confirmed by claims history or submission of medical records

OR

1.2.2 History of contraindication or intolerance to Humulin R U-500 vial (please specify intolerance or contraindication)

OR

2 - BOTH of the following:

2.1 Patient requires more than 200 units of insulin per day

AND

2.2 ONE of the following:

2.2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Humulin N Kwikpen, Novolin N Flexpen, Novolin N Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMULIN N KWIKPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
NOVOLIN N FLEXPEN RELION	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand

NOVOLIN N FLEXPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Humulin N U-100 vial
- Novolin N U-100 vial

OR

1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication):

- Humulin N U-100 vial
- Novolin N U-100 vial

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Humalog Mix Kwikpen 50/50, Insulin Aspart Flexpen 70/30, Humulin Kwikpen 70/30, Novolin Flexpen 70/30, Novolin Flexpen Relion 70/30	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG MIX 50/50 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (50-50)	2710408000D340	Brand
INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
HUMULIN 70/30 KWIKPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLIN 70/30 FLEXPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLIN 70/30 FLEXPEN RELION	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

2 - ONE of the following:

2.1 A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin

OR

2.2 A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin

OR

2.3 The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

Product Name: Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following:

- Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records
- History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - ONE of the following:

- Failure to Insulin Aspart Flexpen 70/30 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin Aspart Flexpen 70/30 100U/ML (please specify intolerance or contraindication)

Product Name: Humalog Mix Kwikpen 72/25	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
HUMALOG MIX 75/25 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25)	2710408000D320	Brand

Approval Criteria

1 - One of the following:

1.1 ONE of the following:

- Failure to the corresponding preferred insulin mix vial confirmed by claims history or submission of medical records

- History of contraindication or intolerance to the corresponding preferred insulin mix vial (please specify intolerance or contraindication)

OR

1.2 ONE of the following:

- A visual impairment that prevents the patient from using a vial and syringe to accurately draw up the dose of insulin
- A physical disability or handicap that prevents the patient from using a vial and syringe to draw up the dose and administer the insulin
- The patient is unable to use the vial dosage form of the drug due to documented poor compliance with vials and syringes resulting in poorly controlled diabetes based on hemoglobin A1c

AND

2 - One of the following:

- Failure to insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Insulin lispro protamine/insulin lispro Kwikpen 75/25 100U/ML (please specify intolerance or contraindication)

Product Name: Basaglar Kwikpen, Insulin Glargine Solostar 100U/ml, Insulin glargine-yfgn Pen, Semglee yfgn Pen Injector	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SEMGLEE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
BASAGLAR KWIKPEN	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name: Basaglar Tempo Pen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BASAGLAR TEMPO PEN	INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML	2710400300D222	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 Prescriber provides a reason or special circumstance the patient has to use the Tempo product

Product Name: Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOUJEO SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
TOUJEO MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
INSULIN GLARGINE MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.3 The provider has given clinical justification why the patient needs a concentrated glargine formulation

AND

1.2 If the request is for Toujeo Solostar or Toujeo Solostar Max, ONE of the following:

1.2.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Insulin glargine Solostar 300U/ml
- Insulin glargine Max Solostar 300U/ml

OR

1.2.2 History of intolerance or contraindication to ONE of the following (please specify intolerance or contraindication):

- Insulin glargine Solostar 300U/ml
- Insulin glargine Max Solostar 300U/ml

Product Name: Levemir Flexpen, Insulin Degludec Flextouch 100U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
LEVEMIR FLEXPEN	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand

Approval Criteria

1 - Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

Product Name: Tresiba Flextouch 100U/mL	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name: Insulin Degludec Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand

Approval Criteria

1 - Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

2 - History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

3 - The provider has given clinical justification why the patient needs a concentrated formulation

Product Name: Tresiba Flextouch 200U/mL	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.3 The provider has given clinical justification why the patient needs a concentrated formulation

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec flextouch product

Product Name: Insulin Glargine vial, Insulin glargine-yfgn vial, Semglee yfgn vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SEMGLEE	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
INSULIN GLARGINE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

1.2 The provider has given clinical justification why the patient is unable to use the preferred insulin glargine products

Product Name: Levemir vial, Insulin Degludec vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LEVEMIR	INSULIN DETEMIR INJ 100 UNIT/ML	27104006002020	Brand
INSULIN DEGLUDEC	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

Product Name: Tresiba vial	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRESIBA	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand

Approval Criteria

1 - One of the following:

1.1 Failure to ONE of the following confirmed by claims history or submission of medical records:

- Rezvoglar Kwikpen
- Lantus (pens or vials)

OR

1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Rezvoglar Kwikpen
- Lantus (pens or vials)

AND

2 - The provider has given clinical justification why the patient is unable to use the insulin degludec product

Product Name: Admelog Solostar, Apidra, Insulin Aspart vial, Insulin Lispro vial, Humalog vial, Novolog vial, Novolog Relion vial, Fiasp vial, Lyumjev vial, Novolog Mix 70/30 vial, Novolog Mix 70/30 Relion vial, Humulin R U-500 vial, Apidra Solostar, Insulin Aspart Flexpen, Insulin Aspart Penfill, Insulin Lispro Junior Kwikpen, Insulin Lispro Kwikpen, Humalog Junior Kwikpen, Humalog Kwikpen, Humalog Tempo Pen, Novolog Flexpen, Novolog Flexpen Relion, Novolog Penfill, Fiasp Flextouch, Fiasp Penfill, Fiasp Pumpcart, Lyumjev Kwikpen, Lyumjev Tempo Pen, Novolin R Flexpen Relion, Novolin R Flexpen, Humulin R U-500 Kwikpen, Humulin N Kwikpen, Novolin N Flexpen Relion, Novolin N Flexpen, Humalog Mix 75/25 Kwikpen, Insulin Lispro Mix Kwikpen 72/25, Humalog Mix 50/50 Kwikpen, Insulin Aspart Protamine/Insulin Aspart 70/30 Flexpen, Humulin 70/30 Kwikpen, Novolin 70/30 Flexpen, Novolin 70/30 Flexpen Relion, Novolog Mix 70/30 Flexpen, Novolog Mix 70/30 Flexpen Relion, Lantus Solostar, Basaglar Tempo Pen, Toujeo Solostar, Insulin Glargine Solostar 300U/ml, Toujeo Max Solostar, Insulin Glargine Max Solostar 300U/ml, Semglee yfgn Pen Injector, Semglee yfgn vial Levemir Flexpen, Tresiba Flextouch, Insulin Degludec Flextouch, Semglee vial, Lantus vial, Levemir vial, Tresiba vial, Insulin Degludec vial, Basaglar Kwikpen, Insulin Glargine vial, Insulin Glargine-YFGN pen and vial, Insulin Glargine Solostar 100U/ml, Humulin R vial, Novolin R vial, Novolin R Relion vial, Humulin N vial, Novolin N Relion vial, Novolin N vial, Insulin Aspart Protamine/Insulin Aspart 70/30 vial, Humalog Mix 75/25 vial, Humalog Mix 50/50 vial, Humulin 70/30 vial, Novolin 70/30 Relion vial, Novolin 70/30 vial, Admelog vial, Humalog Cartridge, Rezvoglar Kwikpen

Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
ADMELOG SOLOSTAR	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
APIDRA	INSULIN GLULISINE INJ 100 UNIT/ML	27104004002022	Brand
INSULIN ASPART	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
INSULIN LISPRO	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
HUMALOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
NOVOLOG	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
FIASP	INSULIN ASPART (WITH NIACINAMIDE) INJ 100 UNIT/ML	27104002202020	Brand
LYUMJEV	INSULIN LISPRO-AABC INJ 100 UNIT/ML	27104005052020	Brand
NOVOLOG MIX 70/30	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand

HUMULIN R U-500 (CONCENTRATED)	INSULIN REGULAR (HUMAN) INJ 500 UNIT/ML	27104010002015	Brand
APIDRA SOLOSTAR	INSULIN GLULISINE SOLN PEN-INJECTOR INJ 100 UNIT/ML	2710400400D220	Brand
INSULIN ASPART FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
INSULIN ASPART PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
INSULIN LISPRO JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
INSULIN LISPRO KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG JUNIOR KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (0.5 UNIT DIAL)	2710400500D221	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 100 UNIT/ML (1 UNIT DIAL)	2710400500D222	Brand
HUMALOG KWIKPEN	INSULIN LISPRO SOLN PEN-INJECTOR 200 UNIT/ML	2710400500D230	Brand
HUMALOG	INSULIN LISPRO SOLN CARTRIDGE 100 UNIT/ML	2710400500E220	Brand
NOVOLOG FLEXPEN	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
NOVOLOG PENFILL	INSULIN ASPART SOLN CARTRIDGE 100 UNIT/ML	2710400200E220	Brand
FIASP FLEXTOUCH	INSULIN ASPART (WITH NIACINAMIDE) SOL PEN-INJ 100 UNIT/ML	2710400220D220	Brand
FIASP PENFILL	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJ 100 UNIT/ML (1 UNIT DIAL)	2710400505D222	Brand
LYUMJEV KWIKPEN	INSULIN LISPRO-AABC SOLN PEN-INJECTOR 200 UNIT/ML	2710400505D230	Brand
NOVOLIN R FLEXPEN RELION	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand
NOVOLIN R FLEXPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 100 UNIT/ML	2710401000D220	Brand
HUMULIN R U-500 KWIKPEN	INSULIN REGULAR (HUMAN) SOLN PEN-INJECTOR 500 UNIT/ML	2710401000D250	Brand
HUMULIN N KWIKPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
NOVOLIN N FLEXPEN RELION	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
NOVOLIN N FLEXPEN	INSULIN NPH (HUMAN) (ISOPHANE) SUSP PEN-INJECTOR 100 UNIT/ML	2710402000D320	Brand
HUMALOG MIX 75/25 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25)	2710408000D320	Brand

HUMALOG MIX 50/50 KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (50-50)	2710408000D340	Brand
INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
HUMULIN 70/30 KWIKPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLIN 70/30 FLEXPEN	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
LANTUS SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
TOUJEO SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
TOUJEO MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand
SEMGLEE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
LANTUS	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
LEVEMIR	INSULIN DETEMIR INJ 100 UNIT/ML	27104006002020	Brand
TRESIBA	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
BASAGLAR KWIKPEN	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
HUMULIN R	INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML	27104010002005	Brand
NOVOLIN R	INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML	27104010002005	Brand
NOVOLIN R RELION	INSULIN REGULAR (HUMAN) INJ 100 UNIT/ML	27104010002005	Brand
HUMULIN N	INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML	27104020001805	Brand
NOVOLIN N RELION	INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML	27104020001805	Brand
NOVOLIN N	INSULIN NPH (HUMAN) (ISOPHANE) INJ 100 UNIT/ML	27104020001805	Brand
INSULIN ASPART PROTAMINE/INSULIN ASPART	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand

HUMALOG MIX 75/25	INSULIN LISPRO PROT & LISPRO INJ 100 UNIT/ML (75-25)	27104080001820	Brand
HUMALOG MIX 50/50	INSULIN LISPRO PROTAMINE & LISPRO INJ 100 UNIT/ML (50-50)	27104080001840	Brand
HUMULIN 70/30	INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30)	27104090001810	Brand
NOVOLIN 70/30 RELION	INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30)	27104090001810	Brand
NOVOLIN 70/30	INSULIN NPH ISOPHANE & REGULAR HUMAN INJ 100 UNIT/ML (70-30)	27104090001810	Brand
ADMELOG	INSULIN LISPRO INJ SOLN 100 UNIT/ML	27104005002022	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
INSULIN GLARGINE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
NOVOLOG MIX 70/30 RELION	INSULIN ASPART PROT & ASPART (HUMAN) INJ 100 UNIT/ML (70-30)	27104070001820	Brand
HUMALOG TEMPO PEN	INSULIN LISPRO SOLN PEN-INJ W/TRANSMITTER PORT 100 UNIT/ML	2710400500D224	Brand
LYUMJEV TEMPO PEN	INSULIN LISPRO-AABC SOLN PEN-INJ W/TRANSMIT PORT 100 UNIT/ML	2710400505D224	Brand
NOVOLOG FLEXPEN RELION	INSULIN ASPART SOLN PEN-INJECTOR 100 UNIT/ML	2710400200D220	Brand
BASAGLAR TEMPO PEN	INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML	2710400300D222	Brand
LEVEMIR FLEXPEN	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
INSULIN DEGLUDEC	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
NOVOLOG RELION	INSULIN ASPART INJ SOLN 100 UNIT/ML	27104002002022	Brand
NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION	INSULIN ASPART PROT & ASPART SUS PEN-INJ 100 UNIT/ML (70-30)	2710407000D320	Brand
INSULIN LISPRO PROTAMINE/INSULIN LISPRO KWIKPEN	INSULIN LISPRO PROT & LISPRO SUS PEN-INJ 100 UNIT/ML (75-25)	2710408000D320	Brand
NOVOLIN 70/30 FLEXPEN RELION	INSULIN NPH & REGULAR SUSP PEN-INJ 100 UNIT/ML (70-30)	2710409000D320	Brand
REZVOGLAR KWIKPEN	INSULIN GLARGINE-AGLR SOLN PEN-INJECTOR 100 UNIT/ML	2710400305D220	Brand

FIASP PUMPCART	INSULIN ASPART (WITH NIACINAMIDE) SOLN CARTRIDGE 100 UNIT/ML	2710400220E220	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
INSULIN GLARGINE MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand

Approval Criteria

1 - Quantity requests exceeding the limited amount will be approved based on physician confirmation that the patient requires a greater quantity due to poorly controlled diabetes based on blood glucose and/or hemoglobin A1c

2 . Background

Benefit/Coverage/Program Information
PDL Link: NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Removed PDL links for CORE markets and added PDL link for NM in background section.

Iressa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146550
Guideline Name	Iressa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Iressa, generic gefitinib	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IRESSA	GEFITINIB TAB 250 MG	21360030000320	Brand
GEFITINIB	GEFITINIB TAB 250 MG	21360030000320	Generic

Approval Criteria

1 - Diagnosis of metastatic non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

2.1 Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions

OR

2.2 Tumors are positive for exon 21 (L858R) substitution mutations

OR

2.3 Tumors are positive for a known sensitizing EGFR mutation (e.g, exon 20 S7681 mutation, exon 18 G719X mutation, exon 21 L861Q mutation)

Product Name: Brand Iressa, generic gefitinib	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IRESSA	GEFITINIB TAB 250 MG	21360030000320	Brand
GEFITINIB	GEFITINIB TAB 250 MG	21360030000320	Generic

Approval Criteria

1 - Documentation of positive clinical response to Iressa therapy

Product Name: Brand Iressa, generic gefitinib

Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IRESSA	GEFITINIB TAB 250 MG	21360030000320	Brand
GEFITINIB	GEFITINIB TAB 250 MG	21360030000320	Generic

Approval Criteria

1 - Diagnosis of central nervous system (CNS) cancer with metastatic lesions

AND

2 - Iressa is active against primary (NSCLC) tumor with a known epidermal growth factor receptor (EGFR) sensitizing mutation

Product Name: Brand Iressa, generic gefitinib	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IRESSA	GEFITINIB TAB 250 MG	21360030000320	Brand
GEFITINIB	GEFITINIB TAB 250 MG	21360030000320	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Iressa therapy

Product Name: Brand Iressa, generic gefitinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IRESSA	GEFITINIB TAB 250 MG	21360030000320	Brand
GEFITINIB	GEFITINIB TAB 250 MG	21360030000320	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Iressa, generic gefitinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IRESSA	GEFITINIB TAB 250 MG	21360030000320	Brand
GEFITINIB	GEFITINIB TAB 250 MG	21360030000320	Generic

Approval Criteria

1 - Documentation of positive clinical response to Iressa therapy

Iron Chelators

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146551
Guideline Name	Iron Chelators
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Brand
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Brand

DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Brand
DEFERASIROX	DEFERASIROX TAB 90 MG	93100025000320	Generic
JADENU	DEFERASIROX TAB 90 MG	93100025000320	Brand
DEFERASIROX	DEFERASIROX TAB 180 MG	93100025000330	Generic
JADENU	DEFERASIROX TAB 180 MG	93100025000330	Brand
DEFERASIROX	DEFERASIROX TAB 360 MG	93100025000340	Generic
JADENU	DEFERASIROX TAB 360 MG	93100025000340	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Brand

Approval Criteria

1 - Diagnosis of chronic iron overload (e.g., sickle cell anemia, thalassemia, etc.) due to blood transfusion

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Brand
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Brand

DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Brand
DEFERASIROX	DEFERASIROX TAB 90 MG	93100025000320	Generic
JADENU	DEFERASIROX TAB 90 MG	93100025000320	Brand
DEFERASIROX	DEFERASIROX TAB 180 MG	93100025000330	Generic
JADENU	DEFERASIROX TAB 180 MG	93100025000330	Brand
DEFERASIROX	DEFERASIROX TAB 360 MG	93100025000340	Generic
JADENU	DEFERASIROX TAB 360 MG	93100025000340	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Brand Ferriprox, generic deferiprone	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEFERIPRONE	DEFERIPRONE TAB 500 MG	93100028000320	Generic
FERRIPROX	DEFERIPRONE TAB 500 MG	93100028000320	Brand
FERRIPROX	DEFERIPRONE ORAL SOLN 100 MG/ML	93100028002020	Brand
FERRIPROX	DEFERIPRONE TAB 1000 MG	93100028000340	Brand

FERRIPROX TWICE-A-DAY	DEFERIPRONE (TWICE DAILY) TAB 1000 MG	93100028000345	Brand
DEFERIPRONE	DEFERIPRONE TAB 1000 MG	93100028000340	Generic

Approval Criteria

1 - BOTH of the following

1.1 Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias

AND

1.2 Ferriprox (deferiprone) will not be used for the treatment of transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia

Product Name: Brand Ferriprox, generic deferiprone	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEFERIPRONE	DEFERIPRONE TAB 500 MG	93100028000320	Generic
FERRIPROX	DEFERIPRONE TAB 500 MG	93100028000320	Brand
FERRIPROX	DEFERIPRONE ORAL SOLN 100 MG/ML	93100028002020	Brand
FERRIPROX	DEFERIPRONE TAB 1000 MG	93100028000340	Brand
FERRIPROX TWICE-A-DAY	DEFERIPRONE (TWICE DAILY) TAB 1000 MG	93100028000345	Brand
DEFERIPRONE	DEFERIPRONE TAB 1000 MG	93100028000340	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Brand
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Brand
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Brand
DEFERASIROX	DEFERASIROX TAB 90 MG	93100025000320	Generic
JADENU	DEFERASIROX TAB 90 MG	93100025000320	Brand
DEFERASIROX	DEFERASIROX TAB 180 MG	93100025000330	Generic
JADENU	DEFERASIROX TAB 180 MG	93100025000330	Brand
DEFERASIROX	DEFERASIROX TAB 360 MG	93100025000340	Generic
JADENU	DEFERASIROX TAB 360 MG	93100025000340	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndrome

AND

1.2 Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with Exjade (deferasirox) or Jadenu (deferasirox)

AND

1.3 Patient has serum ferritin levels consistently greater than 300 micrograms per liter prior to initiation of treatment with Exjade (deferasirox) or Jadenu (deferasirox)

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	Brand
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	Brand
DEFERASIROX	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Generic
EXJADE	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	Brand
DEFERASIROX	DEFERASIROX TAB 90 MG	93100025000320	Generic
JADENU	DEFERASIROX TAB 90 MG	93100025000320	Brand
DEFERASIROX	DEFERASIROX TAB 180 MG	93100025000330	Generic
JADENU	DEFERASIROX TAB 180 MG	93100025000330	Brand
DEFERASIROX	DEFERASIROX TAB 360 MG	93100025000340	Generic

JADENU	DEFERASIROX TAB 360 MG	93100025000340	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 90 MG	93100025003020	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 180 MG	93100025003030	Brand
DEFERASIROX	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Generic
JADENU SPRINKLE	DEFERASIROX GRANULES PACKET 360 MG	93100025003040	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Irritable Bowel Syndrome - Diarrhea

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146347
Guideline Name	Irritable Bowel Syndrome - Diarrhea
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic alosetron, Brand Lotronex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Generic
LOTRONEX	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Brand
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Generic
LOTRONEX	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Brand

Approval Criteria

1 - Diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) with symptoms for at least six months

AND

2 - Patient was female at birth

AND

3 - ONE of the following:

3.1 Failure to a tricyclic antidepressant (e.g., amitriptyline) as confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to a tricyclic antidepressant (e.g., amitriptyline) (please specify intolerance or contraindication)

AND

4 - Anatomic or biochemical abnormalities of the GI (gastrointestinal) tract have been excluded

Product Name: generic alosetron, Brand Lotronex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Generic

LOTRONEX	ALOSETRON HCL TAB 0.5 MG (BASE EQUIV)	52554015100310	Brand
ALOSETRON HYDROCHLORIDE	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Generic
LOTRONEX	ALOSETRON HCL TAB 1 MG (BASE EQUIV)	52554015100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Product Name: Viberzi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIBERZI	ELUXADOLINE TAB 75 MG	52558020000330	Brand
VIBERZI	ELUXADOLINE TAB 100 MG	52558020000340	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

AND

2 - ONE of the following:

2.1 Failure to a tricyclic antidepressant (e.g., amitriptyline) as confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to a tricyclic antidepressant (e.g., amitriptyline) (please specify intolerance or contraindication)

Product Name: Viberzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIBERZI	ELUXADOLINE TAB 75 MG	52558020000330	Brand
VIBERZI	ELUXADOLINE TAB 100 MG	52558020000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Viberzi therapy

Isotretinoin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146823
Guideline Name	Isotretinoin
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Oncology Uses (Off Label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYORISAN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
MYORISAN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic

MYORISAN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
MYORISAN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
CLARAVIS	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
CLARAVIS	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
CLARAVIS	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
CLARAVIS	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
AMNESTEEM	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
AMNESTEEM	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
AMNESTEEM	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ZENATANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ZENATANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ZENATANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ZENATANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ABSORICA	ISOTRETINOIN CAP 10 MG	90050013000110	Brand
ABSORICA	ISOTRETINOIN CAP 20 MG	90050013000120	Brand
ABSORICA	ISOTRETINOIN CAP 25 MG	90050013000125	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 25 MG	90050013000125	Generic
ABSORICA	ISOTRETINOIN CAP 30 MG	90050013000130	Brand
ABSORICA	ISOTRETINOIN CAP 35 MG	90050013000135	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 35 MG	90050013000135	Generic
ABSORICA	ISOTRETINOIN CAP 40 MG	90050013000140	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 8 MG	90050013100110	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 16 MG	90050013100115	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 24 MG	90050013100125	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 32 MG	90050013100135	Brand
ACCUTANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ACCUTANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ACCUTANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ACCUTANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN)

OR

2 - Use is supported by ONE of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYORISAN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
MYORISAN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
MYORISAN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
MYORISAN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
CLARAVIS	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
CLARAVIS	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
CLARAVIS	ISOTRETINOIN CAP 30 MG	90050013000130	Generic

CLARAVIS	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
AMNESTEEM	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
AMNESTEEM	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
AMNESTEEM	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ZENATANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ZENATANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ZENATANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ZENATANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ABSORICA	ISOTRETINOIN CAP 10 MG	90050013000110	Brand
ABSORICA	ISOTRETINOIN CAP 20 MG	90050013000120	Brand
ABSORICA	ISOTRETINOIN CAP 25 MG	90050013000125	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 25 MG	90050013000125	Generic
ABSORICA	ISOTRETINOIN CAP 30 MG	90050013000130	Brand
ABSORICA	ISOTRETINOIN CAP 35 MG	90050013000135	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 35 MG	90050013000135	Generic
ABSORICA	ISOTRETINOIN CAP 40 MG	90050013000140	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 8 MG	90050013100110	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 16 MG	90050013100115	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 24 MG	90050013100125	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 32 MG	90050013100135	Brand
ACCUTANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ACCUTANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ACCUTANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ACCUTANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy

OR

1.2 Diagnosis of treatment resistant acne

AND

2 - ONE of the following:

2.1 Failure to an adequate trial on TWO of the following conventional therapy regimens confirmed by claims history or submission of medical records:

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

AND

3 - If the request is non-preferred*, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (please specify reason or special circumstance)

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Accutane, Myorisan, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYORISAN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
MYORISAN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
MYORISAN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
MYORISAN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ISOTRETINOIN	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
CLARAVIS	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
CLARAVIS	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
CLARAVIS	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
CLARAVIS	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
AMNESTEEM	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
AMNESTEEM	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
AMNESTEEM	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ZENATANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ZENATANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ZENATANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ZENATANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic
ABSORICA	ISOTRETINOIN CAP 10 MG	90050013000110	Brand
ABSORICA	ISOTRETINOIN CAP 20 MG	90050013000120	Brand
ABSORICA	ISOTRETINOIN CAP 25 MG	90050013000125	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 25 MG	90050013000125	Generic
ABSORICA	ISOTRETINOIN CAP 30 MG	90050013000130	Brand
ABSORICA	ISOTRETINOIN CAP 35 MG	90050013000135	Brand
ISOTRETINOIN	ISOTRETINOIN CAP 35 MG	90050013000135	Generic
ABSORICA	ISOTRETINOIN CAP 40 MG	90050013000140	Brand

ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 8 MG	90050013100110	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 16 MG	90050013100115	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 24 MG	90050013100125	Brand
ABSORICA LD	ISOTRETINOIN MICRONIZED CAP 32 MG	90050013100135	Brand
ACCUTANE	ISOTRETINOIN CAP 10 MG	90050013000110	Generic
ACCUTANE	ISOTRETINOIN CAP 20 MG	90050013000120	Generic
ACCUTANE	ISOTRETINOIN CAP 30 MG	90050013000130	Generic
ACCUTANE	ISOTRETINOIN CAP 40 MG	90050013000140	Generic

Approval Criteria

1 - After greater than or equal to 2 months OFF therapy, persistent or recurring severe recalcitrant nodular acne is still present

OR

2 - Total cumulative dose for total duration of therapy is less than 150 milligrams/kilogram (mg/kg) (will be approved up to a total of 150 mg/kg)

2 . Revision History

Date	Notes
4/30/2024	Removed PDL links for CORE markets in background section and ad ded PDL link for NM in notes section, where applicable.

Isturisa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146552
Guideline Name	Isturisa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Isturisa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ISTURISA	OSILODROSTAT PHOSPHATE TAB 1 MG	30022060600320	Brand
ISTURISA	OSILODROSTAT PHOSPHATE TAB 5 MG	30022060600330	Brand
ISTURISA	OSILODROSTAT PHOSPHATE TAB 10 MG	30022060600340	Brand

Approval Criteria

1 - Diagnosis of Cushing's disease

AND

2 - ONE of the following:

- Patient is not a candidate for pituitary surgery
- Pituitary surgery has not been curative

Product Name: Isturisa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ISTURISA	OSILODROSTAT PHOSPHATE TAB 1 MG	30022060600320	Brand
ISTURISA	OSILODROSTAT PHOSPHATE TAB 5 MG	30022060600330	Brand
ISTURISA	OSILODROSTAT PHOSPHATE TAB 10 MG	30022060600340	Brand

Approval Criteria

1 - Documentation of positive response to Isturisa therapy

Iwilfin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146553
Guideline Name	Iwilfin
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Iwilfin	
Diagnosis	High-Risk Neuroblastoma (HRNB)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IWILFIN	EFLORNITHINE HCL TAB 192 MG	21757220300320	Brand

Approval Criteria

1 - Diagnosis of high-risk neuroblastoma (HRNB)

AND

2 - Patient has shown at least a partial response to prior multiagent, multimodality therapy

AND

3 - Prior therapy included anti-GD2 immunotherapy (e.g., Danyelza (naxitamab-gqgk), Unituxin (dinutuximab))

Product Name: Iwilfin	
Diagnosis	High-Risk Neuroblastoma (HRNB)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IWILFIN	EFLORNITHINE HCL TAB 192 MG	21757220300320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Iwilfin therapy

Product Name: Iwilfin	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

IWILFIN	EFLORNITHINE HCL TAB 192 MG	21757220300320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Iwilfin	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
IWILFIN	EFLORNITHINE HCL TAB 192 MG	21757220300320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Iwilfin therapy

Jakafi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146554
Guideline Name	Jakafi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Jakafi	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand

JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - ONE of the following diagnoses:

1.1 Primary myelofibrosis

OR

1.2 Post-polycythemia vera myelofibrosis

OR

1.3 Post-essential thrombocythemia myelofibrosis

Product Name: Jakafi	
Diagnosis	Polycythemia Vera
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Diagnosis of polycythemia vera

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Hydroxyurea
- Interferon therapy (e.g., Intron A, Pegasys)

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Hydroxyurea
- Interferon therapy (e.g., Intron A, Pegasys)

Product Name: Jakafi	
Diagnosis	Essential Thrombocythemia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand

JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand

Approval Criteria

1 - Diagnosis of essential thrombocythemia

AND

2 - Inadequate response or loss of response to ONE of the following:

- Hydroxyurea
- Pegasys (peginterferon alfa-2a)
- Agrylin (Anagrelide)

Product Name: Jakafi	
Diagnosis	Myelofibrosis, Polycythemia Vera, Essential Thrombocythemia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi*	
Notes	*If documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, authorization will be issued for 2 months to allow for dose titration with discontinuation of therapy.

Product Name: Jakafi	
Diagnosis	Graft versus host disease (GVHD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of acute graft versus host disease (GVHD)

AND

1.2 Disease is steroid refractory

OR

2 - BOTH of the following:

2.1 Diagnosis of chronic GVHD

AND

2.2 Failure of one or two lines of systemic therapy

Product Name: Jakafi	
Diagnosis	Graft versus host disease (GVHD)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Documentation that patient has symptom improvement while on Jakafi

Product Name: Jakafi	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - Patient has a JAK2 rearrangement

Product Name: Jakafi	
Diagnosis	Myelodysplastic Syndromes
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of chronic myelomonocytic leukemia (CMML)-2

AND

1.2 Used in combination with a hypomethylating agent (e.g., azacitidine, decitabine)

OR

2 - Diagnosis of BCR-ABL negative atypical chronic myeloid leukemia (aCML)

Product Name: Jakafi	
Diagnosis	T-Cell Lymphomas
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

1.1 Peripheral T-Cell Lymphoma not otherwise specified (PTCL-NOS)

OR

1.2 Enteropathy-associated T-cell lymphoma (EATL)

OR

1.3 Monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL)

OR

1.4 Angioimmunoblastic T-cell lymphoma (AITL)

OR

1.5 Nodal peripheral T-cell lymphoma with T-follicular helper phenotype (PTCL, TFH)

OR

1.6 Follicular T-cell lymphoma (FTCL)

OR

1.7 Anaplastic large cell lymphoma (ALCL)

OR

1.8 Hepatosplenic T-cell lymphoma

AND

2 - Used as initial palliative intent therapy or second-line and subsequent therapy for relapsed/refractory disease

Product Name: Jakafi	
Diagnosis	Myeloid/Lymphoid Neoplasms, Myelodysplastic Syndromes, T-Cell Lymphomas
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Jakafi therapy

Product Name: Jakafi	
Diagnosis	Pediatric Acute Lymphoblastic Leukemia
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Diagnosis of pediatric acute lymphoblastic leukemia

AND

2 - Used as a component of induction therapy

Product Name: Jakafi	
Diagnosis	Immunotherapy-Related Toxicities
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Diagnosis of CAR-T induced G4 cytokine release syndrome

AND

2 - Disease is refractory to high-dose corticosteroids and anti-IL-6 therapy [e.g., Actemra (tocilizumab)]

Product Name: Jakafi	
Diagnosis	NCCN Recommended Regimens
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Jakafi	
Diagnosis	NCCN Recommended Regimens
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	Brand
JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Jakafi therapy

Jaypirca

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146555
Guideline Name	Jaypirca
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Jaypirca	
Diagnosis	Mantle Cell Lymphoma (MCL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAYPIRCA	PIRTOBRUTINIB TAB 50 MG	21532165000320	Brand
JAYPIRCA	PIRTOBRUTINIB TAB 100 MG	21532165000330	Brand

Approval Criteria

1 - Diagnosis of mantle cell lymphoma (MCL)

AND

2 - Disease is relapsed or refractory

AND

3 - Both of the following:

3.1 Patient has received at least two prior systemic therapies for MCL [e.g., Rituxan (rituximab)]

AND

3.2 Patient has received at least one Bruton Tyrosine Kinase (BTK) inhibitor therapy for MCL [e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib)]

Product Name: Jaypirca	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAYPIRCA	PIRTOBRUTINIB TAB 50 MG	21532165000320	Brand
JAYPIRCA	PIRTOBRUTINIB TAB 100 MG	21532165000330	Brand

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia or small lymphocytic lymphoma

AND

2 - Patient has been previously treated with both of the following:

2.1 Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib)]

AND

2.2 B-cell lymphoma 2 (BCL-2) inhibitor therapy [e.g., Venclexta (venetoclax)]

Product Name: Jaypirca	
Diagnosis	Mantle Cell Lymphoma (MCL), Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAYPIRCA	PIRTOBRUTINIB TAB 50 MG	21532165000320	Brand
JAYPIRCA	PIRTOBRUTINIB TAB 100 MG	21532165000330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Jaypirca therapy

Product Name: Jaypirca	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAYPIRCA	PIRTOBRUTINIB TAB 50 MG	21532165000320	Brand
JAYPIRCA	PIRTOBRUTINIB TAB 100 MG	21532165000330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Jaypirca	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JAYPIRCA	PIRTOBRUTINIB TAB 50 MG	21532165000320	Brand
JAYPIRCA	PIRTOBRUTINIB TAB 100 MG	21532165000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Jaypirca therapy

Jesduvroq

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146350
Guideline Name	Jesduvroq
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Jesduvroq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JESDUVROQ	DAPRODUSTAT TAB 1 MG	82402520000310	Brand
JESDUVROQ	DAPRODUSTAT TAB 2 MG	82402520000315	Brand
JESDUVROQ	DAPRODUSTAT TAB 4 MG	82402520000320	Brand
JESDUVROQ	DAPRODUSTAT TAB 6 MG	82402520000325	Brand
JESDUVROQ	DAPRODUSTAT TAB 8 MG	82402520000330	Brand

Approval Criteria

1 - Diagnosis of anemia due to chronic kidney disease (CKD)

AND

2 - Patient has been receiving dialysis for at least four months

AND

3 - BOTH of the following:

- Ferritin greater than 100 mcg/L (micrograms per liter)
- Transferrin saturation (TSAT) greater than 20%

AND

4 - Hemoglobin level is less than 11 g/dL (grams per deciliter)

AND

5 - ONE of the following:

5.1 Failure to an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] as confirmed by claims history or submission of medical records

OR

5.2 History of contraindication or intolerance to an erythropoietin stimulating agent (ESA) (please specify contraindication or intolerance)

AND

6 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Nephrologist

Product Name: Jesduvroq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JESDUVROQ	DAPRODUSTAT TAB 1 MG	82402520000310	Brand
JESDUVROQ	DAPRODUSTAT TAB 2 MG	82402520000315	Brand
JESDUVROQ	DAPRODUSTAT TAB 4 MG	82402520000320	Brand
JESDUVROQ	DAPRODUSTAT TAB 6 MG	82402520000325	Brand
JESDUVROQ	DAPRODUSTAT TAB 8 MG	82402520000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Jesduvroq therapy (e.g., clinically meaningful increase in hemoglobin level)

AND

2 - Adequate iron stores confirmed by both of the following:

- Ferritin greater than 100 mcg/L (micrograms per liter)
- Transferrin saturation (TSAT) greater than 20%

AND

3 - Hemoglobin level does not exceed 12 g/dL (grams per deciliter)

AND

4 - Patient is not on concurrent treatment with an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Hematologist
- Nephrologist

Joenja

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150145
Guideline Name	Joenja
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name: Joenja	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JOENJA	LENIOLISIB PHOSPHATE TAB 70 MG	99391540600320	Brand

Approval Criteria

1 - Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS)

AND

2 - Diagnosis has been confirmed by the presence of an APDS-associated genetic variant in either PIK3CD or PIK3R1

AND

3 - Documentation of other clinical findings and manifestations consistent with APDS (e.g., recurrent respiratory tract infections, recurrent herpesvirus infections, lymphadenopathy, hepatosplenomegaly, autoimmune cytopenia)

AND

4 - ONE of the following:

4.1 Failure to one current standard of care for APDS (e.g., antimicrobial prophylaxis, immunoglobulin replacement therapy, immunosuppressive therapy) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to one current standard of care for APDS (e.g., antimicrobial prophylaxis, immunoglobulin replacement therapy, immunosuppressive therapy) (please specify intolerance or contraindication)

AND

5 - Prescribed by ONE of the following:

- Hematologist
- Immunologist

AND

6 - BOTH of the following:

- Patient is 12 years of age or older
- Patient weighs greater than or equal to 45 kg (kilograms)

Product Name: Joenja	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JOENJA	LENIOLISIB PHOSPHATE TAB 70 MG	99391540600320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Joenja therapy (e.g., reduced lymph node size, increased naïve B-cell percentage, decreased frequency or severity of infections, decreased frequency of hospitalizations)

AND

2 - Prescribed by ONE of the following:

- Hematologist
- Immunologist

AND

3 - Patient weighs greater than or equal to 45 kg

2 . Revision History

Date	Notes
7/23/2024	Updated initial authorization duration to 12 months.

Juxtapid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146557
Guideline Name	Juxtapid
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JUXTAPID	LOMITAPIDE MESYLATE CAP 5 MG (BASE EQUIV)	39480050200120	Brand
JUXTAPID	LOMITAPIDE MESYLATE CAP 10 MG (BASE EQUIV)	39480050200130	Brand
JUXTAPID	LOMITAPIDE MESYLATE CAP 20 MG (BASE EQUIV)	39480050200140	Brand
JUXTAPID	LOMITAPIDE MESYLATE CAP 30 MG (BASE EQUIV)	39480050200150	Brand

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by ONE of the following:

1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 BOTH of the following:

1.2.1 Pre-treatment low density lipoprotein cholesterol (LDL-C) greater than 400 mg/dL (milligrams per deciliter)

AND

1.2.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diet

AND

3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

AND

5 - ONE of the following:

5.1 Failure to Repatha (evolocumab) as confirmed by claims history or submission of medical records

OR

5.2 History of intolerance or contraindication to Repatha (evolocumab) (please specify intolerance or contraindication)

AND

6 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

Product Name: Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JUXTAPID	LOMITAPIDE MESYLATE CAP 5 MG (BASE EQUIV)	39480050200120	Brand
JUXTAPID	LOMITAPIDE MESYLATE CAP 10 MG (BASE EQUIV)	39480050200130	Brand
JUXTAPID	LOMITAPIDE MESYLATE CAP 20 MG (BASE EQUIV)	39480050200140	Brand
JUXTAPID	LOMITAPIDE MESYLATE CAP 30 MG (BASE EQUIV)	39480050200150	Brand

Approval Criteria

1 - Patient continues to receive comprehensive counseling regarding appropriate diet

AND

2 - Patient continues to receive other lipid-lowering therapy (e.g., statin, low density lipoprotein [LDL] apheresis)

AND

3 - Documentation of a positive clinical response to therapy from pre-treatment baseline

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

Jynarque

Prior Authorization Guideline

Guideline ID	GL-146558
Guideline Name	Jynarque
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Jynarque, Jynarque Pak	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 15 MG	3045406000B710	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 30 & 15 MG	3045406000B720	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 45 & 15 MG	3045406000B725	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 60 & 30 MG	3045406000B735	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 90 & 30 MG	3045406000B745	Brand

JYNARQUE	TOLVAPTAN TAB 15 MG	30454060000320	Brand
JYNARQUE	TOLVAPTAN TAB 30 MG	30454060000330	Brand

Approval Criteria

1 - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)

Product Name: Jynarque, Jynarque Pak	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 15 MG	3045406000B710	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 30 & 15 MG	3045406000B720	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 45 & 15 MG	3045406000B725	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 60 & 30 MG	3045406000B735	Brand
JYNARQUE	TOLVAPTAN TAB THERAPY PACK 90 & 30 MG	3045406000B745	Brand
JYNARQUE	TOLVAPTAN TAB 15 MG	30454060000320	Brand
JYNARQUE	TOLVAPTAN TAB 30 MG	30454060000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Jynarque therapy

Kalydeco

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151780
Guideline Name	Kalydeco
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Kalydeco	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KALYDECO	IVACAFTOR TAB 150 MG	45302030000320	Brand
KALYDECO	IVACAFTOR PACKET 25 MG	45302030003010	Brand
KALYDECO	IVACAFTOR PACKET 50 MG	45302030003020	Brand
KALYDECO	IVACAFTOR PACKET 75 MG	45302030003030	Brand
KALYDECO	IVACAFTOR PACKET 13.4 MG	45302030003005	Brand

KALYDECO	IVACAFTOR PACKET 5.8 MG	45302030003002	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results confirming that patient has at least ONE of the mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Kalydeco, listed in Table 1 (see Background)

AND

3 - Prescribed by, or in consultation with a provider who specializes in the treatment of CF

Product Name: Kalydeco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KALYDECO	IVACAFTOR TAB 150 MG	45302030000320	Brand
KALYDECO	IVACAFTOR PACKET 25 MG	45302030003010	Brand
KALYDECO	IVACAFTOR PACKET 50 MG	45302030003020	Brand
KALYDECO	IVACAFTOR PACKET 75 MG	45302030003030	Brand
KALYDECO	IVACAFTOR PACKET 13.4 MG	45302030003005	Brand
KALYDECO	IVACAFTOR PACKET 5.8 MG	45302030003002	Brand

Approval Criteria

1 - Documentation of positive clinical response to Kalydeco therapy (e.g., improved lung function, stable lung function)

2 . Background

Benefit/Coverage/Program Information

Table 1. CFTR Gene Mutations

711+3A→G *	F311del	I148T	R75Q	S589N
2789+5G→A *	F311L	I175V	R117C *	S737F
3272-26A→G *	F508C	I807M	R117G	S945L *
3849+10kbC→T *	F508C;S1251N †	I1027T	R117H *	S977F *
A120T	F1052V	I1139V	R117L	S1159F
A234D	F1074L	K1060T	R117P	S1159P
A349V	G178E	L206W *	R170H	S1251N *
A455E *	G178R *	L320V	R347H *	S1255P *
A1067T	G194R	L967S	R347L	T338I
D110E	G314E	L997F	R352Q *	T1053I
D110H	G551D *	L1480P	R553Q	V232D
D192G	G551S *	M152V	R668C	V562I
D579G *	G576A	M952I	R792G	V754M

D924N	G970D	M952T	R933G	V1293G
D1152H *	G1069R	P67L *	R1070Q	W1282R
D1270N	G1244E *	Q237E	R1070W *	Y1014C
E56K	G1249R	Q237H	R1162L	Y1032C
E193K	G1349D *	Q359R	R1283M	
E822K	H939R	Q1291R	S549N *	
E831X *	H1375P	R74W	S549R *	

* Clinical data exist for these mutations.

† Complex/compound mutations where a single allele of the CFTR gene has multiple mutations; these exist independent of the presence of mutations on the other allele.

3 . Revision History

Date	Notes
8/14/2024	Annual review. Removed prescriber requirement from reauthorization criteria. Updated reference.

Kerendia

Prior Authorization Guideline

Guideline ID	GL-146351
Guideline Name	Kerendia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Kerendia	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KERENDIA	FINERENONE TAB 10 MG	30354030000310	Brand
KERENDIA	FINERENONE TAB 20 MG	30354030000320	Brand

Approval Criteria

1 - Diagnosis of chronic kidney disease

AND

2 - Both of the following:

2.1 UACR (urinary albumin-to-creatinine ratio) greater than or equal to 30 mg/g

AND

2.2 eGFR (estimated glomerular filtration rate) greater than or equal to 25 mL/min/1.73 m2

AND

3 - History of type 2 diabetes

AND

4 - Kerendia is being used to reduce the risk of at least ONE of the following:

- Sustained eGFR decline
- End-stage kidney disease
- Cardiovascular death
- Non-fatal myocardial infarction
- Hospitalization for heart failure

AND

5 - Serum potassium level is less than or equal to 5 mEQ/L (milliequivalents/liter) prior to initiating treatment

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT2 inhibitor (e.g., Farxiga)
- Failure to a SGLT2 inhibitor (e.g., Farxiga) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to a SGLT2 inhibitor (e.g., Farxiga) (please specify intolerance or contraindication)

Product Name: Kerendia	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KERENDIA	FINERENONE TAB 10 MG	30354030000310	Brand
KERENDIA	FINERENONE TAB 20 MG	30354030000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Keveyis

Prior Authorization Guideline

Guideline ID	GL-146560
Guideline Name	Keveyis
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Keveyis, generic dichlorphenamide	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVEYIS	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Brand
DICHLORPHENAMIDE	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Generic

Approval Criteria

1 - Diagnosis of primary hyperkalemic periodic paralysis or related variant

OR

2 - Diagnosis of primary hypokalemic periodic paralysis or related variant

Product Name: Brand Keveyis, generic dichlorphenamide	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVEYIS	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Brand
DICHLORPHENAMIDE	DICHLORPHENAMIDE TAB 50 MG	37100020000305	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Kevzara

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156350
Guideline Name	Kevzara
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Kevzara	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand

KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - One of the following:

2.1 All of the following:

2.1.1 One of the following:

2.1.1.1 Failure to a 3-month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submitted medical records

OR

2.1.1.2 History of intolerance or contraindication to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

2.1.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.1.2 One of the following:

2.1.2.1 Failure of one preferred adalimumab product* confirmed by claims history or submitted medical records

OR

2.1.2.2 History of intolerance or contraindication to all preferred adalimumab products* (please specify intolerance or contraindication)

AND

2.1.3 One of the following:

2.1.3.1 Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records

OR

2.1.3.2 History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

OR

2.2 Patient is currently on Kevzara therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Kevzara	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand

Approval Criteria

1 - Documentation of positive clinical response to Kevzara therapy

AND

2 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

Product Name: Kevzara	
Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand

KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand

Approval Criteria

1 - Diagnosis of polymyalgia rheumatica (PMR)

AND

2 - Patient has had an inadequate response to corticosteroids or cannot tolerate corticosteroid taper

AND

3 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

Product Name: Kevzara	
Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand

Approval Criteria

1 - Documentation of positive clinical response to Kevzara therapy

AND

2 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

Product Name: Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand

Approval Criteria

1 - Diagnosis of active polyarticular juvenile idiopathic arthritis

AND

2 - Patient is NOT receiving Kevzara in combination with another targeted immunomodulator

[e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

3 - One of the following:

- Failure of one preferred adalimumab product* confirmed by claims history or submitted medical records
- History of intolerance or contraindication to all preferred adalimumab products* (please specify intolerance or contraindication)

AND

4 - One of the following:

- Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand

KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand

Approval Criteria

1 - Documentation of positive clinical response to Kevzara therapy

AND

2 - Patient is not receiving Kevzara in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

2 . Revision History

Date	Notes
9/26/2024	Added criteria for pJIA. Updated safety language

Kineret

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155009
Guideline Name	Kineret
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Kineret	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - Patient is not receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - One of the following:

4.1 Patient is currently on Kineret therapy as confirmed by claims history or submission of medical records

OR

4.2 Both of the following:

4.2.1 One of the following:

4.2.1.1 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

OR

4.2.1.2 Failure to a 3 month trial of one non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses confirmed by claims history or submission of medical records

OR

4.2.1.3 History of intolerance or contraindication to one non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

AND

4.2.2 One of the following:

4.2.2.1 Failure of THREE of the following confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Olumiant (baricitinib)
- Tyenne (tocilizumab-aazg)

OR

4.2.2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Olumiant (baricitinib)
- Tyenne (tocilizumab-aazg)

Notes	* For a list of preferred adalimumab products please reference drug c overage tools.

Product Name: Kineret	
Diagnosis	Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	Brand

Approval Criteria

1 - Diagnosis of neonatal-onset multisystem inflammatory disease (NOMID)

AND

2 - Patient is not receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name: Kineret	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	Brand

Approval Criteria

1 - Diagnosis of active systemic juvenile idiopathic arthritis (SJIA) (formerly Still’s Disease)

AND

2 - Patient is not receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - One of the following:

4.1 Patient is currently on Kineret therapy as confirmed by claims history or submission of medical records

OR

4.2 One of the following:

4.2.1 Failure of Tyenne (tocilizumab-aazg) confirmed by claims history or submitted medical records

OR

4.2.2 History of intolerance or contraindication to Tyenne (tocilizumab-aazg) (please specify intolerance or contraindication)

Product Name: Kineret	
Diagnosis	Adult Onset Still’s Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	Brand

Approval Criteria

1 - Diagnosis of adult onset Still's Disease

AND

2 - Patient is not receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name: Kineret	
Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	Brand

Approval Criteria

1 - Diagnosis of deficiency of Interleukin-1 Receptor Antagonist (DIRA)

AND

2 - Patient is not receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name: Kineret	
Diagnosis	Rheumatoid Arthritis (RA), Neonatal-Onset Multisystem Inflammatory Disease (NOMID), Systemic Juvenile Idiopathic Arthritis (SJIA), Adult Onset Still's Disease, Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Kineret therapy

AND

2 - Patient is not receiving Kineret in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

2 . Revision History

Date	Notes
9/16/2024	Updated safety language. Added step through for RA and SJIA for Tyenne

Kisqali

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146563
Guideline Name	Kisqali
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Kisqali	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE	2153107050B720	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB)	2153107050B740	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB)	2153107050B760	Brand

Approval Criteria

1 - Diagnosis of advanced, recurrent, or metastatic breast cancer

AND

2 - BOTH of the following:

- Disease is hormone receptor (HR)-positive
- Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

3 - ONE of the following:

- Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane)
- Used in combination with Faslodex (fulvestrant)

AND

4 - ONE of the following:

4.1 One of the following:

4.1.1 Failure to Verzenio (abemaciclib) confirmed by claims history or submission of medical records

OR

4.1.2 History of contraindication or intolerance to Verzenio (abemaciclib) (please specify intolerance or contraindication)

OR

4.2 Patient is currently on Kisqali therapy

Product Name: Kisqali	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE	2153107050B720	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB)	2153107050B740	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB)	2153107050B760	Brand

Approval Criteria

1 - Diagnosis of recurrent or metastatic endometrial cancer

AND

2 - Tumor is estrogen receptor (ER)-positive

AND

3 - Used in combination with letrozole

Product Name: Kisqali	
Diagnosis	Breast Cancer, Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

KISQALI	RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE	2153107050B720	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB)	2153107050B740	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB)	2153107050B760	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Kisqali therapy

Product Name: Kisqali	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE	2153107050B720	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB)	2153107050B740	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB)	2153107050B760	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Kisqali	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 200 MG DAILY DOSE	2153107050B720	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 400 MG DAILY DOSE (200 MG TAB)	2153107050B740	Brand
KISQALI	RIBOCICLIB SUCCINATE TAB PACK 600 MG DAILY DOSE (200 MG TAB)	2153107050B760	Brand

Approval Criteria

1 - Documentation of positive clinical response to Kisqali therapy

Kisqali Femara Co-Pack

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146564
Guideline Name	Kisqali Femara Co-Pack
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Kisqali Femara Co-Pack	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI FEMARA 200 DOSE	RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B730	Brand
KISQALI FEMARA 400 DOSE	RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B740	Brand

KISQALI FEMARA 600 DOSE	RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B760	Brand

Approval Criteria

1 - Diagnosis of advanced, recurrent, or metastatic breast cancer

AND

2 - Disease is hormone receptor (HR)-positive

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

4 - ONE of the following:

4.1 Failure to Verzenio (abemaciclib) plus an aromatase inhibitor (e.g., anastrozole, letrozole) confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Verzenio (abemaciclib) plus an aromatase inhibitor (e.g., anastrozole, letrozole) (please specify intolerance or contraindication)

OR

4.3 Patient is currently on Kisqali Femara Co-Pack therapy

Product Name: Kisqali Femara Co-Pack	
Diagnosis	Endometrial Carcinoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI FEMARA 200 DOSE	RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B730	Brand
KISQALI FEMARA 400 DOSE	RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B740	Brand
KISQALI FEMARA 600 DOSE	RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B760	Brand

Approval Criteria

1 - Diagnosis of recurrent or metastatic endometrial cancer

AND

2 - Tumor is estrogen receptor (ER)-positive

Product Name: Kisqali Femara Co-Pack	
Diagnosis	Breast Cancer, Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI FEMARA 200 DOSE	RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B730	Brand
KISQALI FEMARA 400 DOSE	RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B740	Brand

KISQALI FEMARA 600 DOSE	RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B760	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Kisqali Femara Co-Pack therapy

Product Name: Kisqali Femara Co-Pack	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI FEMARA 200 DOSE	RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B730	Brand
KISQALI FEMARA 400 DOSE	RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B740	Brand
KISQALI FEMARA 600 DOSE	RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B760	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Kisqali Femara Co-Pack	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KISQALI FEMARA 200 DOSE	RIBOCICLIB 200 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B730	Brand
KISQALI FEMARA 400 DOSE	RIBOCICLIB 400 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B740	Brand
KISQALI FEMARA 600 DOSE	RIBOCICLIB 600 MG DOSE (200 MG TAB) & LETROZOLE 2.5 MG TBPK	2199000260B760	Brand

Approval Criteria

1 - Documentation of positive clinical response to Kisqali Femara Co-Pack therapy

Korlym

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147303
Guideline Name	Korlym
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KORLYM	MIFEPRISTONE TAB 300 MG	27304050000330	Brand
MIFEPRISTONE	MIFEPRISTONE TAB 300 MG	27304050000330	Generic

Approval Criteria

1 - Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

2 - ONE of the following:

- Diagnosis of type 2 diabetes mellitus
- Diagnosis of glucose intolerance

AND

3 - ONE of the following:

- Patient has failed surgery
- Patient is not a candidate for surgery

Product Name: Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KORLYM	MIFEPRISTONE TAB 300 MG	27304050000330	Brand
MIFEPRISTONE	MIFEPRISTONE TAB 300 MG	27304050000330	Generic

Approval Criteria

1 - Documentation of a positive clinical response while on the requested therapy

2 . Revision History

Date	Notes
5/13/2024	Updated reauthorization criteria and added generic mifepristone as a target. Updated product name lists and GPI tables accordingly.

Koselugo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146566
Guideline Name	Koselugo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Koselugo	
Diagnosis	Neurofibromatosis Type 1
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOSELUGO	SELUMETINIB SULFATE CAP 10 MG	21533565500110	Brand
KOSELUGO	SELUMETINIB SULFATE CAP 25 MG	21533565500125	Brand

Approval Criteria

1 - Diagnosis of neurofibromatosis type 1

AND

2 - Patient has plexiform neurofibromas that are BOTH of the following:

- Inoperable
- Causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment, bladder/bowel dysfunction)

Product Name: Koselugo	
Diagnosis	Glioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOSELUGO	SELUMETINIB SULFATE CAP 10 MG	21533565500110	Brand
KOSELUGO	SELUMETINIB SULFATE CAP 25 MG	21533565500125	Brand

Approval Criteria

1 - ONE of the following:

1.1 Circumscribed glioma with presence of BRAF fusion or BRAF V600E activating mutations

OR

1.2 NF-1 mutated glioma

AND

2 - Disease is recurrent or progressive

AND

3 - Used as monotherapy

Product Name: Koselugo	
Diagnosis	Langerhans Cell Histiocytosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOSELUGO	SELUMETINIB SULFATE CAP 10 MG	21533565500110	Brand
KOSELUGO	SELUMETINIB SULFATE CAP 25 MG	21533565500125	Brand

Approval Criteria

1 - Diagnosis of Langerhans cell histiocytosis

AND

2 - ONE of the following:

- Presence of MAP kinase pathway mutation
- No detectable mutation
- Genetic testing not available

AND

3 - Used as monotherapy

Product Name: Koselugo	
Diagnosis	Neurofibromatosis Type 1, Pilocytic Astrocytoma, Langerhans Cell Histiocytosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOSELUGO	SELUMETINIB SULFATE CAP 10 MG	21533565500110	Brand
KOSELUGO	SELUMETINIB SULFATE CAP 25 MG	21533565500125	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Koselugo therapy

Product Name: Koselugo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOSELUGO	SELUMETINIB SULFATE CAP 10 MG	21533565500110	Brand
KOSELUGO	SELUMETINIB SULFATE CAP 25 MG	21533565500125	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Koselugo	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KOSELUGO	SELUMETINIB SULFATE CAP 10 MG	21533565500110	Brand
KOSELUGO	SELUMETINIB SULFATE CAP 25 MG	21533565500125	Brand

Approval Criteria

1 - Documentation of positive clinical response to Koselugo therapy

Krazati

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156450
Guideline Name	Krazati
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Krazati	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name: Krazati	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Diagnosis of colorectal cancer

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name: Krazati	
Diagnosis	Ampullary Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Diagnosis of ampullary adenocarcinoma

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name: Krazati	
Diagnosis	Pancreatic Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Diagnosis of pancreatic adenocarcinoma

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Recurrent
- Advanced

- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name: Krazati	
Diagnosis	Biliary Tract Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder Cancer
- Intrahepatic cholangiocarcinoma
- Extrahepatic cholangiocarcinoma

AND

2 - Presence of KRAS G12C mutation

AND

3 - Disease is ONE of the following:

- Unresectable
- Resected gross residual (R2)
- Metastatic

AND

4 - Patient has received at least one prior systemic therapy

Product Name: Krazati	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Colorectal Cancer, Ampullary Adenocarcinoma, Pancreatic Adenocarcinoma, Biliary Tract Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Krazati therapy

Product Name: Krazati	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Krazati	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KRAZATI	ADAGRASIB TAB 200 MG	21532410000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Krazati therapy

2 . Revision History

Date	Notes
9/30/2024	Combined criteria for colon and rectal cancer in one section – Colorectal Cancer. Added criteria for NCCN recommended use of Krazati in biliary tract cancer.

Kuvan

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146568
Guideline Name	Kuvan
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic sapropterin, Brand Kuvan	
Diagnosis	Phenylketonuria (PKU)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SAPROPTERIN DIHYDROCHLORIDE	SAPROPTERIN DIHYDROCHLORIDE TAB 100 MG	30908565100320	Generic
KUVAN	SAPROPTERIN DIHYDROCHLORIDE TAB 100 MG	30908565100320	Brand
SAPROPTERIN DIHYDROCHLORIDE	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 100 MG	30908565103020	Generic
KUVAN	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 100 MG	30908565103020	Brand

SAPROPTERIN DIHYDROCHLORIDE	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 500 MG	30908565103040	Generic
KUVAN	SAPROPTERIN DIHYDROCHLORIDE POWDER PACKET 500 MG	30908565103040	Brand

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

Kynmobi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146569
Guideline Name	Kynmobi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Kynmobi	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KYNMOBI TITRATION KIT	APOMORPHINE HCL FILM 10/15/20/25/30 MG TITRATION KIT	73203010106420	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 10 MG	73203010108210	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 15 MG	73203010108215	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 20 MG	73203010108220	Brand

KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 25 MG	73203010108225	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 30 MG	73203010108230	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Kynmobi will be used as intermittent treatment for OFF episodes

AND

3 - Prescribed by or in consultation with a neurologist or specialist in the treatment of Parkinson's disease

AND

4 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

5 - Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa-levodopa therapy including BOTH of the following:

5.1 Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet

AND

5.2 Dose and dosing interval optimization

AND

6 - ONE of the following:

6.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from TWO different classes) as confirmed by claims history or submission of medical records:

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

OR

6.2 Contraindication or intolerance to ALL anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (please specify contraindication or intolerance):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

Product Name: Kynmobi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
KYNMOBI TITRATION KIT	APOMORPHINE HCL FILM 10/15/20/25/30 MG TITRATION KIT	73203010106420	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 10 MG	73203010108210	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 15 MG	73203010108215	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 20 MG	73203010108220	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 25 MG	73203010108225	Brand
KYNMOBI	APOMORPHINE HYDROCHLORIDE FILM 30 MG	73203010108230	Brand

Approval Criteria

1 - Documentation of a positive clinical response to Kynmobi therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Lampit

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146352
Guideline Name	Lampit
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lampit	
Diagnosis	Chagas disease (American trypanosomiasis)
Approval Length	60 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAMPIT	NIFURTIMOX TAB 30 MG	16400055000320	Brand
LAMPIT	NIFURTIMOX TAB 120 MG	16400055000340	Brand

Approval Criteria

1 - Diagnosis of Chagas disease (American trypanosomiasis) caused by Trypanosoma cruzi

Lenvima

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146570
Guideline Name	Lenvima
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lenvima	
Diagnosis	Renal Cell Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand

LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Diagnosis of advanced renal cell carcinoma

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to one prior anti-angiogenic therapy as confirmed by claims history or submission of medical records [e.g., Avastin (bevacizumab), Votrient (pazopanib), Sutent (sunitinib), Nexavar (sorafenib)]

OR

2.1.1.2 History of intolerance or contraindication to one prior anti-angiogenic therapy [e.g.,

Avastin (bevacizumab), Votrient (pazopanib), Sutent (sunitinib), Nexavar (sorafenib)] (please specify contraindication or intolerance)

AND

2.1.2 Used in combination with Afinitor (everolimus)

OR

2.2 Used in combination with Keytruda (pembrolizumab)

Product Name: Lenvima	
Diagnosis	Renal Cell Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand

LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lenvima therapy

AND

2 - Used in combination with Afinitor (everolimus) or Keytruda (pembrolizumab)

Product Name: Lenvima	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand

DAILY DOSE			
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Diagnosis of differentiated thyroid cancer (DTC)

AND

2 - Disease is locally recurrent, metastatic, progressive, or symptomatic

AND

3 - Disease is radioactive iodine-refractory or ineligible

Product Name: Lenvima	
Diagnosis	Hepatobiliary Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand

LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of hepatocellular carcinoma

AND

1.1.2 Disease is ONE of the following:

- Unresectable
- Metastatic

OR

1.2 ALL of the following:

1.2.1 Diagnosis of biliary tract cancer

AND

1.2.2 Disease is ONE of the following:

- Unresectable or resected gross residual (R2) disease
- Metastatic

AND

1.2.3 Disease has progressed on or after systemic treatment

AND

1.2.4 Used in combination with Keytruda (pembrolizumab)

Product Name: Lenvima	
Diagnosis	Adenoid Cystic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand

LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Diagnosis of recurrent adenoid cystic carcinoma

Product Name: Lenvima	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand

DAILY DOSE			
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Diagnosis of thymic carcinoma

AND

2 - ONE of the following:

2.1 Used as a single agent for those who cannot tolerate first-line combination regimens

OR

2.2 Used as a second line therapy in unresectable locally advanced disease, solitary metastasis or ipsilateral pleural metastasis, or extrathoracic metastatic disease

Product Name: Lenvima	
Diagnosis	Thyroid Cancer, Hepatobiliary Cancer, Adenoid Cystic Carcinoma, Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lenvima therapy

Product Name: Lenvima	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Diagnosis of endometrial carcinoma

AND

2 - Used in combination with Keytruda (pembrolizumab)

Product Name: Lenvima	
Diagnosis	Cutaneous Melanoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Diagnosis of cutaneous melanoma

AND

2 - Disease is ONE of the following:

- Disease is unresectable
- Disease is metastatic

AND

3 - Used in combination with Keytruda (pembrolizumab)

Product Name: Lenvima	
Diagnosis	Endometrial Carcinoma, Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand
LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

DAILY DOSE			

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lenvima therapy

AND

2 - Used in combination with Keytruda (pembrolizumab)

Product Name: Lenvima	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand

LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Lenvima will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Lenvima	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LENVIMA 4 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 4 MG (4 MG DAILY DOSE)	2133505420B210	Brand
LENVIMA 8 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 4 MG (8 MG DAILY DOSE)	2133505420B215	Brand
LENVIMA 10 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 MG (10 MG DAILY DOSE)	2133505420B220	Brand
LENVIMA 12MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 3 X 4 MG (12 MG DAILY DOSE)	2133505420B223	Brand
LENVIMA 20 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 2 X 10 MG (20 MG DAILY DOSE)	2133505420B230	Brand
LENVIMA 14 MG DAILY DOSE	LENVATINIB CAP THERAPY PACK 10 & 4 MG (14 MG DAILY DOSE)	2133505420B240	Brand

LENVIMA 18 MG DAILY DOSE	LENVATINIB CAP THER PACK 10 MG & 2 X 4 MG (18 MG DAILY DOSE)	2133505420B244	Brand
LENVIMA 24 MG DAILY DOSE	LENVATINIB CAP THER PACK 2 X 10 MG & 4 MG (24 MG DAILY DOSE)	2133505420B250	Brand

Approval Criteria

1 - Documentation of positive clinical response to Lenvima therapy

Lidoderm

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146353
Guideline Name	Lidoderm
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan	
Diagnosis	Post-Herpetic Neuralgia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIDOCAINE	LIDOCAINE PATCH 5%	90850060005930	Generic
LIDOCAN III	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDODERM	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAN	LIDOCAINE PATCH 5%	90850060005930	Brand

LIDOCAINE PATCH 5%	LIDOCAINE PATCH 5%	90850060005930	Generic

Approval Criteria

1 - Diagnosis of post-herpetic neuralgia

Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan	
Diagnosis	Neuropathic Pain
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIDOCAINE	LIDOCAINE PATCH 5%	90850060005930	Generic
LIDOCAN III	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDODERM	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAN	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAINE PATCH 5%	LIDOCAINE PATCH 5%	90850060005930	Generic

Approval Criteria

1 - Diagnosis of neuropathic pain

AND

2 - ONE of the following:

2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- Tricyclic anti-depressant (e.g., amitriptyline)

- SNRI (serotonin and norepinephrine reuptake inhibitor) anti-depressant (e.g., duloxetine, venlafaxine)
- Anticonvulsant (e.g., gabapentin, pregabalin)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Tricyclic anti-depressant (e.g., amitriptyline)
- SNRI anti-depressant (e.g., duloxetine, venlafaxine)
- Anticonvulsant (e.g., gabapentin, pregabalin)

Product Name: generic lidocaine 5% patch, Brand Lidocan III, Brand Lidoderm, Brand Lidocan	
Diagnosis	Neuropathic Pain
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIDOCAINE	LIDOCAINE PATCH 5%	90850060005930	Generic
LIDOCAN III	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDODERM	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAN	LIDOCAINE PATCH 5%	90850060005930	Brand
LIDOCAINE PATCH 5%	LIDOCAINE PATCH 5%	90850060005930	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Litfulo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146284
Guideline Name	Litfulo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Litfulo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LITFULO	RITLECITINIB TOSYLATE CAP 50 MG (BASE EQUIV)	90731060100120	Brand

Approval Criteria

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient has a current episode of alopecia areata with at least 50% scalp hair loss

AND

4 - ONE of the following:

4.1 Patient is less than 18 years of age

OR

4.2 Failure to Olumiant confirmed by claims history or submission of medical records

OR

4.3 History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)

AND

5 - Patient is not receiving Litfulo in combination with any of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib]

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name: Litfulo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LITFULO	RITLECITINIB TOSYLATE CAP 50 MG (BASE EQUIV)	90731060100120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Litfulo therapy

AND

2 - Patient is not receiving Litfulo in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib]

Livmarli

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150937
Guideline Name	Livmarli
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/5/2024

1 . Criteria

Product Name: Livmarli	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML	52350050102020	Brand
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML	52350050102040	Brand

Approval Criteria

1 - Diagnosis of progressive familial intrahepatic cholestasis (PFIC)

AND

2 - Patient does not have a ABCB11 variant resulting in non-functional or complete absence of bile salt export pump (BSEP) protein

AND

3 - Patient is experiencing moderate to severe pruritus associated with PFIC.

AND

4 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory.

AND

5 - Patient has had an inadequate response to at least two conventional treatments for the symptomatic relief of pruritus (e.g., cholestyramine, rifampin, naltrexone, sertraline, phenobarbital).

AND

6 - Prescribed by a gastroenterologist or hepatologist.

Product Name: Livmarli	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML	52350050102020	Brand
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML	52350050102040	Brand

Approval Criteria

1 - Documentation of positive clinical response to Livmarli therapy (e.g., reduced serum bile acids, improved pruritis and less sleep disturbance)

AND

2 - Prescribed by a gastroenterologist or hepatologist

Product Name: Livmarli	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML	52350050102020	Brand
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML	52350050102040	Brand

Approval Criteria

1 - Diagnosis of Alagille syndrome (ALGS)

AND

2 - Confirmation of diagnosis by presence of the JAG1 or Notch2 gene mutation

AND

3 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory.

AND

4 - Patient is experiencing moderate to severe pruritis associated with ALGS

AND

5 - Patient has had an inadequate response to at least two conventional treatments for the symptomatic relief of pruritus (e.g., cholestyramine, rifampin, naltrexone, sertraline, phenobarbital).

AND

6 - Prescribed by a gastroenterologist or hepatologist.

Product Name: Livmarli	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 9.5 MG/ML	52350050102020	Brand
LIVMARLI	MARALIXIBAT CHLORIDE ORAL SOLN 19 MG/ML	52350050102040	Brand

Approval Criteria

1 - Documentation of positive clinical response to Livmarli therapy (e.g., reduced serum bile acids, improved pruritis)

AND

2 - Prescribed by a gastroenterologist or hepatologist.

Livtencity

Prior Authorization Guideline

Guideline ID	GL-146572
Guideline Name	Livtencity
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Livtencity	
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIVTENCITY	MARIBAVIR TAB 200 MG	12200050000320	Brand

Approval Criteria

1 - Diagnosis of post-transplant cytomegalovirus (CMV) infection or CMV disease

AND

2 - CMV infection or disease is refractory to treatment (with or without genotypic resistance) to ONE of the following:

- Ganciclovir
- Valganciclovir
- Cidofovir
- Foscarnet

AND

3 - Patient will not use the requested medication in combination with ganciclovir or valganciclovir

Lokelma, Veltassa

Prior Authorization Guideline

Guideline ID	GL-154650
Guideline Name	Lokelma, Veltassa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Lokelma, Veltassa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 5 GM	99450020003020	Brand
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 10 GM	99450020003040	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 8.4 GM (BASE EQ)	99450060203020	Brand

VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 16.8 GM (BASE EQ)	99450060203030	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 25.2 GM (BASE EQ)	99450060203040	Brand

Approval Criteria

1 - Diagnosis of non-life threatening hyperkalemia

AND

2 - Where clinically appropriate, loop or thiazide diuretic therapy for potassium removal has failed

AND

3 - Patient follows a low potassium diet (less than or equal to 3 grams per day)

Product Name: Lokelma, Veltassa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 5 GM	99450020003020	Brand
LOKELMA	SODIUM ZIRCONIUM CYCLOSILICATE FOR SUSP PACKET 10 GM	99450020003040	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 8.4 GM (BASE EQ)	99450060203020	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 16.8 GM (BASE EQ)	99450060203030	Brand
VELTASSA	PATIROMER SORBITEX CALCIUM FOR SUSP PACKET 25.2 GM (BASE EQ)	99450060203040	Brand

Approval Criteria
1 - Patient has a positive clinical response to Lokelma or Veltassa therapy **AND** **2** - Patient continues to require treatment for hyperkalemia **AND** **3** - Patient follows a low potassium diet (less than or equal to 3 grams per day)

2 . Revision History

Date	Notes
9/9/2024	Removed requirement to adjust medications.

Long-Acting Opioid Products

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146355
Guideline Name	Long-Acting Opioid Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	DUR: Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic

OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic

OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic

METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - ONE of the following:

- Cancer diagnosis
- End of life care, including hospice care
- Palliative care
- Sickle cell anemia

OR

2 - Prescriber attests that the patient has received an opioid within the past 60 days

Notes	*Approval length for cancer, end of life, palliative care, or sickle cell pa in will be issued for 12 months. All other approvals will be issued for th e requested duration, not to exceed one month.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic

Approval Criteria

1 - Patient is being treated for cancer related pain

OR

2 - Patient is in hospice or is receiving end of life care

OR

3 - Patient is being treated for sickle cell anemia related pain

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: hydrocodone bitartrate ER caps, oxymorphone ER	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer related pain

OR

1.2 Patient is in hospice or is receiving end of life care

OR

1.3 Patient is being treated for sickle cell anemia related pain

AND

2 - ONE of the following:

2.1 The patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

2.2 The patient has a history of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

2.3 BOTH of the following:

2.3.1 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, sickle cell anemia related pain, or end of life care related pain

AND

2.3.2 The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, or end of life care pain (document date regimen was started)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER) and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 12 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name: morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER

Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic

OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic

METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer related pain

OR

1.2 Patient is in hospice or is receiving end of life care

OR

1.3 Patient is being treated for sickle cell anemia related pain

AND

2 - ONE of the following:

2.1 The patient has failed a trial of at least THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

2.2 The patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

2.3 BOTH of the following:

2.3.1 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, sickle cell anemia related pain, or end of life care related pain

AND

2.3.2 The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, or end of life care pain (Document date regimen was started)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested q

	uantity for transition to an alternative treatment. If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treat ment with an opioid, but has not tried the preferred alternatives, a deni al should be issued and a maximum 60-day authorization may be auth orized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionall y, a 12 month authorization should be entered for preferred products, depending on what the patient has already tried: • If the patient has tried morphine sulfate controlled release tablets (ge neric MS Contin) or preferred fentanyl transdermal, an authorization s hould be entered for oxymorphone ER-non crush resistant (generic) a nd hydrocodone extended-release capsules (generic Zohydro ER). • If the patient has not tried any of the preferred products [morphine s ulfate controlled release tablets (generic MS Contin), preferred fentan yl transdermal, oxymorphone ER-non crush resistant (generic) or hydr ocodone extended-release capsules (generic Zohydro ER)], an author ization should be entered for morphine sulfate controlled release table ts (generic MS Contin) and preferred fentanyl transdermal.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic

MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

5.1.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication)

OR

5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: hydrocodone bitartrate ER caps, oxymorphone ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic

OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8

weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication) **AND** **5.1.2** Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication) **OR** **5.2** Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days **AND** **6** - ONE of the following: **6.1** Patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials): • morphine sulfate controlled release tablets (generic MS Contin) • preferred fentanyl transdermal **OR** **6.2** Patient has a history of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance): • morphine sulfate controlled release tablets (generic MS Contin) • preferred fentanyl transdermal	
Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER) and th

	e patient is currently taking the requested long-acting opioid for at leas t 30 days and has met the medical necessity authorization criteria req uirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authori zation may be authorized one time for the requested drug/strength co mbination up to the requested quantity for transition to an alternative tr eatment. Additionally, a 6 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and pr eferred fentanyl transdermal.

Product Name: morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand

ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - Prescriber attests to BOTH of the following:

1.1 Patient has been screened for substance abuse/opioid dependence

AND

1.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days [document drug(s) and date of trial]

OR

4.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

4.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.4 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), ONE of the following:

5.1 BOTH of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial) (if contraindicated, document contraindication)

AND

5.1.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) (if contraindicated, document contraindication)

OR

5.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

6 - ONE of the following:

6.1 Patient has failed a trial of at least THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

OR

6.2 Patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal
- oxymorphone ER non-crush resistant (generic)
- hydrocodone extended-release capsules (generic Zohydro ER)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for preferred products, depending on what the patient has already tried:

	• If the patient has tried morphine sulfate controlled release tablets (ge neric MS Contin) or preferred fentanyl transdermal, an authorization s hould be entered for oxymorphone ER-non crush resistant (generic) a nd hydrocodone extended-release capsules (generic Zohydro ER). • If the patient has not tried any of the preferred products [morphine s ulfate controlled release tablets (generic MS Contin), preferred fentan yl transdermal, oxymorphone ER-non crush resistant (generic) or hydr ocodone extended-release capsules (generic Zohydro ER)], an author ization should be entered for morphine sulfate controlled release table ts (generic MS Contin) and preferred fentanyl transdermal.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl 12, 25, 50, 75, 100 mcg/hr patches	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic

FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: hydrocodone bitartrate ER caps, oxymorphone ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - ONE of the following:

4.1 Patient has failed a trial of at least ONE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

OR

4.2 Patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- morphine sulfate controlled release tablets (generic MS Contin)
- preferred fentanyl transdermal

Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for oxymorphone ER-non crush resistant (generic) or

	hydrocodone extended-release capsules (generic Zohydro ER) and th e patient is currently taking the requested long-acting opioid for at leas t 30 days and has met the medical necessity authorization criteria req uirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authori zation may be authorized one time for the requested drug/strength co mbination up to the requested quantity for transition to an alternative tr eatment. Additionally, a 6 month authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and pr eferred fentanyl transdermal.

Product Name: morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, fentanyl 37.5, 62.5, 87.5 mcg/hr patches, methadone tabs/soln, generic methadone conc, Brand Methadose conc, Brand Zohydro ER	
Diagnosis	Non-cancer pain/Non-hospice/Non-sickle cell anemia/Non-end of life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand

ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

3.1 Patient has been screened for substance abuse/opioid dependence

AND

3.2 Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - ONE of the following:

4.1 Patient has failed a trial of at least THREE of the following, as confirmed by claims history or submission of medical records (document drugs and date of trials):

- morphine sulfate controlled release tablets (generic MS Contin)

• preferred fentanyl transdermal • oxymorphone ER non-crush resistant (generic) • hydrocodone extended-release capsules (generic Zohydro ER) **OR** **4.2** Patient has a history of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance): • morphine sulfate controlled release tablets (generic MS Contin) • preferred fentanyl transdermal • oxymorphone ER non-crush resistant (generic) • hydrocodone extended-release capsules (generic Zohydro ER)	
Notes	*If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the request is for a non-preferred product and the patient is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for preferred products, depending on what the patient has already tried: • If the patient has tried morphine sulfate controlled release tablets (generic MS Contin) or preferred fentanyl transdermal, an authorization should be entered for oxymorphone ER-non crush resistant (generic) and hydrocodone extended-release capsules (generic Zohydro ER). • If the patient has not tried any of the preferred products [morphine sulfate controlled release tablets (generic MS Contin), preferred fentanyl transdermal, oxymorphone ER-non crush resistant (generic) or hydrocodone extended-release capsules (generic Zohydro ER)], an authorization should be entered for morphine sulfate controlled release tablets (generic MS Contin) and preferred fentanyl transdermal.

Product Name: tramadol ER, Conzip	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic

Approval Criteria

1 - ONE of the following:

1.1 The patient has failed a trial of tramadol IR (immediate release) as confirmed by claims history or submission of medical records

OR

1.2 The patient has a history of contraindication or intolerance to tramadol IR (please specify contraindication or intolerance)

OR

2 - BOTH of the following:

2.1 ONE of the following:

2.1.1 Patient is being treated for cancer related pain

OR

2.1.2 Patient is in hospice or is receiving end of life care

OR

2.1.3 Patient is being treated for sickle cell anemia related pain

AND

2.2 BOTH of the following:

2.2.1 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, sickle cell anemia related pain, or end of life care related pain

AND

2.2.2 The medication is not a new regimen for treatment of cancer-related pain, hospice, sickle cell anemia related pain, or end of life care pain (document date regimen was started)

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER

Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic

OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic

OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic

METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic

TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists

Notes	Authorization will be issued for: • 12 months for cancer pain/hospice/sickle cell anemia related pain/end of life related pain. • 12 months for all Tramadol ER requests. • 6 months for non-cancer pain/non-hospice/non-sickle cell anemia related pain/non-end of life related pain.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Cancer/Hospice/Sickle Cell Anemia/End of Life Related Pain
Approval Length	12 Months*
Guideline Type	Morphine Milligram Equivalent (MME)

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic

OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic

HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic

FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic

TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - Doses exceeding the cumulative morphine milligram equivalent (MME) of 90 milligrams (mg) will be approved up to the requested amount for ALL opioid products if the patient has cancer pain, hospice pain, end of life diagnosis, or sickle cell anemia

Notes	*Authorization will be issued for 12 months for cancer pain/hospice/sickle cell anemia/end of life related pain. The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Non-cancer pain/non-hospice/non-sickle cell anemia/non-end of life related pain
Approval Length	6 Months*
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalent (MME)

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic

TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - If the dose exceeds the maximum cumulative morphine milligram equivalent (MME) of 90 mg, ALL of the following:

1.1 Prescriber attests the patient has been screened for substance abuse/opioid dependence

AND

1.2 Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

1.3 BOTH of the following:

1.3.1 Patient has been screened for underlying depression and/or anxiety

AND

1.3.2 If applicable, any underlying conditions have been or will be addressed

AND

1.4 ONE of the following:

1.4.1 Opioid medication doses of less than 90 MME have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

OR

1.4.2 Patient is new to plan and currently established on the requested MME for at least the past 30 days

Notes	*Authorization will be issued for 6 months for non-cancer/non-hospice/ non-sickle cell anemia/non-end of life related pain up to the current re quested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization c riteria requirements, a denial should be issued and a maximum 60-da y authorization may be authorized one time for the requested MME do se.

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, oxycodone ER, Oxycontin, Xtampza ER, methadone tabs/soln, generic methadone conc, Brand Methadose conc, tramadol ER, Conzip, Brand Zohydro ER	
Diagnosis	Non-cancer pain/non-hospice/non-sickle cell anemia/non-end of life related pain
Approval Length	6 Months*
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalent (MME)

Product Name	Generic Name	GPI	Brand/Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE CR	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Generic
FENTANYL	FENTANYL TD PATCH 72HR 12 MCG/HR	65100025008610	Generic
FENTANYL	FENTANYL TD PATCH 72HR 25 MCG/HR	65100025008620	Generic
FENTANYL	FENTANYL TD PATCH 72HR 50 MCG/HR	65100025008630	Generic
FENTANYL	FENTANYL TD PATCH 72HR 75 MCG/HR	65100025008640	Generic
FENTANYL	FENTANYL TD PATCH 72HR 100 MCG/HR	65100025008650	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Generic

HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 5 MG	65100080107405	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 7.5 MG	65100080107407	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 10 MG	65100080107410	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 15 MG	65100080107415	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 20 MG	65100080107420	Generic
OXYMORPHONE HYDROCHLORIDE ER	OXYMORPHONE HCL TAB ER 12HR 30 MG	65100080107430	Generic
OXYMORPHONE HYDROCHLORIDEER	OXYMORPHONE HCL TAB ER 12HR 40 MG	65100080107440	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 10 MG	65100055107010	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 20 MG	65100055107020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 30 MG	65100055107030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 50 MG	65100055107040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 60 MG	65100055107045	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 80 MG	65100055107050	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE CAP ER 24HR 100 MG	65100055107060	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 8 MG	65100035107521	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 12 MG	65100035107531	Generic

HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HCL ER	HYDROMORPHONE HCL TAB ER 24HR 16 MG	65100035107541	Generic
HYDROMORPHONE HYDROCHLORIDE ER	HYDROMORPHONE HCL TAB ER 24HR 32 MG	65100035107556	Generic
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	6510003010A810	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	6510003010A820	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	6510003010A830	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	6510003010A840	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	6510003010A850	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG	6510003010A860	Brand
HYDROCODONE BITARTRATE ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Generic
HYSINGLA ER	HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	6510003010A870	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 15 MG	65100055100415	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 30 MG	65100055100432	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 60 MG	65100055100445	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 100 MG	65100055100460	Brand
MS CONTIN	MORPHINE SULFATE TAB ER 200 MG	65100055100480	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 50 MG	65100091107420	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 100 MG	65100091107430	Brand

NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 150 MG	65100091107440	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 200 MG	65100091107450	Brand
NUCYNTA ER	TAPENTADOL HCL TAB ER 12HR 250 MG	65100091107460	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 10 MG	6510007510A710	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 15 MG	6510007510A715	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 20 MG	6510007510A720	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 30 MG	6510007510A730	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 40 MG	6510007510A740	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 60 MG	6510007510A760	Brand
OXYCODONE HYDROCHLORIDE ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCODONE HCL ER	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
OXYCONTIN	OXYCODONE HCL TAB ER 12HR DETER 80 MG	6510007510A780	Generic
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	6510007500A310	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG	6510007500A315	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	6510007500A320	Brand
XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	6510007500A330	Brand

XTAMPZA ER	OXYCODONE CAP ER 12HR ABUSE-DETERRENT 36 MG	6510007500A340	Brand
FENTANYL	FENTANYL TD PATCH 72HR 37.5 MCG/HR	65100025008626	Generic
FENTANYL	FENTANYL TD PATCH 72HR 62.5 MCG/HR	65100025008635	Generic
FENTANYL	FENTANYL TD PATCH 72HR 87.5 MCG/HR	65100025008645	Generic
METHADONE HCL	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 5 MG	65100050100305	Generic
METHADONE HCL	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL TAB 10 MG	65100050100310	Generic
METHADONE HYDROCHLORIDE INTENSOL	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE SUGAR-FREE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HYDROCHLORIDE	METHADONE HCL CONC 10 MG/ML	65100050101310	Generic
METHADOSE	METHADONE HCL CONC 10 MG/ML	65100050101310	Brand
METHADONE HCL	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 5 MG/5ML	65100050102010	Generic
METHADONE HCL	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
METHADONE HYDROCHLORIDE	METHADONE HCL SOLN 10 MG/5ML	65100050102015	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 100 MG	65100095107070	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 200 MG	65100095107080	Generic
TRAMADOL HCL ER	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
CONZIP	TRAMADOL HCL CAP ER 24HR BIPHASIC RELEASE 300 MG	65100095107090	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 100 MG	65100095107520	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic

TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 200 MG	65100095107530	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HYDROCHLORIDE ER	TRAMADOL HCL TAB ER 24HR 300 MG	65100095107540	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 100 MG	65100095107560	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 200 MG	65100095107570	Generic
TRAMADOL HCL ER	TRAMADOL HCL TAB ER 24HR BIPHASIC RELEASE 300 MG	65100095107580	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 30 MG	65100055207020	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 45 MG	65100055207025	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 60 MG	65100055207030	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 75 MG	65100055207035	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 90 MG	65100055207040	Generic
MORPHINE SULFATE ER	MORPHINE SULFATE BEADS CAP ER 24HR 120 MG	65100055207050	Generic
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 10 MG	65100030106910	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 15 MG	65100030106915	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 20 MG	65100030106920	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 30 MG	65100030106930	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 40 MG	65100030106940	Brand
ZOHYDRO ER	HYDROCODONE BITARTRATE CAP ER 12HR 50 MG	65100030106950	Brand

Approval Criteria

1 - If the dose exceeds the maximum cumulative morphine milligram equivalent (MME) of 90 milligrams, ALL of the following:

1.1 Prescriber attests the patient has been screened for substance abuse/opioid dependence **AND** **1.2** Document rationale for not tapering or discontinuing opioid if treatment goals are not being met **AND** **1.3** Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)	
Notes	*Authorization will be issued for 6 months for non-cancer/non-hospice/ non-sickle cell anemia/non-end of life related pain up to the current re quested MME plus 90 MME. If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization c riteria requirements, a denial should be issued and a maximum 60-da y authorization may be authorized one time for the requested MME do se.

Lonhala and Yupelri

Prior Authorization Guideline

Guideline ID	GL-146356
Guideline Name	Lonhala and Yupelri
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lonhala Magnair (Starter Kit and Refill Kit), Yupelri	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONHALA MAGNAIR REFILL KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
LONHALA MAGNAIR STARTER KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand

YUPELRI	REVEFENACIN INHALATION SOLUTION 175 MCG/3ML	44100075002020	Brand

Approval Criteria

1 - Diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD)

AND

2 - ONE of the following:

2.1 One of the following:

- Failure of Incruse Ellipta confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Incruse Ellipta (please specify intolerance or contraindication)

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Incruse Ellipta) to control his/her COPD due to ONE of the following:

- Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment)
- Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is less than 60 liters per minute)

AND

2.2.2 One of the following:

- Failure of ipratropium nebulized solution (generic Atrovent) confirmed by claims history or submitted medical records
- History of intolerance or contraindication to ipratropium nebulized solution (generic Atrovent) (please specify intolerance or contraindication)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONHALA MAGNAIR STARTER KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
LONHALA MAGNAIR REFILL KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
YUPELRI	REVEFENACIN INHALATION SOLUTION 175 MCG/3ML	44100075002020	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Lonsurf

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148216
Guideline Name	Lonsurf
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lonsurf	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG	21990002750330	Brand

Approval Criteria

1 - Diagnosis of advanced or metastatic colorectal cancer (mCRC)

AND

2 - History of failure, contraindication, or intolerance to treatment with ALL of the following:

- Fluoropyrimidine-based chemotherapy
- Oxaliplatin-based chemotherapy
- Irinotecan-based chemotherapy
- Anti-vascular endothelial growth factor (VEGF) biological therapy

AND

3 - ONE of the following:

3.1 Tumors is RAS mutant-type

OR

3.2 BOTH of the following:

- Tumor is RAS wild-type
- History of failure, contraindication, or intolerance to anti-EGFR (epidermal growth factor receptor) therapy

Product Name: Lonsurf	
Diagnosis	Gastric/Gastroesophageal Junction Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG	21990002750330	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Unresectable locally advanced, recurrent, or metastatic gastric cancer
- Unresectable locally advanced, recurrent, or metastatic gastroesophageal junction adenocarcinoma

AND

2 - History of failure, contraindication, or intolerance to treatment with at least TWO prior lines of chemotherapy that consisted of the following agents:

- Fluoropyrimidine (e.g., fluorouracil)
- Platinum (e.g., carboplatin, cisplatin, oxaliplatin)
- Taxane (e.g., docetaxel, paclitaxel) or irinotecan
- Human epidermal growth factor receptor 2 (HER2)/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression)

Product Name: Lonsurf	
Diagnosis	Colorectal Cancer, Gastric/Gastroesophageal Junction Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG	21990002750330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lonsurf therapy

Product Name: Lonsurf	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG	21990002750330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Lonsurf	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 15-6.14 MG	21990002750320	Brand
LONSURF	TRIFLURIDINE-TIPIRACIL TAB 20-8.19 MG	21990002750330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Lonsurf therapy

2 . Revision History

Date	Notes

6/6/2024	Updated diagnostic criteria for colorectal cancer. Updated gastric/gas troesophageal junction adenocarcinoma diagnostic criteria.

Lorbrena

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146574
Guideline Name	Lorbrena
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lorbrena	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

2.1 Disease is BOTH of the following:

- Recurrent, advanced, or metastatic
- Anaplastic lymphoma kinase (ALK)-positive

OR

2.2 BOTH of the following:

2.2.1 Disease is BOTH of the following:

- Recurrent, advanced, or metastatic
- ROS proto-oncogene 1 (ROS1)-positive

AND

2.2.2 Disease has progressed on at least ONE of the following therapies:

- Rozlytrek (entrectinib)
- Xalkori (crizotinib)
- Zykadia (ceritinib)

Product Name: Lorbrena	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - Diagnosis of Erdheim-Chester Disease (ECD)

AND

2 - Disease is BOTH of the following:

- Symptomatic, relapsed, or refractory
- ALK-positive

Product Name: Lorbrena	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with ALK translocation

Product Name: Lorbrena	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - Diagnosis of uterine sarcoma

AND

2 - Disease is ONE of the following:

- Advanced
- Recurrent/metastatic
- Inoperable

AND

3 - Disease is ALK - positive

Product Name: Lorbrena	
Diagnosis	Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Anaplastic large cell lymphoma (ALCL)
- Large B-Cell lymphoma

AND

2 - Disease is relapsed or refractory

AND

3 - Disease is ALK - positive

Product Name: Lorbrena	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Histiocytic Neoplasms, Soft Tissue Sarcoma, Uterine Sarcoma, Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lorbrena therapy

Product Name: Lorbrena	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Lorbrena	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LORBRENA	LORLATINIB TAB 25 MG	21530556000320	Brand
LORBRENA	LORLATINIB TAB 100 MG	21530556000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Lorbrena therapy

Lovenox

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146357
Guideline Name	Lovenox
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Continuation of Therapy Upon Hospital Discharge
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic

LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - Will be approved as continuation of therapy upon hospital discharge

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of DVT - Orthopedic Surgery
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand

ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For deep vein thrombosis (DVT) prophylaxis

AND

2 - Patient is undergoing ONE of the following:

- Hip fracture surgery
- Hip replacement surgery
- Knee replacement surgery

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of DVT - Abdominal Surgery
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For deep vein thrombosis (DVT) prophylaxis following abdominal surgery

AND

2 - Patient is at risk for thromboembolic complications

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of DVT - Restricted Mobility
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic

LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For deep vein thrombosis (DVT) prophylaxis in patients at risk for thromboembolic complications due to severely restricted mobility during acute illness

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	DVT Treatment
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic

LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For the treatment of acute deep vein thrombosis (DVT)

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Prophylaxis of Ischemic Complications
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand

ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For prophylaxis of ischemic complications in ONE of the following:

- Unstable angina
- Non-Q-Wave myocardial infarction

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Acute ST-Segment Elevation Myocardial Infarction
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic

LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - For the treatment of acute ST-segment elevation myocardial infarction (STEMI)

AND

2 - ONE of the following:

- Managed medically
- Managed with subsequent percutaneous coronary intervention

Product Name: Brand Lovenox, generic enoxaparin	
Diagnosis	Off-Label Uses
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 30 MG/0.3ML	8310102010E520	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 40 MG/0.4ML	8310102010E525	Brand

ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 60 MG/0.6ML	8310102010E530	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 80 MG/0.8ML	8310102010E535	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 100 MG/ML	8310102010E540	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 120 MG/0.8ML	8310102010E560	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Generic
LOVENOX	ENOXAPARIN SODIUM INJ SOLN PREF SYR 150 MG/ML	8310102010E565	Brand
ENOXAPARIN SODIUM	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Generic
LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	Brand

Approval Criteria

1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan’s program

Notes	Authorization will be issued for the compendia recommended duration of therapy, not to exceed 12 months.

Lumakras

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155016
Guideline Name	Lumakras
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Lumakras	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUMAKRAS	SOTORASIB TAB 120 MG	21532480000320	Brand
LUMAKRAS	SOTORASIB TAB 320 MG	21532480000340	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

3 - Tumor is KRAS G12C (gene)-mutated

AND

4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)

Product Name: Lumakras	
Diagnosis	Pancreatic Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUMAKRAS	SOTORASIB TAB 120 MG	21532480000320	Brand
LUMAKRAS	SOTORASIB TAB 320 MG	21532480000340	Brand

Approval Criteria

1 - Diagnosis of pancreatic adenocarcinoma

AND

2 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

3 - Tumor is KRAS G12C-mutated

AND

4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)

Product Name: Lumakras	
Diagnosis	Ampullary Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUMAKRAS	SOTORASIB TAB 120 MG	21532480000320	Brand
LUMAKRAS	SOTORASIB TAB 320 MG	21532480000340	Brand

Approval Criteria

1 - Diagnosis of ampullary adenocarcinoma

AND

2 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

3 - Tumor is KRAS G12C-mutation positive

AND

4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)

Product Name: Lumakras	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUMAKRAS	SOTORASIB TAB 120 MG	21532480000320	Brand
LUMAKRAS	SOTORASIB TAB 320 MG	21532480000340	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Colon Cancer
- Rectal Cancer

AND

2 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

3 - Tumor is KRAS G12C-mutation positive

AND

4 - Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)

Product Name: Lumakras	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Pancreatic Adenocarcinoma, Ampullary Adenocarcinoma, Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUMAKRAS	SOTORASIB TAB 120 MG	21532480000320	Brand
LUMAKRAS	SOTORASIB TAB 320 MG	21532480000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lumakras therapy

Product Name: Lumakras	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUMAKRAS	SOTORASIB TAB 120 MG	21532480000320	Brand
LUMAKRAS	SOTORASIB TAB 320 MG	21532480000340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Lumakras	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUMAKRAS	SOTORASIB TAB 120 MG	21532480000320	Brand
LUMAKRAS	SOTORASIB TAB 320 MG	21532480000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Lumakras therapy

2 . Revision History

Date	Notes
9/16/2024	Added criteria for ampullary adenocarcinoma, colon cancer, and rect al cancer

Lupkynis

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152724
Guideline Name	Lupkynis
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPKYNIS	VOCLOSPORIN CAP 7.9 MG	99402080000120	Brand

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - Provider attests to ONE of the following:

- Diagnosis is biopsy proven
- Biopsy is contraindicated in the patient

AND

3 - Provider attests to ONE of the following:

3.1 Clinical progression (e.g., worsening of proteinuria or serum creatinine) after 3 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records

OR

3.2 Failure to respond after 6 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records

AND

4 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

AND

5 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

6 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

Product Name: Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LUPKYNIS	VOCLOSPORIN CAP 7.9 MG	99402080000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Lupkynis therapy

AND

2 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

AND

3 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

4 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

AND

5 - ONE of the following:

5.1 Patient has been on Lupkynis therapy for less than 12 months

OR

5.2 BOTH of the following:

5.2.1 Patient has completed 12 or more months of Lupkynis therapy

AND

5.2.2 The provider attests that the benefit of continuation of therapy exceeds the risk in light of the patient's treatment response and risk of worsening nephrotoxicity

2 . Revision History

Date	Notes
8/27/2024	Annual review. Updated authorization lengths to 12 months.

Lynparza

Prior Authorization Guideline

Guideline ID	GL-154725
Guideline Name	Lynparza
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Lynparza	
Diagnosis	Breast Cancer (High Risk Early)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Diagnosis of high risk early breast cancer

AND

2 - Presence of deleterious or suspected deleterious germline breast cancer (BRCA)-mutations (gBRCAm)

AND

3 - Disease is human growth factor receptor 2 (HER2)-negative

AND

4 - ONE of the following:

4.1 Patient is hormone receptor (HR) negative

OR

4.2 BOTH of the following:

4.2.1 Patient is hormone receptor (HR) positive

AND

4.2.2 Patient is continuing concurrent treatment with endocrine therapy

AND

5 - Patient has been treated with neoadjuvant or adjuvant chemotherapy

AND

6 - Treatment duration has not exceeded 12 months of therapy

Product Name: Lynparza	
Diagnosis	Breast Cancer (Metastatic or Recurrent)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

1.1 Metastatic breast cancer

OR

1.2 Recurrent breast cancer

AND

2 - Presence of deleterious or suspected deleterious germline breast cancer (BRCA)-mutations (gBRCAm)

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

3.1.2 ONE of the following:

3.1.2.1 Disease is hormone receptor (HR) negative

OR

3.1.2.2 BOTH of the following:

3.1.2.2.1 Disease is hormone receptor (HR) positive

AND

3.1.2.2.2 ONE of the following:

- Disease has progressed on previous endocrine therapy
- Provider attestation that treatment with endocrine therapy is inappropriate

OR

3.2 Disease is human epidermal growth factor receptor 2 (HER2)-positive

Product Name: Lynparza	
Diagnosis	Ovarian Cancer (Maintenance Therapy)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - Disease is one of the following:

- Advanced
- Recurrent

AND

3 - ONE of the following:

3.1 Presence of deleterious or suspected deleterious germline or somatic BRCA-mutations

OR

3.2 Both of the following:

3.2.1 Cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation or genomic instability

AND

3.2.2 Used in combination with bevacizumab (e.g., Avastin, Mvasi)

AND

4 - Patient has had a complete or partial response to platinum-based chemotherapy

AND

5 - Request is for maintenance therapy

Product Name: Lynparza	
Diagnosis	Ovarian Cancer (Treatment)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - Disease is ONE of the following:

- Advanced
- Persistent
- Recurrent

AND

3 - Presence of deleterious or suspected deleterious germline BRCA (breast cancer gene)-mutation

AND

4 - Patient has been treated with two or more prior lines of chemotherapy

Product Name: Lynparza	
Diagnosis	Pancreatic Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Diagnosis of pancreatic adenocarcinoma

AND

2 - Disease is metastatic

AND

3 - Presence of deleterious or suspected deleterious germline BRCA1/2 (breast cancer gene)-mutation

AND

4 - Disease has NOT progressed while receiving at least 16 weeks of a first-line platinum-based chemotherapy regimen

Product Name: Lynparza	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Diagnosis of metastatic castration-resistant prostate cancer

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Presence of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutations

AND

2.1.2 Disease has progressed following prior treatment with ONE of the following:

- Enzalutamide (Xtandi)
- Abiraterone (e.g., Zytiga, Yonsa)

OR

2.2 ALL of the following:

2.2.1 Presence of deleterious or suspected deleterious BRCA-mutation

AND

2.2.2 Used in combination with abiraterone (e.g., Zytiga, Yonsa)

AND

2.2.3 Used in combination with ONE of the following:

- Prednisone
- Prednisolone

AND

3 - ONE of the following:

3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

3.2 Patient has had bilateral orchiectomy

Product Name: Lynparza	
Diagnosis	Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Diagnosis of uterine sarcoma

AND

2 - The requested medication is NOT used as first-line therapy

Product Name: Lynparza	
Diagnosis	Breast Cancer (Metastatic or Recurrent), Ovarian Cancer (Maintenance or Treatment), Pancreatic Cancer, Prostate Cancer, Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lynparza therapy

Product Name: Lynparza	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Lynparza	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYNPARZA	OLAPARIB TAB 100 MG	21535560000330	Brand
LYNPARZA	OLAPARIB TAB 150 MG	21535560000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Lynparza therapy

Lyrica

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146358
Guideline Name	Lyrica
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lyrica	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYRICA	PREGABALIN CAP 25 MG	72600057000110	Brand
LYRICA	PREGABALIN CAP 50 MG	72600057000115	Brand
LYRICA	PREGABALIN CAP 75 MG	72600057000120	Brand
LYRICA	PREGABALIN CAP 100 MG	72600057000125	Brand
LYRICA	PREGABALIN CAP 150 MG	72600057000135	Brand
LYRICA	PREGABALIN CAP 200 MG	72600057000145	Brand

LYRICA	PREGABALIN CAP 225 MG	72600057000150	Brand
LYRICA	PREGABALIN CAP 300 MG	72600057000160	Brand
LYRICA	PREGABALIN SOLN 20 MG/ML	72600057002020	Brand

Approval Criteria

1 - Requested for the treatment of a seizure disorder

OR

2 - BOTH of the following:

2.1 Diagnosis of ONE of the following:

- Fibromyalgia
- Diabetic peripheral neuropathy (DPN)
- Post herpetic neuralgia (PHN)
- Neuropathic pain associated with spinal cord injury

AND

2.2 ONE of the following:

2.2.1 Failure to generic pregabalin at a minimum dose of 300 mg (milligrams) daily for 4 weeks as confirmed by claims history or submission of medical records

OR

2.2.2 History of intolerance or contraindication to generic pregabalin (please specify intolerance or contraindication)

Product Name: Brand Lyrica CR, generic pregabalin ER	
Diagnosis	Diabetic Peripheral Neuropathy (DPN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYRICA CR	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Generic
PREGABALIN ER	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Generic
PREGABALIN ER	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Generic

Approval Criteria

1 - Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2 - ONE of the following:

2.1 Failure to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for 4 weeks as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to gabapentin (generic Neurontin) (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to treatment with ONE of the following classes of medications as confirmed by claims history or submission of medical records:

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant

- Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant (e.g., duloxetine, venlafaxine)

OR

3.2 History of intolerance or contraindication to treatment from BOTH classes of medications (please specify intolerance or contraindication)

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant
- SNRI antidepressant (e.g., duloxetine, venlafaxine)

AND

4 - ONE of the following:

4.1 Failure to generic pregabalin immediate-release capsules or generic pregabalin suspension as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to generic pregabalin immediate-release capsules or generic pregabalin suspension (please specify intolerance or contraindication)

Product Name: Brand Lyrica CR, generic pregabalin ER	
Diagnosis	Post Herpetic Neuralgia (PHN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYRICA CR	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Generic
PREGABALIN ER	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Generic

PREGABALIN ER	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Generic

Approval Criteria

1 - Diagnosis of post herpetic neuralgia (PHN)

AND

2 - ONE of the following:

2.1 Failure to gabapentin (generic Neurontin) at a minimum dose of 1800 mg daily for 4 weeks as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to gabapentin (generic Neurontin) (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to a tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks as confirmed by claims history of submission of medical records

OR

3.2 History of intolerance of contraindication to a tricyclic antidepressant (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Failure to generic pregabalin immediate-release capsules or generic pregabalin suspension as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to generic pregabalin immediate-release capsules or generic pregabalin suspension (please specify intolerance or contraindication)

Lysteda

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146359
Guideline Name	Lysteda
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lysteda, generic tranexamic acid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYSTEDA	TRANEXAMIC ACID TAB 650 MG	84100040000320	Brand
TRANEXAMIC ACID	TRANEXAMIC ACID TAB 650 MG	84100040000320	Generic

Approval Criteria

1 - Diagnosis of cyclic heavy menstrual bleeding

Lytgobi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146578
Guideline Name	Lytgobi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Lytgobi	
Diagnosis	Cholangiocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE)	2153222800B720	Brand
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE)	2153222800B725	Brand
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE)	2153222800B730	Brand

Approval Criteria

1 - Diagnosis of cholangiocarcinoma (intrahepatic or extrahepatic)

AND

2 - Disease is ONE of the following:

- Unresectable locally advanced
- Metastatic

AND

3 - Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement

AND

4 - Patient has been previously treated

Product Name: Lytgobi	
Diagnosis	Cholangiocarcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE)	2153222800B720	Brand
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE)	2153222800B725	Brand
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE)	2153222800B730	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Lytgobi therapy

Product Name: Lytgobi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE)	2153222800B720	Brand
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE)	2153222800B725	Brand
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE)	2153222800B730	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Lytgobi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (12 MG DAILY DOSE)	2153222800B720	Brand
LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (16 MG DAILY DOSE)	2153222800B725	Brand

LYTGOBI	FUTIBATINIB TAB THERAPY PACK 4 MG (20 MG DAILY DOSE)	2153222800B730	Brand

Approval Criteria

1 - Documentation of positive clinical response to Lytgobi therapy

Marinol, Syndros

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146360
Guideline Name	Marinol, Syndros
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Syndros	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNDROS	DRONABINOL SOLN 5 MG/ML	50300030002020	Brand

Approval Criteria

1 - Patient is receiving cancer chemotherapy

AND

2 - ONE of the following:

2.1 Failure to formulary generic dronabinol as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to formulary generic dronabinol (please specify contraindication or intolerance)

OR

2.3 Patient is unable to swallow capsules

AND

3 - ONE of the following:

3.1 Failure to a 5HT-3 (5-hydroxytriptamine) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to a 5HT-3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] (please specify contraindication or intolerance)

AND

4 - ONE of the following:

4.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

Product Name: Brand Marinol, generic dronabinol	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic
DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic

Approval Criteria

1 - Patient is receiving cancer chemotherapy

AND

2 - ONE of the following:

2.1 Failure to a 5HT-3 (5-hydoxytriptamine) receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to a 5HT-3 receptor antagonist [e.g., Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)
- Olanzapine (generic Zyprexa)

OR

3.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Lorazepam (generic Ativan)
- Prochlorperazine (generic Compazine)
- Dexamethasone (generic Decadron)
- Haloperidol (generic Haldol)
- Promethazine (generic Phenergan)
- Metoclopramide (generic Reglan)

- Olanzapine (generic Zyprexa)

Product Name: Syndros	
Diagnosis	Anorexia in a patient with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNDROS	DRONABINOL SOLN 5 MG/ML	50300030002020	Brand

Approval Criteria

1 - Diagnosis of anorexia with weight loss in a patient with AIDS (acquired immunodeficiency syndrome)

AND

2 - Patient is on antiretroviral therapy

AND

3 - ONE of the following:

3.1 Patient is 65 years of age or greater

OR

3.2 BOTH of the following:

3.2.1 Patient is less than 65 years of age

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to megestrol (generic Megace) as confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to megestrol (generic Megace) (please specify intolerance or contraindication)

AND

4 - ONE of the following:

4.1 Failure to formulary generic dronabinol as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to formulary generic dronabinol (please specify contraindication or intolerance)

OR

4.3 Patient is unable to swallow capsules

Product Name: Brand Marinol, generic dronabinol	
Diagnosis	Anorexia in a patient with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MARINOL	DRONABINOL CAP 2.5 MG	50300030000110	Brand
DRONABINOL	DRONABINOL CAP 2.5 MG	50300030000110	Generic

DRONABINOL	DRONABINOL CAP 5 MG	50300030000115	Generic
DRONABINOL	DRONABINOL CAP 10 MG	50300030000120	Generic

Approval Criteria

1 - Diagnosis of anorexia with weight loss in a patient with AIDS (acquired immunodeficiency syndrome)

AND

2 - Patient is on antiretroviral therapy

AND

3 - ONE of the following:

3.1 Patient is 65 years of age or greater

OR

3.2 BOTH of the following:

3.2.1 Patient is less than 65 years of age

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to megestrol (generic Megace) as confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to megestrol (generic Megace) (please specify intolerance or contraindication)

Mavenclad

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146579
Guideline Name	Mavenclad
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Mavenclad	
Diagnosis	Relapsing Forms of Multiple Sclerosis (MS)
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (4 TABS)	6240101500B718	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (5 TABS)	6240101500B722	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (6 TABS)	6240101500B726	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (7 TABS)	6240101500B732	Brand

MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (8 TABS)	6240101500B736	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (9 TABS)	6240101500B740	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (10 TABS)	6240101500B744	Brand

Approval Criteria

1 - Diagnosis of relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary progressive MS with relapses)

AND

2 - Prescribed by, or in consultation with, a specialist in the treatment of MS (e.g., neurologist)

AND

3 - ONE of the following:

3.1 Trial and failure (after trial of at least 4 weeks) to TWO of the following disease-modifying therapies for MS (one of which must be a preferred dimethyl fumarate product) as confirmed by claims history or submission of medical records:

- Interferon beta-1a (Avonex*, Rebif*, Plegridy)
- Interferon beta-1b (Betaseron*, Extavia*)
- Glatiramer acetate products (e.g., Copaxone, Glatopa)
- A preferred dimethyl fumarate product (e.g., Tecfidera)
- Aubagio (teriflunomide)
- Gilenya (fingolimod)
- Mayzent (siponimod)
- Tysabri (natalizumab)**
- Ocrevus (ocrelizumab)**
- Lemtrada (alemtuzumab)**
- Zeposia (ozanimod)*
- Kesimpta (ofatumumab)*
- Bafiertam (monomethyl fumarate)*

OR

3.2 History of contraindication or intolerance to TWO of the following disease-modifying therapies for MS (please specify contraindication or intolerance)

- Interferon beta-1a (Avonex*, Rebif*, Plegridy)
- Interferon beta-1b (Betaseron*, Extavia*)
- Glatiramer acetate products (e.g., Copaxone, Glatopa)
- A preferred dimethyl fumarate product (e.g., Tecfidera)
- Aubagio (teriflunomide)
- Gilenya (fingolimod)
- Mayzent (siponimod)
- Tysabri (natalizumab)**
- Ocrevus (ocrelizumab)**
- Lemtrada (alemtuzumab)**
- Zeposia (ozanimod)*
- Kesimpta (ofatumumab)*
- Bafiertam (monomethyl fumarate)*

OR

3.3 Patient is currently on Mavenclad

AND

4 - Patient is NOT receiving Mavenclad in combination with another disease modifying therapy [e.g., interferon beta preparations, glatiramer acetate products, Tecfidera (dimethyl fumarate), Tysabri (natalizumab), Gilenya (fingolimod), Mayzent (siponimod), Ocrevus (ocrelizumab), Lemtrada (alemtuzumab), or Aubagio (teriflunomide)]

Notes	*Avonex, Rebif, Betaseron, Bafiertam, Kesimpta, Zeposia, and Extavia are non-preferred and should not be included in denial to provider. **Tysabri, Ocrevus, and Lemtrada are medical benefit and should not be included in denial to provider.

Product Name: Mavenclad	
Diagnosis	Relapsing Forms of Multiple Sclerosis (MS)
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (4 TABS)	6240101500B718	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (5 TABS)	6240101500B722	Brand

MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (6 TABS)	6240101500B726	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (7 TABS)	6240101500B732	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (8 TABS)	6240101500B736	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (9 TABS)	6240101500B740	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (10 TABS)	6240101500B744	Brand

Approval Criteria

1 - Documentation of positive clinical response to Mavenclad treatment

AND

2 - Patient is NOT receiving Mavenclad in combination with another disease modifying therapy [e.g., interferon beta preparations, glatiramer acetate products, Tecfidera (dimethyl fumarate), Tysabri (natalizumab), Gilenya (fingolimod), Mayzent (siponimod), Ocrevus (ocrelizumab), Lemtrada (alemtuzumab), or Aubagio (teriflunomide)]

AND

3 - Patient has not exceeded the FDA (Food and Drug Administration)-recommended limit of 2 treatment courses (4 treatment cycles) of Mavenclad

Notes	Duration of coverage will be limited to 1 reauthorization to allow 2 cum ulative treatment courses (4 treatment cycles) of Mavenclad therapy.

Mekinist

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151095
Guideline Name	Mekinist
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/7/2024

1 . Criteria

Product Name: Mekinist	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 ONE of the following:

1.1.1.1 Unresectable melanoma

OR

1.1.1.2 Metastatic melanoma

OR

1.1.1.3 BOTH of the following:

1.1.1.3.1 Prescribed as adjuvant therapy for melanoma involving the lymph node(s)

AND

1.1.1.3.2 Used in combination with Tafinlar (dabrafenib)

AND

1.1.2 Cancer is positive for BRAF V600 (gene) mutation

OR

1.2 Distant metastatic uveal melanoma

AND

2 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Advanced
- Recurrent

AND

3 - Cancer is positive for BRAF V600E (gene) mutation

AND

4 - Used in combination with Tafinlar (dabrafenib)

AND

5 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of anaplastic thyroid cancer (ATC)

AND

1.1.2 Cancer is positive for BRAF V600E (gene) mutation

AND

1.1.3 Used in combination with Tafinlar (dabrafenib)

AND

1.1.4 ONE of the following:

1.1.4.1 Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

OR

1.1.4.2 Prescribed as adjuvant therapy following resection

OR

1.2 ALL of the following:

1.2.1 ONE of the following diagnoses:

- Follicular Carcinoma
- Oncocytic Carcinoma
- Papillary Carcinoma

AND

1.2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.2.4 Disease is refractory to radioactive iodine treatment

AND

1.2.5 Cancer is positive for BRAF V600 mutation

AND

1.2.6 Used in combination with Tafinlar (dabrafenib)

AND

2 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Patient has metastatic brain lesions

AND

1.1.2 Mekinist is active against the primary tumor (melanoma)

OR

1.2 Patient has a glioma

AND

2 - Cancer is positive for BRAF V600E (gene) mutation

AND

3 - Used in combination with Tafinlar (dabrafenib)

AND

4 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial Ovarian Cancer
- Fallopian Tube Cancer
- Primary Peritoneal Cancer

AND

2 - ONE of the following:

- Persistent disease
- Recurrence in BRAF V600E positive tumors
- Recurrence of low-grade serous carcinoma

AND

3 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic Cholangiocarcinoma
- Intrahepatic Cholangiocarcinoma

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E (gene) mutation

AND

5 - Used in combination with Tafinlar (dabrafenib)

AND

6 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease
- Rosai-Dorfman Disease

AND

2 - ONE of the following:

- Mitogen-activated protein (MAP) kinase pathway mutation
- No detectable mutation
- Testing not available

AND

3 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Presence of solid tumor

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E (gene) mutation

AND

5 - Used in combination with Tafinlar (dabrafenib)

AND

6 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Pancreatic Cancer, Ambullary Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Pancreatic adenocarcinoma
- Ampullary adenocarcinoma

AND

2 - Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Tafinlar (dabrafenib)

AND

5 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of hairy cell leukemia

AND

2 - Used in combination with Tafinlar (dabrafenib)

AND

3 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Disease is one of the following:

- Recurrent and unresectable
- Metastatic

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Tafinlar (dabrafenib)

AND

5 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Diagnosis of BRAF V600E-mutated gastrointestinal stromal tumor (GIST)

AND

2 - Disease is one of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Progressive

- Recurrent
- Metastatic

AND

3 - Used in combination with Tafinlar (dabrafenib)

AND

4 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	Melanoma, NSCLC, Thyroid Cancer, CNS Cancers, Epithelial Ovarian /Fallopian Tube /Primary Peritoneal Cancers, Hepatobiliary Cancers, Histiocytic Neoplasms, Solid Tumors, Pancreatic /Ampullary Cancer , Hairy Cell Leukemia, Salivary Gland Tumor, GIST
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Mekinist therapy

Product Name: Mekinist	
Diagnosis	NCCN Recommended Regimen

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

AND

2 - If the request is for Mekinist solution, there is a reason or special circumstance why the patient is unable to use Mekinist tablets (document reason or special circumstance)

Product Name: Mekinist	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 0.5 MG (BASE EQUIVALENT)	21533570100310	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE TAB 2 MG (BASE EQUIVALENT)	21533570100330	Brand
MEKINIST	TRAMETINIB DIMETHYL SULFOXIDE FOR SOLN 0.05 MG/ML (BASE EQ)	21533570102120	Brand

Approval Criteria **1** - Documentation of positive clinical response to Mekinist therapy

2 . Revision History

Date	Notes
8/6/2024	Copy core

Mektovi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156463
Guideline Name	Mektovi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Mektovi	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following diagnoses:

- Unresectable melanoma
- Metastatic melanoma

AND

1.2 Patient is positive for BRAFV600 mutation

AND

1.3 Used in combination with Braftovi (encorafenib)

AND

1.4 ONE of the following:

1.4.1 Patient has a contraindication or history of intolerance to ONE of the following regimens (please specify intolerance or contraindication):

- Tafinlar (dabrafenib) plus Mekinist (trametinib)
- Zelboraf (vemurafenib) plus Cotellic (cobimetinib)

OR

1.4.2 Provider attests that the patient is not an appropriate candidate based on the patient's clinical status or comorbidities for either of the following regimens:

- Tafinlar (dabrafenib) plus Mekinist (trametinib)
- Zelboraf (vemurafenib) plus Cotellic (cobimetinib)

OR

1.4.3 For continuation of prior Mektovi therapy

OR

2 - BOTH of the following:

2.1 Diagnosis of melanoma NRAS-mutated tumor

AND

2.2 Progression after prior immune checkpoint inhibitor therapy

Product Name: Mektovi	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Mektovi therapy

AND

2 - ONE of the following:

2.1 BOTH of the following:

- BRAFV600 mutation positive
- Used in combination with Braftovi (encorafenib)

OR

2.2 NRAS-mutated tumor

Product Name: Mektovi	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Multisystem Langerhans Cell Histiocytosis
- Single-system lung Langerhans Cell Histiocytosis
- Langerhans Cell Histiocytosis with CNS (central nervous system) lesions

AND

2 - ONE of the following:

- Disease is positive for mitogen-activated protein (MAP) kinase pathway mutation
- No detectable mutation
- Testing is not available

Product Name: Mektovi	
Diagnosis	Serous Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Diagnosis of low-grade serous carcinoma

AND

2 - Disease is recurrent

Product Name: Mektovi	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Diagnosis of succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST)

AND

2 - Disease is ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture

- Progressive
- Recurrent
- Metastatic

AND

3 - Used in combination with imatinib mesylate (generic Gleevec)

Product Name: Mektovi	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is metastatic

AND

3 - Patient is positive for BRAFV600 mutation

AND

4 - Used in combination with Braftovi (encorafenib)

AND

5 - ONE of the following:

5.1 Patient has a contraindication or history of intolerance to Tafinlar (dabrafenib) plus Mekinist (trametinib) (please specify intolerance or contraindication)

OR

5.2 Provider attests that the patient is not an appropriate candidate based on the patient's clinical status or comorbidities for Tafinlar (dabrafenib) plus Mekinist (trametinib)

OR

5.3 For continuation of prior Mektovi therapy

Product Name: Mektovi	
Diagnosis	Histiocytic Neoplasms, Serous Carcinoma, Gastrointestinal Stromal Tumor (GIST), Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Mektovi therapy

Product Name: Mektovi	
Diagnosis	NCCN Recommended Regimen

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Mektovi	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEKTOVI	BINIMETINIB TAB 15 MG	21533520000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Mektovi therapy

2 . Revision History

Date	Notes
9/30/2024	Added trial of alternative regimen to the non-small cell lung cancer section

Mepron

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146361
Guideline Name	Mepron
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Prophylaxis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEPRON	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Brand
ATOVAQUONE	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Generic

Approval Criteria

1 - The patient has a diagnosis [e.g., HIV (human immunodeficiency virus)] warranting PCP (pneumocystis jirovecii pneumonia) infection prophylaxis

AND

2 - The patient has a documented intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) and dapsone (please specify intolerance or contraindication)

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Treatment
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MEPRON	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Brand
ATOVAQUONE	ATOVAQUONE SUSP 750 MG/5ML	16400020001820	Generic

Approval Criteria

1 - The patient has a diagnosis of mild to moderate pneumonia caused by pneumocystis jirovecii

AND

2 - ONE of the following:

2.1 Failure of trimethoprim-sulfamethoxazole (TMP-SMX) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to TMP-SMX (please specify intolerance or contraindication)

Migranal, Trudhesa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146363
Guideline Name	Migranal, Trudhesa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DIHYDROERGOTAMINE MESYLATE	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Generic
MIGRANAL	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Brand
TRUDHESA	DIHYDROERGOTAMINE MESYLATE HFA NASAL AEROSOL 0.725 MG/ACT	67000030113420	Brand

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - ONE of the following:

2.1 Failure to THREE preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray, confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to THREE preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray (please specify intolerance or contraindication)

Product Name: Brand Migranal, generic dihydroergotamine mesylate nasal spray, Trudhesa	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
DIHYDROERGOTAMINE MESYLATE	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Generic
MIGRANAL	DIHYDROERGOTAMINE MESYLATE NASAL SPRAY 4 MG/ML	67000030102060	Brand
TRUDHESA	DIHYDROERGOTAMINE MESYLATE HFA NASAL AEROSOL 0.725 MG/ACT	67000030113420	Brand

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - Prescribed by, or in consultation with, ONE of the following:

- Neurologist

- Pain management specialist

AND

3 - Currently receiving prophylactic therapy with at least ONE of the following:

- Amitriptyline (Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA (Botox)**
- Topiramate (Topamax)
- Venlafaxine (Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

4 - BOTH of the following:

4.1 ONE of the following:

4.1.1 Higher dose or quantity is supported by the manufacturer's prescribing information

OR

4.1.2 Higher dose or quantity is supported by ONE of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

4.1.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the Food and Drug Administration (FDA) for the diagnosis indicated

AND **4.2** Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity	
Notes	*Timolol and candesartan are non-preferred and should not be include d in denial to provider. **This is a medical benefit, should not be included in denial to provider .

Mozobil

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146582
Guideline Name	Mozobil
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Mozobil, generic plerixafor	
Diagnosis	Hematopoietic Stem Cell Mobilization
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOZOBIL	PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML)	82502060002020	Brand
PLERIXAFOR	PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML)	82502060002020	Generic

Approval Criteria

1 - ONE of the following:

- Patients with non-Hodgkin's lymphoma (NHL) who will be undergoing autologous hematopoietic stem cell (HSC) transplantation
- Patients with multiple myeloma (MM) who will be undergoing autologous HSC transplantation

AND

2 - Used in combination with granulocyte-colony stimulating factor (G-CSF) [e.g., Zarxio (filgrastim)]

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Brand Mozobil, generic plerixafor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOZOBIL	PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML)	82502060002020	Brand
PLERIXAFOR	PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML)	82502060002020	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Mozobil, generic plerixafor

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOZOBIL	PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML)	82502060002020	Brand
PLERIXAFOR	PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML)	82502060002020	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

MS Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151111
Guideline Name	MS Agents
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/7/2024

1 . Criteria

Product Name: generic dimethyl fumarate, generic fingolimod, generic glatiramer, Glatopa, Mayzent, Plegridy, generic teriflunomide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic
GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic
GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic
GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic

PLEGRIDY	PEGINTERFERON BETA-1A SOLN PEN-INJECTOR 125 MCG/0.5ML	6240307530D520	Brand
PLEGRIDY STARTER PACK	PEGINTERFERON BETA-1A SOLN PEN-INJ 63 & 94 MCG/0.5ML PACK	6240307530D550	Brand
PLEGRIDY	PEGINTERFERON BETA-1A SOLN PREFILLED SYRINGE 125 MCG/0.5ML	6240307530E520	Brand
PLEGRIDY	PEGINTERFERON BETA-1A IM SOLN PREFILLED SYR 125 MCG/0.5ML	6240307530E521	Brand
PLEGRIDY STARTER PACK	PEGINTERFERON BETA-1A SOLN PREF SYR 63 & 94 MCG/0.5ML PACK	6240307530E550	Brand
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Generic
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Generic
MAYZENT STARTER PACK	SIPONIMOD FUMARATE TAB 0.25 MG (7) STARTER PACK	6240707020B710	Brand
MAYZENT STARTER PACK	SIPONIMOD FUMARATE TAB 0.25 MG (12) STARTER PACK	6240707020B720	Brand
MAYZENT	SIPONIMOD FUMARATE TAB 0.25 MG (BASE EQUIV)	62407070200320	Brand
MAYZENT	SIPONIMOD FUMARATE TAB 1 MG (BASE EQUIV)	62407070200330	Brand
MAYZENT	SIPONIMOD FUMARATE TAB 2 MG (BASE EQUIV)	62407070200340	Brand
FINGOLIMOD	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Generic
TERIFLUNOMIDE	TERIFLUNOMIDE TAB 7 MG	62404070000320	Generic
TERIFLUNOMIDE	TERIFLUNOMIDE TAB 14 MG	62404070000330	Generic
DIMETHYL FUMARATE STARTERPACK	DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG	6240552500B320	Generic

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

Product Name: Avonex, Bafiertam, Betaseron, Extavia, Kesimpta, Ponvory, Rebif, Vumerity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AVONEX	INTERFERON BETA-1A IM PREFILLED SYRINGE KIT 30 MCG/0.5ML	6240306045F830	Brand
AVONEX PEN	INTERFERON BETA-1A IM AUTO-INJECTOR KIT 30 MCG/0.5ML	6240306045F530	Brand
BETASERON	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
EXTAVIA	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
VUMERITY	DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG	62405530006540	Brand
BAFIERTAM	MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG	62405550006520	Brand
KESIMPTA	OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML	6240506500D520	Brand
PONVORY 14-DAY STARTER PACK	PONESIMOD TAB STARTER PACK 2,3,4,5,6,7,8,9 &10 MG	6240706000B720	Brand
PONVORY	PONESIMOD TAB 20 MG	62407060000320	Brand
REBIF REBIDOSE	INTERFERON BETA-1A SOLN AUTO-INJ 22 MCG/0.5ML	6240306045D520	Brand
REBIF REBIDOSE	INTERFERON BETA-1A SOLN AUTO-INJ 44 MCG/0.5ML	6240306045D540	Brand
REBIF REBIDOSE TITRATION PACK	INTERFERON BETA-1A AUTO-INJ 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML	6240306045D560	Brand
REBIF	INTERFERON BETA-1A SOLN PREF SYR 22 MCG/0.5ML	6240306045E520	Brand
REBIF	INTERFERON BETA-1A SOLN PREF SYR 44 MCG/0.5ML	6240306045E540	Brand
REBIF TITRATION PACK	INTERFERON BETA-1A PREF SYR 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML	6240306045E560	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - ONE of the following:

2.1 Failure of at least two of the preferred* alternatives (one of which must be a preferred dimethyl fumarate product) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to all of the preferred* alternatives (please specify intolerance or contraindication)

OR

2.3 Patient is currently on the requested drug therapy as confirmed by claims history or submission of medical records

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Tascenso ODT	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.25 MG	62407025207220	Brand
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.5 MG	62407025207230	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - Patient is 10 years of age or older

AND

3 - ONE of the following:

3.1 Failure of fingolimod 0.5mg (generic Gilenya 0.5 mg) confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to fingolimod 0.5mg (generic Gilenya 0.5 mg) (please specify intolerance or contraindication)

OR

3.3 Patient is currently on Tascenso ODT therapy as documented by claims history or submission of medical records

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Brand Aubagio, Brand Copaxone, Brand Gilenya 0.5mg, Brand Tecfidera	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUBAGIO	TERIFLUNOMIDE TAB 7 MG	62404070000320	Brand
AUBAGIO	TERIFLUNOMIDE TAB 14 MG	62404070000330	Brand
GILENYA	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Brand
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Brand
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Brand
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Brand

TECFIDERA STARTER PACK	DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG	6240552500B320	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - ONE of the following:

2.1 Failure of at least two of the preferred* alternatives (one of which must be a preferred dimethyl fumarate product) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to all of the preferred* alternatives (please specify intolerance or contraindication)

OR

2.3 Patient is currently on the requested drug therapy as confirmed by claims history or submission of medical records

AND

3 - ONE of the following:

3.1 The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic/authorized generic equivalent (specify the adverse reaction, allergy, or sensitivity)

OR

3.2 The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records

OR

3.3 The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient.

OR

3.4 Special clinical circumstances exist that preclude the use of a generic/authorized generic equivalent of the brand medication for the patient (document special clinical circumstances)

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Avonex, Bafiertam, Betaseron, Extavia, Kesimpta, Ponvory, Rebif, Brand Vumerity, Tascenso ODT, Brand Aubagio, Brand Copaxone, Brand Gilenya 0.5 mg, Brand Tecfidera	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
AUBAGIO	TERIFLUNOMIDE TAB 7 MG	62404070000320	Brand
AUBAGIO	TERIFLUNOMIDE TAB 14 MG	62404070000330	Brand
GILENYA	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Brand
AVONEX	INTERFERON BETA-1A IM PREFILLED SYRINGE KIT 30 MCG/0.5ML	6240306045F830	Brand
AVONEX PEN	INTERFERON BETA-1A IM AUTO-INJECTOR KIT 30 MCG/0.5ML	6240306045F530	Brand
BETASERON	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
EXTAVIA	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
VUMERITY	DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG	62405530006540	Brand
BAFIERTAM	MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG	62405550006520	Brand
KESIMPTA	OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML	6240506500D520	Brand

PONVORY 14-DAY STARTER PACK	PONESIMOD TAB STARTER PACK 2,3,4,5,6,7,8,9 &10 MG	6240706000B720	Brand
PONVORY	PONESIMOD TAB 20 MG	62407060000320	Brand
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Brand
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Brand
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Brand
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Brand
REBIF REBIDOSE	INTERFERON BETA-1A SOLN AUTO-INJ 22 MCG/0.5ML	6240306045D520	Brand
REBIF REBIDOSE	INTERFERON BETA-1A SOLN AUTO-INJ 44 MCG/0.5ML	6240306045D540	Brand
REBIF REBIDOSE TITRATION PACK	INTERFERON BETA-1A AUTO-INJ 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML	6240306045D560	Brand
REBIF	INTERFERON BETA-1A SOLN PREF SYR 22 MCG/0.5ML	6240306045E520	Brand
REBIF	INTERFERON BETA-1A SOLN PREF SYR 44 MCG/0.5ML	6240306045E540	Brand
REBIF TITRATION PACK	INTERFERON BETA-1A PREF SYR 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML	6240306045E560	Brand
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.25 MG	62407025207220	Brand
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.5 MG	62407025207230	Brand
TECFIDERA STARTER PACK	DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG	6240552500B320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
8/6/2024	Updated GPIs

Mulpleta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146584
Guideline Name	Mulpleta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Mulpleta	
Diagnosis	Thrombocytopenia
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MULPLETA	LUSUTROMBOPAG TAB 3 MG	82405045000320	Brand

Approval Criteria

1 - Diagnosis of thrombocytopenia

AND

2 - Patient has chronic liver disease

AND

3 - Patient is scheduled to undergo a procedure

Multaq

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146364
Guideline Name	Multaq
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Multaq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MULTAQ	DRONEDARONE HCL TAB 400 MG (BASE EQUIVALENT)	35400028100320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Paroxysmal Atrial Fibrillation (AF)
- Persistent AF defined as AF less than 6 months duration

AND

1.2 ONE of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

AND

1.3 Patient does NOT have New York Heart Association (NYHA) Class IV heart failure

AND

1.4 Patient does NOT have symptomatic heart failure with recent decompensation requiring hospitalization

OR

2 - For continuation of current therapy

Myalept

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146585
Guideline Name	Myalept
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYALEPT	METRELEPTIN FOR SUBCUTANEOUS INJ 11.3 MG	30906050002120	Brand

Approval Criteria

1 - Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

AND

4 - Patient has at least ONE of the following:

4.1 Diabetes mellitus or insulin resistance with persistent hyperglycemia (hemoglobin A1C greater than 7.0%) despite BOTH of the following:

- Dietary intervention
- Optimized insulin therapy at maximum tolerated doses

OR

4.2 Persistent hypertriglyceridemia (triglycerides greater than 250 milligrams per deciliter) despite BOTH of the following:

- Dietary intervention
- Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYALEPT	METRELEPTIN FOR SUBCUTANEOUS INJ 11.3 MG	30906050002120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Myalept therapy

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

Mycapssa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147670
Guideline Name	Mycapssa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYCAPSSA	OCTREOTIDE ACETATE CAP DELAYED RELEASE 20 MG	30170070106520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of acromegaly by ONE of the following:

- Serum GH (growth hormone) level > 1 ng/mL (nanogram/milliliter) after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis
- Elevated serum IGF-1 (insulin-like growth factor-1) levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis

AND

1.2 ONE of the following:

1.2.1 Inadequate response to ONE of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

1.2.2 Not a candidate for ALL of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

AND

1.3 Patient has responded to and tolerated treatment with ONE of the following somatostatin analogs:

- Sandostatin (octreotide) or Sandostatin LAR
- Somatuline Depot (lanreotide) [Note: Somatuline Depot (lanreotide) might not be covered on your pharmacy prescription drug benefit. Coverage might be available on your medical benefit.]

AND

1.4 The provider has submitted clinical justification why the patient is unable to be maintained on current octreotide or lanreotide therapy*

OR

2 - Patient is currently on Mycapssa therapy for acromegaly

Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity.

Product Name: Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYCAPSSA	OCTREOTIDE ACETATE CAP DELAYED RELEASE 20 MG	30170070106520	Brand

Approval Criteria

1 - Documentation of a positive clinical response to Mycapssa therapy

2 . Revision History

Date	Notes
5/22/2024	Updated note to state: "[Note: Somatuline Depot (lanreotide) might n ot be covered on your pharmacy prescription drug benefit. Coverage might be available on your medical benefit.]" and placed note next to the alternative "Somatuline Depot (lanreotide)" within the criteria (inst ead of Notes section) per PA team request.

Mytesi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146365
Guideline Name	Mytesi
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Mytesi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYTESI	CROFELEMER TAB DELAYED RELEASE 125 MG	47250025000620	Brand

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) associated diarrhea

Namzaric

Prior Authorization Guideline

Guideline ID	GL-146367
Guideline Name	Namzaric
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Namzaric	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 14-10 MG	62059902507030	Brand
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 28-10 MG	62059902507050	Brand
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 7-10 MG	62059902507020	Brand
NAMZARIC	MEMANTINE HCL-DONEPEZIL HCL CAP ER 24HR 21-10 MG	62059902507040	Brand

NAMZARIC	MEMANTINE-DONEPEZIL CAP ER 24HR 7 & 14 & 21 & 28-10 MG PACK	6205990250B630	Brand

Approval Criteria

1 - BOTH of the following:

1.1 History of BOTH of the following as confirmed by claims history or submission of medical records:

1.1.1 Memantine (generic Namenda)

AND

1.1.2 Donepezil (generic Aricept)

AND

1.2 Patient is stabilized on 10mg of donepezil once daily as confirmed by claims history or submission of medical records

Nasonex, Xhance

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155837
Guideline Name	Nasonex, Xhance
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Brand Nasonex, generic mometasone (Rx version only), Allergy nasal spray	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MOMETASONE FUROATE	MOMETASONE FUROATE NASAL SUSP 50 MCG/ACT	42200045101820	Generic
NASONEX 24HR	MOMETASONE FUROATE NASAL SUSP 50 MCG/ACT	42200045101820	Brand
ALLERGY NASAL SPRAY	MOMETASONE FUROATE NASAL SUSP 50 MCG/ACT	42200045101820	Generic

Approval Criteria

1 - Failure to ONE of the following as confirmed by claims history or submission of medical record

- Prescription fluticasone nasal spray (generic Flonase)
- Flonase allergy relief (fluticasone propionate) OTC brand or generic

OR

2 - History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Prescription fluticasone nasal spray (generic Flonase)
- Flonase allergy relief (fluticasone propionate) OTC brand or generic

Product Name: Xhance	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XHANCE	FLUTICASONE PROPIONATE NASAL EXHALER SUSP 93 MCG/ACT	4220003230G720	Brand

Approval Criteria

1 - One of the following:

1.1 Diagnosis of chronic rhinosinusitis with nasal polyps

OR

1.2 Diagnosis of chronic rhinosinusitis without nasal polyps

AND

2 - One of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records

- Fluticasone nasal spray (generic Flonase, Flonase Allergy)
- Mometasone nasal spray (generic Nasonex or Nasonex 24H Allergy)

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Fluticasone nasal spray (generic Flonase, Flonase Allergy)
- Mometasone nasal spray (generic Nasonex or Nasonex 24H Allergy)

2 . Revision History

Date	Notes
9/24/2024	Copy Core

Natpara

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146587
Guideline Name	Natpara
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Natpara	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 25 MCG	3004405510E110	Brand
NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 50 MCG	3004405510E120	Brand
NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 75 MCG	3004405510E130	Brand

NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 100 MCG	3004405510E140	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism

AND

1.2 25-hydroxy vitamin D level is above the lower limit of the normal laboratory reference range

AND

1.3 Patient is currently on active vitamin D (calcitriol) therapy

AND

1.4 Total serum calcium level (albumin corrected) is above 7.5 milligrams per deciliter

AND

2 - ONE of the following:

2.1 Patient is currently on calcium supplementation of 1-2 grams per day of elemental calcium in divided doses as confirmed by claims history or submission of medical records

OR

2.2 Patient has a contraindication to calcium supplementation (please specify contraindication)

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Product Name: Natpara	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 25 MCG	3004405510E110	Brand
NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 50 MCG	3004405510E120	Brand
NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 75 MCG	3004405510E130	Brand
NATPARA	PARATHYROID HORMONE (RECOMBINANT) FOR INJ CARTRIDGE 100 MCG	3004405510E140	Brand

Approval Criteria

1 - Total serum calcium level (albumin corrected) within the lower half of the normal range (approximately 8 to 9 milligrams per deciliter)

AND

2 - Patient continues to take concomitant calcium supplementation that is sufficient to meet daily requirements

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Nayzilam and Valtoco

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148227
Guideline Name	Nayzilam and Valtoco
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nayzilam	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NAYZILAM	MIDAZOLAM NASAL SPRAY SOLN 5 MG/0.1 ML	72100060002010	Brand

Approval Criteria

1 - Diagnosis of epilepsy

AND

2 - Nayzilam is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

AND

3 - The prescriber provides a reason or special circumstance that precludes the use of diazepam rectal gel

Product Name: Nayzilam	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NAYZILAM	MIDAZOLAM NASAL SPRAY SOLN 5 MG/0.1 ML	72100060002010	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Valtoco	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALTOCO 15 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 7.5 MG/0.1ML (15 MG DOSE)	7210003000C440	Brand

VALTOCO 20 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 10 MG/0.1ML (20 MG DOSE)	7210003000C450	Brand
VALTOCO 5 MG DOSE	DIAZEPAM NASAL SPRAY 5 MG/0.1 ML	72100030000920	Brand
VALTOCO 10 MG DOSE	DIAZEPAM NASAL SPRAY 10 MG/0.1 ML	72100030000930	Brand

Approval Criteria

1 - Diagnosis of epilepsy

AND

2 - Valtoco is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

AND

3 - The prescriber provides a reason or special circumstance that precludes the use of diazepam rectal gel

AND

4 - ONE of the following:

4.1 Patient is less than 12 years of age

OR

4.2 ONE of the following:

4.2.1 Failure of Nayzilam confirmed by claims history or submitted medical records

OR

4.2.2 History of contraindication or intolerance to Nayzilam (please specify contraindication or intolerance)

Product Name: Valtoco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALTOCO 15 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 7.5 MG/0.1ML (15 MG DOSE)	7210003000C440	Brand
VALTOCO 20 MG DOSE	DIAZEPAM NASAL SPRAY THER PACK 2 X 10 MG/0.1ML (20 MG DOSE)	7210003000C450	Brand
VALTOCO 5 MG DOSE	DIAZEPAM NASAL SPRAY 5 MG/0.1 ML	72100030000920	Brand
VALTOCO 10 MG DOSE	DIAZEPAM NASAL SPRAY 10 MG/0.1 ML	72100030000930	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
6/10/2024	Revised drug table for Valtoco name change.

Nerlynx

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155031
Guideline Name	Nerlynx
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Nerlynx	
Diagnosis	Early-Stage or Node-Positive Breast Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NERLYNX	NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT)	21533035100320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of early-stage breast cancer

AND

1.2 Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

1.3 Used as extended adjuvant therapy following adjuvant trastuzumab containing therapy (e.g., Herceptin, Kanjinti)

AND

1.4 Patient will not have more than 12 months of treatment per occurrence*

OR

2 - ALL of the following:

2.1 Diagnosis of node positive breast cancer

AND

2.2 Disease is hormone receptor (HR)-positive and HER2-positive

AND

2.3 Used as extended adjuvant therapy following adjuvant trastuzumab containing therapy (e.g., Herceptin, Kanjinti)

AND

2.4 Patient has a perceived high risk of recurrence

AND

2.5 Patient will not have more than 12 months of treatment per occurrence*

Notes	*Duration of coverage is limited to 12 months per occurrence.

Product Name: Nerlynx	
Diagnosis	Advanced or Metastatic Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NERLYNX	NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT)	21533035100320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of advanced or metastatic breast cancer

AND

1.2 Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

1.3 Patient has received two or more prior anti-HER2 based regimens in metastatic setting

AND

1.4 Will be used in combination with capecitabine (generic Xeloda)

OR

2 - BOTH of the following:

2.1 Diagnosis of stage IV (M1) breast cancer

AND

2.2 ONE of the following:

2.2.1 Both of the following:

- Disease is hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative disease
- Patient has already received a CDK4/6 inhibitor therapy

OR

2.2.2 Triple negative disease

Product Name: Nerlynx	
Diagnosis	Breast Cancer with Brain Metastases
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NERLYNX	NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT)	21533035100320	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Patient has brain metastases

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

4 - Used in combination with ONE of the following:

- capecitabine (generic Xeloda)
- Paclitaxel

Product Name: Nerlynx	
Diagnosis	Advanced or Metastatic Breast Cancer, Breast Cancer with Brain Metastases
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NERLYNX	NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT)	21533035100320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Nerlynx therapy

Product Name: Nerlynx	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NERLYNX	NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT)	21533035100320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Nerlynx	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NERLYNX	NERATINIB MALEATE TAB 40 MG (BASE EQUIVALENT)	21533035100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nerlynx therapy

2 . Revision History

Date	Notes
9/16/2024	Updated formatting, no changes to criteria

Nexavar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146589
Guideline Name	Nexavar
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nexavar	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Diagnosis of renal cell carcinoma (RCC)

AND

2 - ONE of the following:

2.1 Disease has relapsed

OR

2.2 BOTH of the following:

- Medically or surgically unresectable tumor
- Diagnosis of Stage IV disease

Product Name: Nexavar	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Diagnosis of hepatocellular carcinoma

AND

2 - ONE of the following:

2.1 Patient has metastatic disease

OR

2.2 Patient has extensive liver tumor burden

OR

2.3 Patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only)

OR

2.4 BOTH of the following:

- Patient is not a transplant candidate
- Disease is unresectable

Product Name: Nexavar	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand

SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

1.2 ONE of the following:

- Unresectable recurrent disease
- Persistent locoregional disease
- Metastatic disease

AND

1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.4 Disease is refractory to radioactive iodine treatment

OR

2 - ALL of the following:

2.1 Diagnosis of medullary thyroid carcinoma

AND

2.2 ONE of the following:

- Disease is progressive
- Disease is symptomatic with distant metastases

AND

2.3 ONE of the following:

2.3.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

Product Name: Nexavar	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand

SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Diagnosis of angiosarcoma

OR

2 - Diagnosis of desmoid tumors/aggressive fibromatosis

OR

3 - BOTH of the following:

3.1 Diagnosis of progressive gastrointestinal stromal tumors (GIST)

AND

3.2 ONE of the following:

3.2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

OR

3.2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- imatinib (generic for Gleevec)
- sunitinib (generic for Sutent)

- Stivarga (regorafenib)
- Qinlock (ripretinib)

OR

4 - Diagnosis of solitary fibrous tumor/hemangiopericytoma

Product Name: Nexavar	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of chordoma

AND

1.2 Disease is recurrent

OR

2 - BOTH of the following:

2.1 ONE of the following:

- Diagnosis of osteosarcoma
- Diagnosis of dedifferentiated chondrosarcoma
- Diagnosis of high-grade undifferentiated pleomorphic sarcoma (UPS)

AND

2.2 Not used as first-line therapy

Product Name: Nexavar	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - Patient has FLT3-ITD mutation-positive disease

AND

3 - ONE of the following:

- Patient has relapsed disease
- Patient has refractory disease

AND

4 - Used in combination with ONE of the following:

- azacytidine (generic for Vidaza)
- decitabine (generic for Dacogen)

AND

5 - Patient is unable to tolerate more aggressive treatment regimens

Product Name: Nexavar	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - ONE of the following:

- Patient has persistent disease
- Patient has recurrent disease

AND

3 - Disease is platinum-resistant

AND

4 - Used in combination with topotecan

Product Name: Nexavar	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Disease is ONE of the following:

- Recurrent and unresectable
- Metastatic

Product Name: Nexavar	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and FLT3 rearrangement

Product Name: Nexavar	
Diagnosis	Renal Cell Carcinoma (RCC), Hepatocellular Carcinoma, Thyroid Cancer, Soft Tissue Sarcoma, Bone Cancer, Acute Myeloid Leukemia, Ovarian Cancer, Salivary Gland Tumor, Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Nexavar therapy

Product Name: Nexavar	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Nexavar	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Brand
SORAFENIB	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic
SORAFENIB TOSYLATE	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533060400320	Generic

Approval Criteria

1 - Documentation of positive clinical response to Nexavar therapy

Nexletol, Nexlizet

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152706
Guideline Name	Nexletol, Nexlizet
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Nexletol, Nexlizet	
Diagnosis	Hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXLETOL	BEMPEDOIC ACID TAB 180 MG	39380020000320	Brand
NEXLIZET	BEMPEDOIC ACID-EZETIMIBE TAB 180-10 MG	39991002200320	Brand

Approval Criteria

1 - ONE of the following diagnoses:

1.1 Primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH)

OR

1.2 Established cardiovascular disease (CVD) as documented by one of the following:

- coronary artery disease
- symptomatic peripheral arterial disease
- cerebrovascular atherosclerotic disease

OR

1.3 High risk for cardiovascular disease (CVD) as documented by one of the following:

- Diabetes and over 60 years old
- Reynolds risk score greater than 30%
- Coronary artery calcium score greater than 400 Agatston units
- ASCVD risk score greater than or equal to 20% with the American College of Cardiology/American Heart Association (ACC/AHA) risk estimator

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following [prescription claims history may be used in conjunction as confirmation of medication use, dose, and duration]:

2.1 Patient has been receiving at least 12 consecutive weeks of high intensity statin therapy [i.e., atorvastatin 40-80 mg (milligrams), rosuvastatin 20-40 mg] and will continue to receive a high intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without CK (creatine kinase) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin extended-release 80 mg, fluvastatin 20-40 mg up to 40mg twice daily or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) confirming ONE of the following

LDL-C (low-density lipoprotein cholesterol) values while on maximally tolerated lipid lowering therapy within the last 120 days:

- LDL-C greater than or equal to 100 mg/dL (milligrams/deciliter) with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) confirming ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following [prescription claims history may be used in conjunction as confirmation of medication use, dose, and duration]:

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication, or intolerance to ezetimibe

Product Name: Nexletol, Nexlizet	
Diagnosis	Hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NEXLETOL	BEMPEDOIC ACID TAB 180 MG	39380020000320	Brand

NEXLIZET	BEMPEDOIC ACID-EZETIMIBE TAB 180-10 MG	39991002200320	Brand

Approval Criteria

1 - Documentation of a positive clinical response to therapy

AND

2 - Patient continues to receive statin at maximally tolerated dose (unless patient has documented inability to take statins)

2 . Revision History

Date	Notes
8/27/2024	Updated indications to include established and high risk for CVD bas ed on updated labeling. Lowered LDL-C threshold for initiation of ther apy. Updated background.

Ninlaro

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151702
Guideline Name	Ninlaro
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Ninlaro	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NINLARO	IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT)	21536045100120	Brand
NINLARO	IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT)	21536045100130	Brand
NINLARO	IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT)	21536045100140	Brand

Approval Criteria

1 - Diagnosis of multiple myeloma

Product Name: Ninlaro	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NINLARO	IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT)	21536045100120	Brand
NINLARO	IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT)	21536045100130	Brand
NINLARO	IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT)	21536045100140	Brand

Approval Criteria

1 - Diagnosis of relapsed or refractory systemic light chain amyloidosis

Product Name: Ninlaro	
Diagnosis	Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NINLARO	IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT)	21536045100120	Brand
NINLARO	IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT)	21536045100130	Brand
NINLARO	IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT)	21536045100140	Brand

Approval Criteria

1 - Diagnosis of Waldenström macroglobulinemia/lymphoplasmacytic lymphoma

AND

2 - Used in combination with rituximab and dexamethasone

Product Name: Ninlaro	
Diagnosis	Multiple Myeloma, Systemic Light Chain Amyloidosis, Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NINLARO	IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT)	21536045100120	Brand
NINLARO	IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT)	21536045100130	Brand
NINLARO	IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT)	21536045100140	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Ninlaro therapy

Product Name: Ninlaro	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NINLARO	IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT)	21536045100120	Brand
NINLARO	IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT)	21536045100130	Brand
NINLARO	IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT)	21536045100140	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Ninlaro	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NINLARO	IXAZOMIB CITRATE CAP 2.3 MG (BASE EQUIVALENT)	21536045100120	Brand
NINLARO	IXAZOMIB CITRATE CAP 3 MG (BASE EQUIVALENT)	21536045100130	Brand
NINLARO	IXAZOMIB CITRATE CAP 4 MG (BASE EQUIVALENT)	21536045100140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ninlaro therapy

2 . Revision History

Date	Notes
8/13/2024	Simplified criteria for multiple myeloma to only require diagnosis chec k.

Nityr

Prior Authorization Guideline

Guideline ID	GL-146591
Guideline Name	Nityr
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nityr	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NITYR	NITISINONE TAB 2 MG	30904045000310	Brand
NITYR	NITISINONE TAB 5 MG	30904045000320	Brand
NITYR	NITISINONE TAB 10 MG	30904045000330	Brand

Approval Criteria

1 - Diagnosis of hereditary tyrosinemia type 1

Nocdurna

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146371
Guideline Name	Nocdurna
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nocdurna	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 27.7 MCG	30201010100710	Brand
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 55.3 MCG	30201010100715	Brand

Approval Criteria

1 - Diagnosis of nocturia due to nocturnal polyuria (as defined by nighttime urine production that exceeds one-third of the 24-hour urine production)

AND

2 - Patient wakes at least twice per night on a reoccurring basis to void

AND

3 - Documented serum sodium level is currently within normal limits of the normal laboratory reference range and has been within normal limits over the previous six months

AND

4 - The patient has been evaluated for other medical causes and has either not responded to, tolerated, or has a contraindication to treatments for identifiable medical causes [e.g., overactive bladder, benign prostatic hyperplasia/lower urinary tract symptoms (BPH/LUTS), elevated post-void residual urine, and heart failure]

AND

5 - Prescriber attests that the risks have been assessed and benefits outweigh the risks

Product Name: Nocdurna	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 27.7 MCG	30201010100710	Brand
NOCDURNA	DESMOPRESSIN ACETATE SUBLINGUAL TAB 55.3 MCG	30201010100715	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nocdurna therapy

AND

2 - Patient has routine monitoring for serum sodium levels

AND

3 - Prescriber attests that the risks of hyponatremia have been assessed and benefits outweigh the risks

Non-Preferred Drugs

Prior Authorization Guideline

Guideline ID	GL-146833
Guideline Name	Non-Preferred Drugs
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Non-Preferred Drugs	
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
multi-source brand medication			
multi-source brand			
non-preferred			
non preferred			

Approval Criteria

1 - If the requested medication is a behavioral health medication, ONE of the following:

1.1 The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)

OR

1.2 The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

OR

2 - ALL of the following:

2.1 One of the following:

2.1.1 Both of the following:

2.1.1.1 One of the following:

- History of failure to at least THREE preferred alternatives as confirmed by claims history or submission of medical records.* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to all of the preferred products.
- History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to all of the preferred products.

AND

2.1.1.2 One of the following:

2.1.1.2.1 If the request is for a multi-source brand medication, OR a branded medication with an authorized generic, one of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic/authorized generic equivalent (specify the adverse reaction, allergy, or sensitivity)

- The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records
- The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient.
- Special clinical circumstances exist that preclude the use of a generic/authorized generic equivalent of the brand medication for the patient (document special clinical circumstances)

OR

2.1.1.2.2 If the request is for a generic when there is a brand available and the brand is the preferred formulation, one of the following:

- The generic is being requested because of an adverse reaction, allergy or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity).
- The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records.
- The generic is being requested because transition to the brand could result in destabilization of the patient.
- Special clinical circumstances exist that preclude the use of the brand equivalent of the generic medication for the patient (document special clinical circumstances).

OR

2.1.2 There are no preferred formulary alternatives for the requested drug.

AND

2.2 One of the following:

2.2.1 The requested drug must be used for an FDA-approved indication

OR

2.2.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex

• Clinical pharmacology • United States Pharmacopeia-National Formulary (USP-NF) **AND** **2.3** The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program.	
Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.

2 . Revision History

Date	Notes
4/30/2024	Removed PDL links for CORE markets in background section and added PDL link for NM in notes section.

Northera

Prior Authorization Guideline

Guideline ID	GL-148221
Guideline Name	Northera
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Northera, generic droxidopa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NORTHERA	DROXIDOPA CAP 100 MG	38700030000130	Brand
DROXIDOPA	DROXIDOPA CAP 100 MG	38700030000130	Generic
NORTHERA	DROXIDOPA CAP 200 MG	38700030000140	Brand
DROXIDOPA	DROXIDOPA CAP 200 MG	38700030000140	Generic
NORTHERA	DROXIDOPA CAP 300 MG	38700030000150	Brand

DROXIDOPA	DROXIDOPA CAP 300 MG	38700030000150	Generic

Approval Criteria

1 - Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) as defined by ONE of the following when an upright position is assumed or when using a head-up tilt-table testing at an angle of at least 60 degrees:

- At least a 20 millimeters of mercury (mm Hg) fall in systolic pressure
- At least a 10 mm Hg fall in diastolic pressure

AND

2 - nOH caused by ONE of the following:

- Primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, and pure autonomic failure)
- Dopamine beta-hydroxylase deficiency
- Non-diabetic autonomic neuropathy

AND

3 - Diagnostic evaluation has excluded other causes associated with orthostatic hypotension (e.g., congestive heart failure, fluid restriction, malignancy)

AND

4 - The patient has tried at least TWO of the following non-pharmacologic interventions:

- Discontinuation of drugs which can cause orthostatic hypotension [e.g., diuretics, antihypertensive medications (primarily sympathetic blockers), anti-anginal drugs (nitrates), alpha-adrenergic antagonists, and antidepressants]
- Raising the head of the bed 10 to 20 degrees
- Compression garments to the lower extremities or abdomen
- Physical maneuvers to improve venous return (e.g., regular modest-intensity exercise)
- Increased salt and water intake, if appropriate
- Avoiding precipitating factors (e.g., overexertion in hot weather, arising too quickly from supine to sitting or standing)

AND

5 - No previous diagnosis of supine hypertension

AND

6 - Prescribed by or in consultation with ONE of the following specialists:

- Cardiologist
- Neurologist
- Nephrologist

AND

7 - ONE of the following:

7.1 Failure (after a trial of at least 30 days) of BOTH of the following confirmed by claims history or submitted medical records:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

OR

7.2 History of contraindication or intolerance to BOTH of the following:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

Product Name: Brand Northera, generic droxidopa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NORTHERA	DROXIDOPA CAP 100 MG	38700030000130	Brand
DROXIDOPA	DROXIDOPA CAP 100 MG	38700030000130	Generic
NORTHERA	DROXIDOPA CAP 200 MG	38700030000140	Brand
DROXIDOPA	DROXIDOPA CAP 200 MG	38700030000140	Generic
NORTHERA	DROXIDOPA CAP 300 MG	38700030000150	Brand
DROXIDOPA	DROXIDOPA CAP 300 MG	38700030000150	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - Physiological countermeasures for neurogenic orthostatic hypotension (nOH) continue to be employed

2 . Revision History

Date	Notes
6/6/2024	Updated initial authorization duration to 12 months.

Nourianz

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146374
Guideline Name	Nourianz
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nourianz	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOURIANZ	ISTRADEFYLLINE TAB 20 MG	73401025000320	Brand
NOURIANZ	ISTRADEFYLLINE TAB 40 MG	73401025000340	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Used as adjunctive treatment to levodopa/carbidopa in patients experiencing "off" episodes

AND

3 - ONE of the following:

3.1 Failure to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes) as confirmed by claims history or submission of medical records:

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

OR

3.2 History of contraindication or intolerance to ALL anti-Parkinson's disease therapy from the following adjunctive pharmacotherapy classes (trial must be from all classes) (please specify intolerance or contraindication):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

Product Name: Nourianz	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NOURIANZ	ISTRADEFYLLINE TAB 20 MG	73401025000320	Brand

NOURIANZ	ISTRADEFYLLINE TAB 40 MG	73401025000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nourianz therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

Nubeqa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146593
Guideline Name	Nubeqa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nubeqa	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUBEQA	DAROLUTAMIDE TAB 300 MG	21402425000320	Brand

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Disease is non-metastatic

AND

2.1.2 Disease is castration-resistant or recurrent

OR

2.2 ALL of the following:

2.2.1 Disease is metastatic

AND

2.2.2 Disease is hormone-sensitive

AND

2.2.3 Nubeqa will be used in combination with docetaxel

AND

3 - ONE of the following:

3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

3.2 Patient has had bilateral orchiectomy

Product Name: Nubeqa	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUBEQA	DAROLUTAMIDE TAB 300 MG	21402425000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Nubeqa therapy

Product Name: Nubeqa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUBEQA	DAROLUTAMIDE TAB 300 MG	21402425000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Nubeqa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUBEQA	DAROLUTAMIDE TAB 300 MG	21402425000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nubeqa therapy

Nucala

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155049
Guideline Name	Nucala
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of EGPA

AND

2 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following

- Reduction in the frequency and/or severity of relapses
- Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant
- Disease remission
- Reduction in severity or frequency of EGPA-related symptoms

AND

3 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by one of the following

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Diagnosis of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA) as defined by ALL of the following:

1.1 Diagnosis of EGPA

AND

1.2 Past medical history or presence of asthma

AND

1.3 Presence of at least TWO of the following characteristics typical of EGPA:

1.3.1 Histopathological evidence of ALL of the following:

- Eosinophilic vasculitis
- Perivascular eosinophilic infiltration
- Eosinophil-rich granulomatous inflammation

OR

1.3.2 Neuropathy, mono or poly (motor deficit or nerve conduction abnormality)

OR

1.3.3 Pulmonary infiltrates, non-fixed

OR

1.3.4 Sino-nasal abnormality

OR

1.3.5 Cardiomyopathy [established by echocardiography or magnetic resonance imaging (MRI)]

OR

1.3.6 Glomerulonephritis (hematuria, red cell casts, proteinuria)

OR

1.3.7 Alveolar hemorrhage

OR

1.3.8 Palpable purpura

OR

1.3.9 Anti-neutrophil cytoplasmic antibody (ANCA) positive

AND

1.4 History of relapsing or refractory disease defined as ONE of the following:

1.4.1 Relapsing disease as defined as a past history (within the past 2 years) of at least one EGPA relapse (requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization)

OR

1.4.2 Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens

AND

2 - Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisone, methylprednisolone)] with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab) as supported by claims history or submitted medical records

AND

3 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

1.1 Reduction in the frequency and/or severity of relapses

OR

1.2 Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant

OR

1.3 Disease remission

OR

1.4 Reduction in severity or frequency of eosinophilic granulomatosis with polyangiitis (EGPA)-related symptoms

AND

2 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma

AND

2 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

3 - Nucala is being used in combination with an inhaled corticosteroid (ICS) containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

4 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Diagnosis of severe asthma

AND

2 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

2.1 Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20]

OR

2.2 Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months

OR

2.3 Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)

OR

2.4 Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal)]

OR

2.5 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

4 - Nucala will be used in combination with ONE of the following:

4.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

4.2 Combination therapy including BOTH of the following:

4.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

4.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

5 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

AND

7 - ONE of the following:

- Failure to a 4 month trial of Fasenra (benralizumab) as confirmed by claims history or submitted medical records
- History of contraindication or intolerance to Fasenra (benralizumab) (please specify intolerance or contraindication)

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

1.1 Reduction in the frequency of exacerbations

OR

1.2 Decreased utilization of rescue medications

OR

1.3 Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline

OR

1.4 Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

OR

1.5 Reduction in oral corticosteroid requirements

AND

2 - Nucala is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of hypereosinophilic syndrome (HES).

AND

2 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least one of the following

- Reduction in frequency of HES flares
- Maintenance or reduction in background HES therapy requirements

AND

3 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by ONE of the following:

- Allergist
- Cardiologist
- Hematologist
- Immunologist

- Pulmonologist

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Diagnosis of Hypereosinophilic Syndrome (HES) greater than or equal to 6 months ago

AND

2 - Both of the following:

2.1 There is no identifiable non-hematologic secondary cause of the patient's HES [e.g., drug hypersensitivity, parasitic helminth infection, HIV (human immunodeficiency virus) infection, non-hematologic malignancy]

AND

2.2 HES is not FIP1L1-PDGFR alpha (gene) kinase-positive

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting both of the following:

3.1 Baseline [pre-Nucala (mepolizumab) treatment] blood eosinophil level greater than or equal to 1000 cells/microliter within the past 4 weeks

AND

3.2 Patient is currently receiving a stable dose of background HES therapy (e.g., oral corticosteroid, immunosuppressor, or cytotoxic therapy)

AND

4 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by ONE of the following:

- Allergist
- Cardiologist
- Hematologist
- Immunologist
- Pulmonologist

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

1.1 Reduction in the frequency of Hypereosinophilic Syndrome (HES) flares

OR

1.2 Maintenance or reduction in background HES therapy requirements

AND

2 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of chronic rhinosinusitis with nasal polyps (CRSwNP).

AND

2 - Documentation of positive clinical response to Nucala therapy

AND

3 - Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

4 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by ONE of the following

- Allergist
- Immunologist
- Otolaryngologist

- Pulmonologist

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization – Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by ALL of the following:

1.1 Two or more of the following symptoms for longer than 12 weeks duration:

- Nasal mucopurulent discharge
- Nasal obstruction, blockage, or congestion
- Facial pain, pressure, and/or fullness
- Reduction or loss of sense of smell

AND

1.2 One of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

1.3 ONE of the following:

- Presence of bilateral nasal polyposis
- Patient has previously required surgical removal of bilateral nasal polyps

AND

1.4 ONE of the following:

1.4.1 Patient has required prior sinus surgery

OR

1.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years

OR

1.4.3 Patient has been unable to obtain symptom relief after trial of TWO of the following classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

AND

2 - Patient will receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone).

AND

3 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]

- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Product Name: Nucala auto-injector and pre-filled syringe	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy

AND

2 - Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is not receiving Nucala in combination with ONE of the following

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor therapy [e.g., Tezspire (tezepelumab)]

2 . Revision History

Date	Notes
9/17/2024	Specified existing prior authorization for under the medical benefit.

Nuedexta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146375
Guideline Name	Nuedexta
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nuedexta	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUEDEXTA	DEXTROMETHORPHAN HBR-QUINIDINE SULFATE CAP 20-10 MG	62609902300120	Brand

Approval Criteria

1 - Diagnosis of pseudobulbar affect (PBA)

Nuplazid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146376
Guideline Name	Nuplazid
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUPLAZID	PIMAVANSERIN TARTRATE CAP 34 MG (BASE EQUIVALENT)	59400028200120	Brand
NUPLAZID	PIMAVANSERIN TARTRATE TAB 10 MG (BASE EQUIVALENT)	59400028200310	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is currently experiencing hallucinations and delusions associated with Parkinson's disease psychosis (i.e., hallucination and delusion symptoms started after Parkinson's disease diagnosis)

Product Name: Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NUPLAZID	PIMAVANSERIN TARTRATE CAP 34 MG (BASE EQUIVALENT)	59400028200120	Brand
NUPLAZID	PIMAVANSERIN TARTRATE TAB 10 MG (BASE EQUIVALENT)	59400028200310	Brand

Approval Criteria

1 - Documentation of positive clinical response to Nuplazid therapy

Nurtec, Qulipta, Ubrelvy, Zavzpret

Prior Authorization Guideline

Guideline ID	GL-156787
Guideline Name	Nurtec, Qulipta, Ubrelvy, Zavzpret
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Nurtec ODT	
Diagnosis	Acute Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - One of the following:

2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to TWO of the following as confirmed by claims history or submission of medical records:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ALL of the following prophylactic therapies or classes (please specify contraindication or intolerance):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Ubrelvy, Zavzpret)

Notes	* Timolol, candesartan, Ajovy and Qulipta are non-preferred and shoul d not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefits and should not be i ncluded in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a p rior authorization.

Product Name: Nurtec ODT	
Diagnosis	Preventive Treatment of Episodic Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - Diagnosis of episodic migraines with greater than or equal to 4 migraine days per month

AND

2 - Used for preventive treatment of migraines

AND

3 - One of the following:

3.1 Failure (after a trial of at least two months), to TWO of the following prophylactic therapies as confirmed by claims history or submission of medical records:

- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- Topiramate (generic Topamax)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 History of contraindication or intolerance to ALL of the following prophylactic therapies (please specify contraindication or intolerance):

- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- Topiramate (generic Topamax)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]

- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Vyepti)

Notes	* Timolol and candesartan are non-preferred and should not be included in denial to provider

Product Name: Nurtec ODT	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NURTEC	RIMEGEPANT SULFATE TAB DISINT 75 MG	67701060707220	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - ONE of the following:

2.1 Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Ubrelvy, Zavzpret)

OR

2.2 Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Vyepti)

Product Name: Zavzpret	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZAVZPRET	ZAVEGEPANT HCL NASAL SPRAY 10 MG/ACT	67701090202020	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - One of the following:

2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to BOTH of the following as confirmed by claims history or submission of medical records:

2.1.1 TWO preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray

AND

2.1.2 ONE of the following:

- Nurtec ODT
- Ubrelvy

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

2.2.1 TWO preferred 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray

AND

2.2.2 Nurtec ODT

AND

2.2.3 Ubrelvy

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims history or submission of medical records:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ALL of the following prophylactic therapies or classes (please specify contraindication or intolerance):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)

- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Nurtec ODT, Ubrelvy)

Notes	* Timolol, candesartan, Ajovy and Qulipta are non-preferred and shoul d not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefits and should not be i ncluded in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a p rior authorization.

Product Name: Ubrelvy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
UBRELVY	UBROGEPANT TAB 50 MG	67701080000320	Brand
UBRELVY	UBROGEPANT TAB 100 MG	67701080000340	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - One of the following:

2.1 Failure (after at least 3 migraine episodes and a minimum of a 30-day trial) to TWO of the following as confirmed by claims history or submission of medical records:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance)

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

AND

3 - One of the following:

3.1 Patient is currently treated with ONE of the following prophylactic therapies or classes as confirmed by claims or submission of medical records:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ALL of the following prophylactic therapies or classes (please specify contraindication or intolerance):

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)*
- Candesartan* (generic Atacand)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig, Ajovy*, Emgality, Qulipta*, Vyepti**] ***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (generic Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Nurtec ODT, Zavzpret)

Notes	* Timolol, Ajovy, Qulipta and candesartan are non-preferred and shoul d not be included in denial to provider **Vyepti, OnabotulinumtoxinA are medical benefit and should not be i ncluded in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a p rior authorization.

Product Name: Ubrelvy, Zavzpret	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZAVZPRET	ZAVEGEPANT HCL NASAL SPRAY 10 MG/ACT	67701090202020	Brand
UBRELVY	UBROGEPANT TAB 50 MG	67701080000320	Brand
UBRELVY	UBROGEPANT TAB 100 MG	67701080000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Nurtec ODT)

Product Name: Qulipta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QULIPTA	ATOGEPANT TAB 10 MG	67701010000310	Brand
QULIPTA	ATOGEPANT TAB 30 MG	67701010000320	Brand
QULIPTA	ATOGEPANT TAB 60 MG	67701010000330	Brand

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 Patient has 4 to 7 migraine days per month and at least ONE of the following:

2.1.1 Less than 15 headache days per month

OR

2.1.2 Provider attests this is the member's predominant headache diagnosis (i.e., primary driver of headaches is not different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - One of the following:

3.1 Failure (after a trial of at least two months) to TWO of the following prophylactic therapies as confirmed by claims history or submission of medical records:

- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (Atacand)
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 History of contraindication or intolerance to ALL of the following prophylactic therapies (please specify contraindication or intolerance):

- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (Atacand)
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA** (generic Botox)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - One of the following:

4.1 Failure (after a trial of at least three months) to Nurtec ODT as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Nurtec ODT (please specify contraindication or intolerance)

AND

5 - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g. Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti)

Notes	* Timolol, candesartan are non-preferred and should not be included i n denial to provider **OnabotulinumtoxinA is a medical benefit and should not be included in denial to provider.

Product Name: Qulipta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QULIPTA	ATOGEPANT TAB 10 MG	67701010000310	Brand
QULIPTA	ATOGEPANT TAB 30 MG	67701010000320	Brand
QULIPTA	ATOGEPANT TAB 60 MG	67701010000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti)

2 . Background

Benefit/Coverage/Program Information
PDL Link: NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
10/1/2024	Updated list of potential prophylactic therapies

Nuzyra

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146378
Guideline Name	Nuzyra
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Nuzyra tablets			
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
NUZYRA	OMADACYCLINE TOSYLATE TAB 150 MG (BASE EQUIVALENT)	04200050200320	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - ALL of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

3.3 ONE of the following:

3.3.1 Failure to THREE of the following antibiotics or antibiotic regimens, as confirmed by claims history or submitted medical records:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

3.3.2 History of intolerance or contraindication to ALL of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication):

- Amoxicillin
- A macrolide
- Doxycycline

- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

4 - ALL of the following:

4.1 ONE of the following diagnoses:

4.1.1 BOTH of the following:

4.1.1.1 Acute bacterial skin and skin structure infections

AND

4.1.1.2 Infection caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

4.1.2 BOTH of the following:

4.1.2.1 Empirical treatment of a patient with acute bacterial skin and skin structure infections

AND

4.1.2.2 Presence of MRSA infection is likely

AND

4.2 ONE of the following:

4.2.1 Failure to linezolid (generic Zyvox) as confirmed by claims history or submitted medical records

OR

4.2.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

4.3 ONE of the following:

4.3.1 Failure to ONE of the following antibiotics as confirmed by claims history or submitted medical records:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

4.3.2 History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

OR

5 - ALL of the following:

5.1 Diagnosis of acute bacterial skin and skin structure infections

AND

5.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

5.3 ONE of the following:

5.3.1 Failure to THREE of the following antibiotics confirmed by claims history or submitted medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

OR

5.3.2 History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

OR

6 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Notes	Authorization duration for CABP and acute bacterial skin and skin structure infections will be issued for up to 14 days. For all IDSA recognized indications, authorization duration is based on provider and IDSA recommended treatment durations, up to 6 months.

OAB Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149508
Guideline Name	OAB Agents
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/3/2024

1 . Criteria

Product Name: generic tolterodine IR	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
TOLTERODINE TARTRATE	TOLTERODINE TARTRATE TAB 1 MG	54100060200320	Generic
TOLTERODINE TARTRATE	TOLTERODINE TARTRATE TAB 2 MG	54100060200330	Generic

Approval Criteria

1 - Failure to treatment with oxybutynin immediate release as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to oxybutynin immediate release (please specify contraindication or intolerance)

Product Name: generic tolterodine ER	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
TOLTERODINE TARTRATE ER	TOLTERODINE TARTRATE CAP ER 24HR 2 MG	54100060207020	Generic
TOLTERODINE TARTRATE ER	TOLTERODINE TARTRATE CAP ER 24HR 4 MG	54100060207030	Generic

Approval Criteria

1 - Failure to treatment with oxybutynin extended-release as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to oxybutynin extended-release (please specify contraindication or intolerance)

Product Name: Brand Detrol LA, Brand Ditropan XL, darifenacin ER, Gelnique, Gemtesa, trospium ER, Brand Vesicare	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DETROL LA	TOLTERODINE TARTRATE CAP ER 24HR 2 MG	54100060207020	Brand

DETROL LA	TOLTERODINE TARTRATE CAP ER 24HR 4 MG	54100060207030	Brand
DITROPAN XL	OXYBUTYNIN CHLORIDE TAB ER 24HR 5 MG	54100045207520	Brand
DITROPAN XL	OXYBUTYNIN CHLORIDE TAB ER 24HR 10 MG	54100045207530	Brand
DARIFENACIN HYDROBROMIDE ER	DARIFENACIN HYDROBROMIDE TAB ER 24HR 7.5 MG (BASE EQUIV)	54100010207520	Generic
DARIFENACIN HYDROBROMIDE ER	DARIFENACIN HYDROBROMIDE TAB ER 24HR 15 MG (BASE EQUIV)	54100010207530	Generic
GELNIQUE	OXYBUTYNIN CHLORIDE TD GEL 10%	54100045204030	Brand
TROSPIUM CHLORIDE ER	TROSPIUM CHLORIDE CAP ER 24HR 60 MG	54100065207020	Generic
VESICARE	SOLIFENACIN SUCCINATE TAB 5 MG	54100055200320	Brand
VESICARE	SOLIFENACIN SUCCINATE TAB 10 MG	54100055200330	Brand
GEMTESA	VIBEGRON TAB 75 MG	54200080000320	Brand

Approval Criteria

1 - Failure to a trial of THREE of the following confirmed by claims history or submission of medical records:

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

Product Name: Oxytrol (Rx)	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXYTROL	OXYBUTYNIN TD PATCH TWICE WEEKLY 3.9 MG/24HR	54100045008720	Brand

Approval Criteria

1 - Failure to a trial of THREE of the following, confirmed by claims history or submission of medical records:

- Oxytrol for Women (oxybutynin OTC) patch
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Oxytrol for Women (oxybutynin OTC) patch
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

Product Name: flavoxate, oxybutynin oral solution, Brand Detrol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DETROL	TOLTERODINE TARTRATE TAB 1 MG	54100060200320	Brand
DETROL	TOLTERODINE TARTRATE TAB 2 MG	54100060200330	Brand
FLAVOXATE HCL	FLAVOXATE HCL TAB 100 MG	54400025100310	Generic

OXYBUTYNIN CHLORIDE	OXYBUTYNIN CHLORIDE SOLUTION 5 MG/5ML	54100045202010	Generic

Approval Criteria

1 - Failure to a trial of ALL of the following, confirmed by claims history or submission of medical records:

- oxybutynin syrup or tablet
- tolterodine tablet (generic Detrol)
- trospium tablet

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup or tablet
- tolterodine tablet (generic Detrol)
- trospium tablet

Product Name: Vesicare LS	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VESICARE LS	SOLIFENACIN SUCCINATE SUSP 5 MG/5ML (1 MG/ML)	54100055201820	Brand

Approval Criteria

1 - Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2 - ONE of the following:

2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

Product Name: Brand Myrbetriq tabs, generic mirabegron tabs, generic fesoterodine ER, Brand Toviaz	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYRBETRIQ	MIRABEGRON TAB ER 24 HR 25 MG	54200050007520	Brand
MYRBETRIQ	MIRABEGRON TAB ER 24 HR 50 MG	54200050007530	Brand
FESOTERODINE FUMARATE ER	FESOTERODINE FUMARATE TAB ER 24HR 4 MG	54100020207520	Generic
TOVIAZ	FESOTERODINE FUMARATE TAB ER 24HR 4 MG	54100020207520	Brand
FESOTERODINE FUMARATE ER	FESOTERODINE FUMARATE TAB ER 24HR 8 MG	54100020207530	Generic
TOVIAZ	FESOTERODINE FUMARATE TAB ER 24HR 8 MG	54100020207530	Brand
MIRABEGRON ER	MIRABEGRON TAB ER 24 HR 25 MG	54200050007520	Generic
MIRABEGRON ER	MIRABEGRON TAB ER 24 HR 50 MG	54200050007530	Generic

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of overactive bladder (OAB)

AND

1.2 ONE of the following:

1.2.1 Failure to a trial of THREE of the following confirmed by claims history or submission of medical records:

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

1.2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin extended-release tablet (generic Ditropan XL)
- tolterodine immediate release (generic Detrol) or tolterodine extended-release capsule (generic Detrol LA)
- trospium tablet
- solifenacin tablet (generic Vesicare)

OR

2 - BOTH of the following:

2.1 Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2.2 ONE of the following:

2.2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

2.2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

Product Name: Myrbetriq granules	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYRBETRIQ	MIRABEGRON GRANULES FOR ORAL EXTENDED RELEASE SUSP 8 MG/ML	5420005000G220	Brand

Approval Criteria

1 - Diagnosis of neurogenic detrusor overactivity (NDO) (neurogenic bladder)

AND

2 - ONE of the following:

2.1 Failure to a trial of ONE of the following, as confirmed by claims history or submission of medical records:

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oxybutynin syrup
- oxybutynin tablet
- oxybutynin extended release tablet (generic Ditropan XL)

AND

3 - ONE of the following:

3.1 Patient is 3 years of age to (including) 17 years of age

OR

3.2 BOTH of the following:

3.2.1 Physician has provided rationale for needing to use this medication in an unapproved age range

AND

3.2.2 The use of this medication for a patient outside the FDA (Food and Drug Administration) approved age range is supported by information from ONE of the following appropriate compendia:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia - National Formulary (USP-NF)

2 . Revision History

Date	Notes
7/3/2024	Copy core

Ocaliva

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146595
Guideline Name	Ocaliva
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ocaliva	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCALIVA	OBETICHOLIC ACID TAB 5 MG	52750060000320	Brand
OCALIVA	OBETICHOLIC ACID TAB 10 MG	52750060000330	Brand

Approval Criteria

1 - Diagnosis of primary biliary cholangitis

AND

2 - ONE of the following:

2.1 Patient does not have cirrhosis

OR

2.2 Patient has compensated cirrhosis without evidence of portal hypertension

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol)

AND

3.1.2 Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 consecutive months of treatment with ursodeoxycholic acid (e.g., Urso, ursodiol)

OR

3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol) (please specify contraindication or intolerance)

AND

4 - Prescribed by ONE of the following:

- Hepatologist

- Gastroenterologist

Product Name: Ocaliva	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCALIVA	OBETICHOLIC ACID TAB 5 MG	52750060000320	Brand
OCALIVA	OBETICHOLIC ACID TAB 10 MG	52750060000330	Brand

Approval Criteria

1 - Submission of medical records (e.g., laboratory values) documenting a reduction in alkaline phosphatase (ALP) level from pre-treatment baseline (i.e., prior to Ocaliva therapy) while on Ocaliva therapy

AND

2 - ONE of the following:

2.1 Patient does not have cirrhosis

OR

2.2 Patient has compensated cirrhosis without evidence of portal hypertension

AND

3 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

Odomzo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146596
Guideline Name	Odomzo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Odomzo	
Diagnosis	Basal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ODOMZO	SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT)	21370060200120	Brand

Approval Criteria

1 - Diagnosis of metastatic basal cell carcinoma (BCC)

OR

2 - Diagnosis of diffuse basal cell carcinoma (BCC) formation (e.g., Gorlin syndrome, other genetic forms of multiple BCC)

OR

3 - BOTH of the following:

3.1 Diagnosis of locally advanced basal cell carcinoma

AND

3.2 ONE of the following:

- Cancer has recurred following surgery
- Cancer has recurred following radiation
- Patient is not a candidate for surgery
- Patient is not a candidate for radiation

Product Name: Odomzo	
Diagnosis	Basal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ODOMZO	SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT)	21370060200120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Odomzo therapy

Product Name: Odomzo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ODOMZO	SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT)	21370060200120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Odomzo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ODOMZO	SONIDEGIB PHOSPHATE CAP 200 MG (BASE EQUIVALENT)	21370060200120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Odomzo therapy

Ogsiveo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146597
Guideline Name	Ogsiveo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ogsiveo	
Diagnosis	Desmoid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 50 MG	21532350200320	Brand

Approval Criteria

1 - Diagnosis of desmoid tumor

AND

2 - Disease is progressive

AND

3 - Patient requires systemic treatment

Product Name: Ogsiveo	
Diagnosis	Desmoid Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 50 MG	21532350200320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Ogsiveo therapy

Product Name: Ogsiveo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 50 MG	21532350200320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Ogsiveo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OGSIVEO	NIROGACESTAT HYDROBROMIDE TAB 50 MG	21532350200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ogsiveo therapy

Ojemda

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151313
Guideline Name	Ojemda
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Ojemda	
Diagnosis	Pediatric Low-Grade Glioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJEMDA	TOVORAFENIB TAB 100 MG	21532075000320	Brand
OJEMDA	TOVORAFENIB FOR ORAL SUSP 25 MG/ML	21532075001920	Brand

Approval Criteria

1 - Diagnosis of pediatric low-grade glioma

AND

2 - Disease is relapsed or refractory

AND

3 - Presence of one of the following genetic mutations:

- BRAF fusion or rearrangement
- BRAF V600 mutation

Product Name: Ojemda	
Diagnosis	Pediatric Low-Grade Glioma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJEMDA	TOVORAFENIB TAB 100 MG	21532075000320	Brand
OJEMDA	TOVORAFENIB FOR ORAL SUSP 25 MG/ML	21532075001920	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Ojemda therapy

Product Name: Ojemda	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJEMDA	TOVORAFENIB TAB 100 MG	21532075000320	Brand
OJEMDA	TOVORAFENIB FOR ORAL SUSP 25 MG/ML	21532075001920	Brand

Approval Criteria

1 - Ojemda will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.

Product Name: Ojemda	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJEMDA	TOVORAFENIB TAB 100 MG	21532075000320	Brand
OJEMDA	TOVORAFENIB FOR ORAL SUSP 25 MG/ML	21532075001920	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ojemda therapy

2 . Revision History

Date	Notes
8/12/2024	New guideline

Ojjaara

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146598
Guideline Name	Ojjaara
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ojjaara	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG	21537540300320	Brand
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG	21537540300330	Brand
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG	21537540300340	Brand

Approval Criteria

1 - Disease is considered intermediate or high-risk based on one of the following diagnoses:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

AND

2 - Patient has anemia

Product Name: Ojjaara	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG	21537540300320	Brand
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG	21537540300330	Brand
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG	21537540300340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Ojjaara therapy

Product Name: Ojjaara	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG	21537540300320	Brand

OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG	21537540300330	Brand
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG	21537540300340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Ojjaara	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 100 MG	21537540300320	Brand
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 150 MG	21537540300330	Brand
OJJAARA	MOMELOTINIB DIHYDROCHLORIDE TAB 200 MG	21537540300340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ojjaara therapy

Olumiant

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146847
Guideline Name	Olumiant
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Olumiant 1mg, Olumiant 2mg	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OLUMIANT	BARICITINIB TAB 2 MG	66603010000320	Brand
OLUMIANT	BARICITINIB TAB 1 MG	66603010000310	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - Patient is not receiving Olumiant in combination with one of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - One of the following:

4.1 Patient is currently on Olumiant therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 One of the following:

4.2.1.1 Failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submission of medical records

OR

4.2.1.2 History of contraindication or intolerance to one non-biologic disease modifying anti-

rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify contraindication or intolerance)

OR

4.2.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

4.2.2 One of the following:

4.2.2.1 Failure to at least one TNF antagonist therapy as confirmed by claims history or submission of medical records

OR

4.2.2.2 History of intolerance or contraindication to at least one TNF antagonist therapy (please specify intolerance or contraindication)

OR

4.2.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria3)

Notes	Olumiant used for the treatment of alopecia areata is considered cos metic, is excluded, and is to be denied as a benefit exclusion.

Product Name: Olumiant 1mg, Olumiant 2mg	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OLUMIANT	BARICITINIB TAB 2 MG	66603010000320	Brand
OLUMIANT	BARICITINIB TAB 1 MG	66603010000310	Brand

Approval Criteria

1 - Documentation of positive clinical response to Olumiant therapy

AND

2 - Patient is not receiving Olumiant in combination with one of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib)]

Notes	Olumiant used for the treatment of alopecia areata is considered cos metic, is excluded, and is to be denied as a benefit exclusion.

2 . Revision History

Date	Notes
4/30/2024	Removed references to other states in GL name.

Omega

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146380
Guideline Name	Omega
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Lovaza, generic omega-3-acid ethyl esters, Brand Vascepa, generic icosapent ethyl	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOVAZA	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Brand
OMEGA-3-ACID ETHYL ESTERS	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Generic

VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Diagnosis of severe hypertriglyceridemia [pre-treatment triglyceride level of greater than or equal to 500 milligrams/deciliter (mg/dL)]

AND

2 - Patient is on an appropriate lipid-lowering diet and exercise regimen

AND

3 - ONE of the following:

3.1 Failure to at least 90 days of a fibric acid derivative, as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to a fibric acid derivative (please specify contraindication or intolerance)

AND

4 - If the request is for a non-preferred* product, ONE of the following:

4.1 Failure to omega-3-acid ethyl esters (generic Lovaza), as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to omega-3-acid ethyl esters (generic Lovaza) (please specify contraindication or intolerance)

Notes	*Omega 3-acid esters (generic Lovaza) is preferred. Other omega-3 a cid derivatives are non-preferred.

Product Name: Brand Lovaza, generic omega-3-acid ethyl esters, Brand Vascepa, generic icosapent ethyl	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LOVAZA	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Brand
OMEGA-3-ACID ETHYL ESTERS	OMEGA-3-ACID ETHYL ESTERS CAP 1 GM	39500045200130	Generic
VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is on an appropriate lipid-lowering diet and exercise regimen

Product Name: Brand Vascepa, generic icosapent ethyl	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Diagnosis of hypertriglyceridemia [pre-treatment triglyceride level greater than or equal to 150 milligrams/deciliter (mg/dL)]

AND

2 - Patient currently has or is considered high or very high risk for cardiovascular disease (CVD) as evidenced by ONE of the following:

2.1 BOTH of the following:

2.1.1 At least 45 years of age

AND

2.1.2 Established CVD confirmed by ONE of the following:

- Acute coronary syndrome
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack

- Peripheral arterial disease

OR

2.2 ALL of the following:

2.2.1 Diagnosis of Type 2 diabetes

AND

2.2.2 TWO of the following risk factors for developing cardiovascular disease:

- Men at least 55 years and women at least 65 years
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension [pretreatment blood pressure greater than or equal to 140 millimeters of mercury (mmHg) systolic or greater than or equal to 90 mmHg diastolic]
- HDL-C (high-density lipoprotein cholesterol) less than or equal to 40 mg/dL for men or less than or equal to 50 mg/dL for women
- High-sensitivity C-reactive protein greater than 3.0 mg/L (liter)
- Creatinine clearance greater than 30 and less than 60 milliliters/minute (mL/min)
- Retinopathy
- Micro- or macro-albuminuria
- Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

3.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy (i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive a high-intensity statin at maximally tolerated dose

OR

3.2 BOTH of the following:

3.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

3.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily, or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

AND

4 - Submission of medical record (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

4.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (generic Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

4.2 History of contraindication or intolerance to ezetimibe (please specify contraindication or intolerance)

OR

4.3 Patient has an LDL-C (low density lipoprotein cholesterol) less than 100 mg/dL while on maximally tolerated statin therapy

AND

5 - Used as an adjunct to a low-fat diet and exercise

AND

6 - Prescribed by or in consultation with ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

Product Name: Brand Vascepa, generic icosapent ethyl	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VASCEPA	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 0.5 GM	39500035100110	Generic
VASCEPA	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Brand
ICOSAPENT ETHYL	ICOSAPENT ETHYL CAP 1 GM	39500035100120	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is on an appropriate low-fat diet and exercise regimen

AND

3 - Patient is receiving maximally tolerated statin therapy

Omnipod 5

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147315
Guideline Name	Omnipod 5
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Omnipod 5	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD 5 G6 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G6 INTRO KIT (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand

OMNIPOD 5 G7 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G7 INTRO KIT (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand

Approval Criteria

1 - Diagnosis of diabetes

AND

2 - ALL of the following:

2.1 Patient has done ONE of the following for at least 8 weeks:

- Regularly tests blood glucose at least 4 times/day
- Utilizes a continuous glucose monitor (CGM)

AND

2.2 Patient has completed a diabetes management program

AND

2.3 Patient injects insulin at least 3 times/day

AND

3 - ONE of the following:

- Unexplained, nocturnal, or severe hypoglycemia
- Hypoglycemia unawareness
- Dawn phenomenon blood glucose greater than 200 mg/dL (milligrams/deciliter)
- Wide and unpredictable (erratic) swings in blood glucose levels
- Glycemic targets within individualized range but lifestyle requires increased flexibility of insulin pump use

- HbA1C greater than 7% or outside individualized targets

AND

4 - BOTH of the following:

4.1 Patient or caregiver is motivated to assume responsibility for self-care and insulin management

AND

4.2 Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning

AND

5 - Prescriber attests that there is a reason or special circumstance the patient cannot use external insulin pumps obtained on the medical benefit

Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name: Omnipod 5	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD 5 G6 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G6 INTRO KIT (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand
OMNIPOD 5 G7 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G7	*INSULIN INFUSION DISPOSABLE PUMP KIT***	97201030506400	Brand

INTRO KIT (GEN 5)			

Approval Criteria

1 - Documentation of positive clinical response

Notes	If patient meets criteria, approve using NDC List OMNIPOD5

Product Name: Omnipod 5 G6 or G7 pods	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
OMNIPOD 5 G6 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand
OMNIPOD 5 G7 PODS (GEN 5)	*INSULIN INFUSION DISPOSABLE PUMP RESERVOIR***	97201030506300	Brand

Approval Criteria

1 - Physician confirmation that the patient requires a greater quantity

Notes	Authorization for quantity limit overrides should be entered at the NDC level for the requested Omnipod 5 G6 or G7 pods, for the requested quantity.

2 . Revision History

Date	Notes
5/13/2024	Added Omnipod 5 G7 products.

Omvoh

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146601
Guideline Name	Omvoh
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Omvoh SC	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OMVOH	MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	5250405040D520	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - ONE of the following:

2.1 Patient has been established on therapy with Omvoh for moderately to severely active ulcerative colitis under an active UnitedHealthcare prior authorization

OR

2.2 Patient is currently on Omvoh therapy for moderately to severely active ulcerative colitis as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

3 - Patient is NOT receiving Omvoh in combination with any of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Olumiant (baricitinib), Xeljanz/XR (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name: Omvoh SC	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

OMVOH	MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	5250405040D520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Omvoh therapy

AND

2 - Patient is NOT receiving Omvoh in combination with any of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)
- Janus kinase inhibitor [e.g., Cibinqo (abrocitinib), Olumiant (baricitinib), Xeljanz/XR (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Onureg

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146602
Guideline Name	Onureg
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Onureg	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ONUREG	AZACITIDINE TAB 200 MG	21300003000320	Brand
ONUREG	AZACITIDINE TAB 300 MG	21300003000330	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia

AND

2 - Achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy

AND

3 - Patient is not able to complete intensive curative therapy (e.g., transplant-ineligible)

Product Name: Onureg	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ONUREG	AZACITIDINE TAB 200 MG	21300003000320	Brand
ONUREG	AZACITIDINE TAB 300 MG	21300003000330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Onureg therapy

Product Name: Onureg	
Diagnosis	NCCN Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ONUREG	AZACITIDINE TAB 200 MG	21300003000320	Brand
ONUREG	AZACITIDINE TAB 300 MG	21300003000330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Onureg	
Diagnosis	NCCN Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ONUREG	AZACITIDINE TAB 200 MG	21300003000320	Brand
ONUREG	AZACITIDINE TAB 300 MG	21300003000330	Brand

Approval Criteria

1 - There is documentation of positive clinical response to Onureg therapy

Opfolda

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146603
Guideline Name	Opfolda
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Opfolda	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPFOLDA	MIGLUSTAT (GAA DEFICIENCY) CAP 65 MG	30907760000120	Brand

Approval Criteria

1 - Diagnosis of late-onset Pompe disease as confirmed by ONE of the following:

1.1 Absence or deficiency (less than 40% of the lab specific normal mean) of acid alpha-glucosidase (GAA) activity in lymphocytes, fibroblasts or muscle

OR

1.2 Molecular genetic testing for deletion or mutations in the GAA gene

AND

2 - Presence of clinical signs and symptoms of the disease (e.g., cardiac hypertrophy, respiratory distress, skeletal muscle weakness, etc.)

AND

3 - Provider attests that the patient is not improving on their current enzyme replacement therapy (ERT) (e.g., Lumizyme, Nexviazyme) for the treatment of late-onset Pompe disease and this therapy will be stopped

AND

4 - Patient weighs at least 40kg

AND

5 - Opfolda will be prescribed in combination with Pombiliti (cipaglucosidase alfa-atga)

Product Name: Opfolda	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPFOLDA	MIGLUSTAT (GAA DEFICIENCY) CAP 65 MG	30907760000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Opfolda plus Pombiliti

AND

2 - Opfolda continues to be prescribed in combination with Pombiliti

Ophthalmic Antihistamine

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146382
Guideline Name	Ophthalmic Antihistamine
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: azelastine ophth soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
AZELASTINE HCL	AZELASTINE HCL OPHTH SOLN 0.05%	86802006102020	Generic
AZELASTINE HYDROCHLORIDE	AZELASTINE HCL OPHTH SOLN 0.05%	86802006102020	Generic

Approval Criteria

1 - Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

Product Name: olopatadine ophth soln (Rx formulation)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OLOPATADINE HYDROCHLORIDE	OLOPATADINE HCL OPHTH SOLN 0.1% (BASE EQUIVALENT)	86802065102020	Generic
OLOPATADINE HCL	OLOPATADINE HCL OPHTH SOLN 0.1% (BASE EQUIVALENT)	86802065102020	Generic
OLOPATADINE HYDROCHLORIDE	OLOPATADINE HCL OPHTH SOLN 0.2% (BASE EQUIVALENT)	86802065102030	Generic

Approval Criteria

1 - ONE of the following:

1.1 Failure to Pataday OTC (over-the-counter), as confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to Pataday OTC (please specify contraindication or intolerance)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- Azelastine ophthalmic solution
- Ketotifen
- Cromolyn

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Azelastine ophthalmic solution
- Ketotifen
- Cromolyn

Opzelura

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146383
Guideline Name	Opzelura
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Opzelura	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPZELURA	RUXOLITINIB PHOSPHATE CREAM 1.5%	90272060503720	Brand

Approval Criteria

1 - Diagnosis of mild to moderate atopic dermatitis*

AND

2 - ONE of the following:

2.1 Failure to TWO of the following topical therapeutic classes as confirmed by claims history or submission of medical records:

2.1.1 ONE of the following:

2.1.1.1 For mild atopic dermatitis: a topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

OR

2.1.1.2 For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

OR

2.1.2 One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]

OR

2.1.3 Eucrisa (crisaborole)

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapeutic classes (please specify intolerance or contraindication):

2.2.1 ONE of the following:

2.2.1.1 For mild atopic dermatitis: a topical corticosteroid [e.g., DesOwen (desonide), hydrocortisone] (any potency)

OR

2.2.1.2 For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency topical corticosteroid [e.g., Elocon (mometasone furoate), Synalar (fluocinolone acetonide), Lidex (fluocinonide)]

AND

2.2.2 One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]

AND

2.2.3 Eucrisa (crisaborole)

OR

2.3 Patient is currently on Opzelura therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Opzelura in combination with another biologic medication [e.g., Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)] nor JAK inhibitor [e.g., Jakafi (ruxolitinib), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

4 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

Notes	*Medications for the treatment of Nonsegmental Vitiligo are considered cosmetic, are excluded, and are to be denied as a benefit exclusion.

Product Name: Opzelura

Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPZELURA	RUXOLITINIB PHOSPHATE CREAM 1.5%	90272060503720	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is NOT receiving Opzelura in combination with another biologic medication [e.g., Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)] nor JAK inhibitor [e.g., Jakafi (ruxolitinib, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

3 - Patient is NOT receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

Orencia

Prior Authorization Guideline

Guideline ID	GL-155146
Guideline Name	Orencia
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Orencia	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML	6640001000E510	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML	6640001000E515	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML	6640001000E520	Brand

ORENCIA CLICKJECT	ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML	6640001000D520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis

AND

1.2 One of the following:

1.2.1 Failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.4 ONE of the following:

1.4.1 Failure of THREE of the following confirmed by claims history or submitted medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)
- Olumiant (baricitinib)

OR

1.4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)
- Olumiant (baricitinib)

AND

1.5 Prescribed by, or in consultation with, a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Orencia therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of moderately to severely active rheumatoid arthritis

AND

2.3 Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.4 Prescribed by, or in consultation with, a rheumatologist

Notes	*For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Orencia	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML	6640001000E510	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML	6640001000E515	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML	6640001000E520	Brand
ORENCIA CLICKJECT	ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML	6640001000D520	Brand

Approval Criteria

1 - Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis

AND

2 - Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - ONE of the following:

3.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

3.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

3.3 Patient is currently on Orencia therapy as confirmed by claims history or submitted medical records

AND

4 - Prescribed by, or in consultation with, a rheumatologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Orencia

Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML	6640001000E510	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML	6640001000E515	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML	6640001000E520	Brand
ORENCIA CLICKJECT	ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML	6640001000D520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Orencia therapy

AND

2 - Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

Product Name: Orencia	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML	6640001000E510	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML	6640001000E515	Brand

ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML	6640001000E520	Brand
ORENCIA CLICKJECT	ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML	6640001000D520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]]

AND

1.3 Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

1.4 BOTH of the following:

1.4.1 ONE of the following:

1.4.1.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab pegol)

OR

1.4.1.2 History of intolerance or contraindication ALL of the following (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab pegol)

AND

1.4.2 One of the following:

1.4.2.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

OR

1.4.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

AND

1.5 Prescribed by, or in consultation with, ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Orencia therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is not receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	*For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Orencia	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML	6640001000E510	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML	6640001000E515	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML	6640001000E520	Brand
ORENCIA CLICKJECT	ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML	6640001000D520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Orencia therapy

AND

2 - Patient is NOT receiving Orencia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

2 . Background

Benefit/Coverage/Program Information
PDL Link NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
9/17/2024	Updated step through agents to include Tyenne. Updated safety lang uage with new examples and therefore reformatted reauth sections.

Orfadin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146605
Guideline Name	Orfadin
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Orfadin, generic nitisinone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NITISINONE	NITISINONE CAP 2 MG	30904045000110	Generic
ORFADIN	NITISINONE CAP 2 MG	30904045000110	Brand
NITISINONE	NITISINONE CAP 5 MG	30904045000120	Generic
ORFADIN	NITISINONE CAP 5 MG	30904045000120	Brand
NITISINONE	NITISINONE CAP 10 MG	30904045000130	Generic

ORFADIN	NITISINONE CAP 10 MG	30904045000130	Brand
ORFADIN	NITISINONE CAP 20 MG	30904045000140	Brand
NITISINONE	NITISINONE CAP 20 MG	30904045000140	Generic
ORFADIN	NITISINONE SUSP 4 MG/ML	30904045001820	Brand

Approval Criteria

1 - Diagnosis of hereditary tyrosinemia type 1

AND

2 - Special clinical circumstances exist that precludes the use of Nityr (nitisinone) tablets for the patient (document special clinical circumstance)

Product Name: Brand Orfadin, generic nitisinone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
NITISINONE	NITISINONE CAP 2 MG	30904045000110	Generic
ORFADIN	NITISINONE CAP 2 MG	30904045000110	Brand
NITISINONE	NITISINONE CAP 5 MG	30904045000120	Generic
ORFADIN	NITISINONE CAP 5 MG	30904045000120	Brand
NITISINONE	NITISINONE CAP 10 MG	30904045000130	Generic
ORFADIN	NITISINONE CAP 10 MG	30904045000130	Brand
ORFADIN	NITISINONE CAP 20 MG	30904045000140	Brand
NITISINONE	NITISINONE CAP 20 MG	30904045000140	Generic
ORFADIN	NITISINONE SUSP 4 MG/ML	30904045001820	Brand

Approval Criteria

1 - Patient shows evidence of positive clinical response (e.g., decrease in urinary/plasma succinylacetone and alpha-1-microglobulin levels) while on Orfadin therapy

Orgovyx

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146606
Guideline Name	Orgovyx
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Orgovyx	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORGOVYX	RELUGOLIX TAB 120 MG	21405570000320	Brand

Approval Criteria

1 - Diagnosis of advanced prostate cancer

AND

2 - Patient is a candidate for at least one year of continuous androgen-deprivation therapy

AND

3 - ONE of the following:

- Evidence of biochemical [PSA (prostate-specific antigen)] or clinical relapse after local primary intervention with curative intent
- Newly diagnosed hormone-sensitive metastatic disease
- Advanced localized disease unlikely to be cured by local primary intervention with curative intent

AND

4 - Patient has been without any major adverse cardiovascular events within 6 months before initiation (e.g., myocardial infarction, stroke)

Product Name: Orgovyx	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORGOVYX	RELUGOLIX TAB 120 MG	21405570000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Orgovyx	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORGOVYX	RELUGOLIX TAB 120 MG	21405570000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Orgovyx	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORGOVYX	RELUGOLIX TAB 120 MG	21405570000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Orgovyx therapy

Oriahnn_MyFembree

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146385
Guideline Name	Oriahnn_MyFembree
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Oriahnn, MyFembree	
Diagnosis	Uterine Fibroids
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORIAHNN	ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK	2499350340B220	Brand
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Diagnosis of uterine fibroids (leiomyomas)

AND

2 - Used for the management of heavy menstrual bleeding

AND

3 - ONE of the following:

3.1 Failure after a three-month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Estrogen/progestin contraceptive (e.g., Loestrin FE)
- Progestin-releasing intrauterine devices (IUDs) (e.g., Mirena)*
- Progestin-only contraceptive [e.g., norethindrone (generic Aygestin)]

OR

3.2 Contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Estrogen/progestin contraceptive (e.g., Loestrin FE)
- Progestin-releasing intrauterine devices (IUDs) (e.g., Mirena)*
- Progestin-only contraceptive [e.g., norethindrone (generic Aygestin)]

AND

4 - ONE of the following:

4.1 Failure after a three-month trial of tranexamic acid (e.g., Lysteda) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to tranexamic acid (e.g., Lysteda) (please specify contraindication or intolerance)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Notes	*This is a medical benefit, should not be included in denial to provider.

Product Name: Oriahnn, MyFembree	
Diagnosis	Uterine Fibroids
Approval Length	12 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORIAHNN	ELAGOLIX-ESTRAD-NORETH 300-1-0.5MG & ELAGOLIX 300MG CAP PACK	2499350340B220	Brand
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months*	
Notes	*Authorization will be issued for 12 months up to a maximum treatmen t duration of 24 months. Oriahnn and MyFembree are indicated for a maximum treatment duration of 24 months.

Product Name: MyFembree	
Diagnosis	Pain Associated with Endometriosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three-month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to a three-month trial of ONE of the following, as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Notes	*This is a medical benefit, should not be included in denial to provider.

Product Name: MyFembree	
Diagnosis	Pain Associated with Endometriosis
Approval Length	12 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MYFEMBREE	RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TAB 40-1-0.5 MG	24993503800320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy **AND** **2** - Impact to bone mineral density has been considered **AND** **3** - Treatment duration has not exceeded a total of 24 months*	
Notes	*Authorization will be issued for 12 months up to a maximum treatment duration of 24 months. MyFembree are indicated for a maximum treatment duration of 24 months.

Orilissa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146387
Guideline Name	Orilissa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Orilissa 150 mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 150 MG (BASE EQUIV)	30090030100320	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify contraindication or intolerance)

AND

3 - ONE of the following:

3.1 Failure to a three month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance)

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Treatment duration of Orilissa 150 mg once daily has not exceeded a total of 24 months, as confirmed by claims history or submission of medical records

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Product Name: Orilissa 150 mg	
Approval Length	12 months up to a maximum treatment duration of 24 months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 150 MG (BASE EQUIV)	30090030100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months, as confirmed by claims history or submission of medical records

Product Name: Orilissa 200 mg	
Approval Length	Up to a maximum of 6 months
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORILISSA	ELAGOLIX SODIUM TAB 200 MG (BASE EQUIV)	30090030100330	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 Failure (e.g., inadequate pain relief) to a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen), as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to TWO analgesics (e.g., ibuprofen, meloxicam, naproxen) (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure after a three month trial to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Hormonal contraceptives

- Progestins [e.g., norethindrone (generic Aygestin)]

AND

4 - Treatment duration of Orilissa 200 mg twice daily has not exceeded a total of 6 months, as confirmed by claims history or submission of medical records

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Orkambi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151772
Guideline Name	Orkambi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Orkambi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORKAMBI	LUMACAFTOR-IVACAFTOR GRANULES PACKET 100-125 MG	45309902303010	Brand
ORKAMBI	LUMACAFTOR-IVACAFTOR GRANULES PACKET 150-188 MG	45309902303020	Brand
ORKAMBI	LUMACAFTOR-IVACAFTOR TAB 100-125 MG	45309902300310	Brand
ORKAMBI	LUMACAFTOR-IVACAFTOR TAB 200-125 MG	45309902300320	Brand

ORKAMBI	LUMACAFTOR-IVACAFTOR GRANULES PACKET 75-94 MG	45309902303005	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results confirming that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - The patient is greater than or equal to 1 years of age

AND

4 - Prescribed by, or in consultation with, a provider who specializes in the treatment of CF

Product Name: Orkambi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORKAMBI	LUMACAFTOR-IVACAFTOR GRANULES PACKET 100-125 MG	45309902303010	Brand
ORKAMBI	LUMACAFTOR-IVACAFTOR GRANULES PACKET 150-188 MG	45309902303020	Brand
ORKAMBI	LUMACAFTOR-IVACAFTOR TAB 100-125 MG	45309902300310	Brand
ORKAMBI	LUMACAFTOR-IVACAFTOR TAB 200-125 MG	45309902300320	Brand
ORKAMBI	LUMACAFTOR-IVACAFTOR GRANULES PACKET 75-94 MG	45309902303005	Brand

Approval Criteria

1 - Documentation of positive clinical response to Orkambi therapy (e.g., improved lung function, stable lung function)

2 . Revision History

Date	Notes
8/14/2024	Removed prescriber requirement from reauthorization criteria

Orladeyo

Prior Authorization Guideline

Guideline ID	GL-147208
Guideline Name	Orladeyo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Orladeyo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORLADEYO	BEROTRALSTAT HCL CAP 110 MG	85840010200120	Brand
ORLADEYO	BEROTRALSTAT HCL CAP 150 MG	85840010200130	Brand

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown

AND

2 - ALL of the following:

2.1 Prescribed for the prophylaxis of HAE attacks

AND

2.2 Not used in combination with other approved products indicated for prophylaxis against HAE attacks (i.e., Cinryze, Haegarda, Takhzyro)

AND

2.3 Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Orladeyo

AND

3 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

4 - ONE of the following:

4.1 Failure to Haegarda as confirmed by history or submission of medical records

OR

4.2 History of contraindication, or intolerance to Haegarda (please specify a contraindication or intolerance)

OR

4.3 Patient is unable to self-inject Haegarda due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure [refer to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) for specific phobia diagnostic criteria]

OR

4.4 Patient is currently on Orladeyo therapy, as confirmed by claims history or submission of medical records

Product Name: Orladeyo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORLADEYO	BEROTRALSTAT HCL CAP 110 MG	85840010200120	Brand
ORLADEYO	BEROTRALSTAT HCL CAP 150 MG	85840010200130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Orladeyo therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest), as confirmed by claims history or submission of medical records, while on Orladeyo therapy

AND

3 - BOTH of the following:

3.1 Prescribed for the prophylaxis of HAE attacks

AND

3.2 Not used in combination with other products indicated for prophylaxis against HAE attacks (i.e., Cinryze, Haegarda, Takhzyro)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
5/9/2024	Update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated and simplified reauthorization criteria.

Orserdu

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147251
Guideline Name	Orserdu
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Orserdu	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 86 MG	21403720100320	Brand
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 345 MG	21403720100340	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - ONE of the following:

- Advanced
- Metastatic

AND

3 - Disease is estrogen receptor (ER)-positive

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - Presence of an ESR1 gene mutation

AND

6 - Patient is ONE of the following:

- Postmenopausal woman
- Male
- Premenopausal woman treated with ovarian ablation/suppression

AND

7 - Disease has progressed following at least one line of endocrine therapy

Product Name: Orserdu	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 86 MG	21403720100320	Brand
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 345 MG	21403720100340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Orserdu therapy

Product Name: Orserdu	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 86 MG	21403720100320	Brand
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 345 MG	21403720100340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Orserdu	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 86 MG	21403720100320	Brand
ORSERDU	ELACESTRANT HYDROCHLORIDE TAB 345 MG	21403720100340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Orserdu therapy

2 . Revision History

Date	Notes
5/10/2024	Specified postmenopausal “woman” and added premenopausal wom an treated with ovarian ablation/suppression to coverage criteria per NCCN.

Osphena

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146849
Guideline Name	Osphena
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Osphena	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OSPHENA	OSPEMIFENE TAB 60 MG	30053050000330	Brand

Approval Criteria

1 - Treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy (VVA), due to menopause*

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Estradiol vaginal cream
- Estradiol vaginal tablet

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Estradiol vaginal cream
- Estradiol vaginal tablet

Notes	*Treatment of dyspareunia is a benefit exclusion.

Product Name: Osphena	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OSPHENA	OSPEMIFENE TAB 60 MG	30053050000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
4/30/2024	Removed reference to other states in GL name

Otezla

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151733
Guideline Name	Otezla
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Otezla	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OTEZLA	APREMILAST TAB 30 MG	66700015000330	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG	6670001500B720	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG	6670001500B710	Brand

OTEZLA	APREMILAST TAB 20 MG	66700015000320	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 One of the following:

1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose, as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Skyrizi (risankizumab-rzaa)]

AND

1.3 Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Otezla therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Otezla	
Diagnosis	Plaque Psoriasis

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OTEZLA	APREMILAST TAB 30 MG	66700015000330	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG	6670001500B720	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG	6670001500B710	Brand
OTEZLA	APREMILAST TAB 20 MG	66700015000320	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of plaque psoriasis in those who are candidates for phototherapy or systemic therapy

AND

1.2 One of the following:

1.2.1 All of the following:

1.2.1.1 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.2.1.2 One of the following:

1.2.1.2.1 Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication)

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.2.1.3 One of the following:

1.2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

1.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

AND

1.3 Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx

(secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.4 Prescribed by or in consultation with a dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Otezla therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of plaque psoriasis in those who are candidates for phototherapy or systemic therapy

AND

2.3 Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.4 Prescribed by or in consultation with a dermatologist

Product Name: Otezla	
Diagnosis	Behcet's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OTEZLA	APREMILAST TAB 30 MG	66700015000330	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG	6670001500B720	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG	6670001500B710	Brand
OTEZLA	APREMILAST TAB 20 MG	66700015000320	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of Behcet's Disease

AND

1.2 Patient has active oral ulcers attributed to Behcet's Disease

AND

1.3 One of the following:

1.3.1 Failure to one non-biologic (e.g., corticosteroids, colchicine) used for treating Behcet's Disease, as confirmed by claims history or submission of medical records

OR

1.3.2 History of contraindication or intolerance to one non-biologic (e.g., corticosteroids, colchicine) used for treating Behcet's Disease (please specify contraindication or intolerance)

OR

1.3.3 Patient has been previously treated with a biologic disease-modifying antirheumatic

drug (DMARD) used for the treatment of Behcet's Disease as confirmed by claims history or submission of medical records [e.g., Remicade (infliximab), adalimumab, Enbrel (etanercept)]

AND

1.4 Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.5 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - All of the following:

2.1 Patient is currently on Otezla therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of Behcet's Disease

AND

2.3 Patient has active oral ulcers attributed to Behcet's Disease

AND

2.4 Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept),

adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.5 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Product Name: Otezla	
Diagnosis	Psoriatic Arthritis, Behcet's Disease, Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OTEZLA	APREMILAST TAB 30 MG	66700015000330	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG	6670001500B720	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG	6670001500B710	Brand
OTEZLA	APREMILAST TAB 20 MG	66700015000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Otezla therapy

AND

2 - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

Oxbryta

Prior Authorization Guideline

Guideline ID	GL-146611
Guideline Name	Oxbryta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Oxbryta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXBRYTA	VOXELOTOR TAB 300 MG	82805080000310	Brand
OXBRYTA	VOXELOTOR TAB 500 MG	82805080000320	Brand
OXBRYTA	VOXELOTOR TAB FOR ORAL SUSP 300 MG	82805080007320	Brand

Approval Criteria

1 - Diagnosis of sickle cell disease

AND

2 - Patient is at least 4 years of age

AND

3 - ONE of the following:

3.1 Patient is currently receiving hydroxyurea therapy

OR

3.2 Failure to hydroxyurea therapy as confirmed by claims history or submission of medical records

OR

3.3 History of contraindication or intolerance to hydroxyurea therapy (please specify contraindication or intolerance)

AND

4 - Patient has previously experienced 1 or more sickle cell-related vaso-occlusive crises within the previous 12 months

AND

5 - Baseline hemoglobin (Hb) is less than or equal to 10.5 g/dL (grams/deciliter)

AND

6 - Patient is not receiving concomitant chronic, prophylactic blood transfusion therapy

AND

7 - Patient is not to receive Oxbryta in combination with Adakveo (crizanlizumab-tmca)

AND

8 - Prescribed by, or in consultation with, a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease

Product Name: Oxbryta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXBRYTA	VOXELOTOR TAB 300 MG	82805080000310	Brand
OXBRYTA	VOXELOTOR TAB 500 MG	82805080000320	Brand
OXBRYTA	VOXELOTOR TAB FOR ORAL SUSP 300 MG	82805080007320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Oxbryta therapy as demonstrated by at least ONE of the following:

1.1 Increase in hemoglobin (Hb) by greater than or equal to 1 g/dL (gram/deciliter) from baseline

OR

1.2 Decrease in indirect bilirubin from baseline

OR

1.3 Decrease in percent reticulocyte count from baseline

OR

1.4 Patient has experienced a reduction in sickle cell-related vaso-occlusive crises

AND

2 - Patient is not receiving Oxbryta in combination with Adakveo (crizanlizumab-tmca)

AND

3 - Patient is not receiving concomitant chronic, prophylactic blood transfusion therapy

AND

4 - Prescribed by, or in consultation with a hematologist, or other specialist with expertise in the diagnosis and management of sickle cell disease

Oxervate

Prior Authorization Guideline

Guideline ID	GL-146612
Guideline Name	Oxervate
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Oxervate	
Diagnosis	Neurotrophic keratitis
Approval Length	8 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OXERVATE	CENEGERMIN-BKBJ OPHTH SOLN 0.002% (20 MCG/ML)	86770020202020	Brand

Approval Criteria

1 - Diagnosis of Stage 2 or 3 neurotrophic keratitis

AND

2 - Failure to at least ONE OTC (over the counter) ocular artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP) as confirmed by claims history or submission of medical records

AND

3 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist

PAH

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151105
Guideline Name	PAH
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/7/2024

1 . Criteria

Product Name: Adempas, Brand Letairis, generic ambrisentan, Opsumit, generic sildenafil 20 mg, Brand Revatio tabs/susp, generic sildenafil susp, Tracleer, generic bosentan	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADEMPAS	RIOCIGUAT TAB 0.5 MG	40134050000310	Brand
ADEMPAS	RIOCIGUAT TAB 1 MG	40134050000320	Brand
ADEMPAS	RIOCIGUAT TAB 1.5 MG	40134050000330	Brand
ADEMPAS	RIOCIGUAT TAB 2 MG	40134050000340	Brand

ADEMPAS	RIOCIGUAT TAB 2.5 MG	40134050000350	Brand
LETAIRIS	AMBRISENTAN TAB 5 MG	40160007000310	Brand
AMBRISENTAN	AMBRISENTAN TAB 5 MG	40160007000310	Generic
LETAIRIS	AMBRISENTAN TAB 10 MG	40160007000320	Brand
AMBRISENTAN	AMBRISENTAN TAB 10 MG	40160007000320	Generic
OPSUMIT	MACITENTAN TAB 10 MG	40160050000320	Brand
SILDENAFIL CITRATE	SILDENAFIL CITRATE TAB 20 MG	40143060100320	Generic
REVATIO	SILDENAFIL CITRATE TAB 20 MG	40143060100320	Brand
SILDENAFIL CITRATE	SILDENAFIL CITRATE FOR SUSPENSION 10 MG/ML	40143060101920	Generic
REVATIO	SILDENAFIL CITRATE FOR SUSPENSION 10 MG/ML	40143060101920	Brand
TRACLEER	BOSENTAN TAB 62.5 MG	40160015000320	Brand
BOSENTAN	BOSENTAN TAB 62.5 MG	40160015000320	Generic
TRACLEER	BOSENTAN TAB 125 MG	40160015000330	Brand
BOSENTAN	BOSENTAN TAB 125 MG	40160015000330	Generic
TRACLEER	BOSENTAN TAB FOR ORAL SUSP 32 MG	40160015007320	Brand
SILDENAFIL	SILDENAFIL CITRATE FOR SUSPENSION 10 MG/ML	40143060101920	Generic

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension (PAH)

Product Name: Brand Adcirca, Alyq, generic tadalafil (PAH, generic of Adcirca)	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADCIRCA	TADALAFIL TAB 20 MG (PAH)	40143080000320	Brand
ALYQ	TADALAFIL TAB 20 MG (PAH)	40143080000320	Generic

TADALAFIL	TADALAFIL TAB 20 MG (PAH)	40143080000320	Generic

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

2.1.1 ONE of the following:

- A PDE-5 inhibitor (phosphodiesterase-5) [e.g., sildenafil citrate (Revatio)]
- Adempas

AND

2.1.2 An ERA (endothelin receptor antagonist) [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

2.2.1 ONE of the following:

- A PDE-5 inhibitor [e.g., sildenafil citrate (Revatio)]
- Adempas

AND

2.2.2 An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

Product Name: Liqrev, Tadliq	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LIQREV	SILDENAFIL CITRATE ORAL SUSP 10 MG/ML	40143060101825	Brand
TADLIQ	TADALAFIL ORAL SUSP 20 MG/5ML (PAH)	40143080001820	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

2.1.1 ONE of the following:

- sildenafil citrate oral suspension (generic Revatio)
- Adempas

AND

2.1.2 An ERA (endothelin receptor antagonist) [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

2.2.1 ONE of the following:

- A PDE-5 inhibitor (e.g., sildenafil citrate (Revatio))
- Adempas

AND

2.2.2 An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

Product Name: Opsynvi	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OPSYNVI	MACITENTAN-TADALAFIL TAB 10-20 MG	40995502500310	Brand

OPSYNVI	MACITENTAN-TADALAFIL TAB 10-40 MG	40995502500320	Brand

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2 - Failure to BOTH of the following taken together as confirmed by claims history or submission of medical records:

- Sildenafil citrate (generic Revatio)
- A preferred ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

Product Name: Orenitram, Tyvaso DPI, Uptravi titration pack, Uptravi tabs	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 0.125 MG (BASE EQUIV)	40170080050410	Brand
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 0.25 MG (BASE EQUIV)	40170080050415	Brand

ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 1 MG (BASE EQUIV)	40170080050420	Brand
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 2.5 MG (BASE EQUIV)	40170080050425	Brand
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 5 MG (BASE EQUIV)	40170080050435	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG	40170080002970	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG	40170080002980	Brand
UPTRAVI TITRATION PACK	SELEXIPAG TAB THERAPY PACK 200 MCG (140) & 800 MCG (60)	4012007000B720	Brand
UPTRAVI	SELEXIPAG TAB 200 MCG	40120070000310	Brand
UPTRAVI	SELEXIPAG TAB 400 MCG	40120070000315	Brand
UPTRAVI	SELEXIPAG TAB 600 MCG	40120070000320	Brand
UPTRAVI	SELEXIPAG TAB 800 MCG	40120070000325	Brand
UPTRAVI	SELEXIPAG TAB 1000 MCG	40120070000330	Brand
UPTRAVI	SELEXIPAG TAB 1200 MCG	40120070000335	Brand
UPTRAVI	SELEXIPAG TAB 1400 MCG	40120070000340	Brand
UPTRAVI	SELEXIPAG TAB 1600 MCG	40120070000345	Brand
ORENITRAM TITRATION KIT MONTH 1	TREPROSTINIL TAB ER TITR PK (MO1) 126 X0.125MG & 42 X0.25MG	4017008005C110	Brand
ORENITRAM TITRATION KIT MONTH 2	TREPROSTINIL TAB ER TITR PK (MO2) 126 X0.125MG & 210 X0.25MG	4017008005C120	Brand
ORENITRAM TITRATION KIT MONTH 3	TREPROSTINIL TAB ER TITR PK(MO3)126X0.125MG&42X0.25MG&84X1MG	4017008005C130	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand

TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand

Approval Criteria

1 - ALL of the following:

1.1 As continuation of therapy

AND

1.2 Patient is not taking the requested medication in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

AND

1.3 Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 BOTH of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

2.1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2.2 ONE of the following:

2.2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

2.2.1.1 ONE of the following:

- A PDE-5 inhibitor (phosphodiesterase-5) [e.g. sildenafil citrate (generic Revatio)]
- Adempas

AND

2.2.1.2 An ERA (endothelin receptor antagonist) [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

OR

2.2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

2.2.2.1 ONE of the following:

- A PDE-5 inhibitor [e.g., sildenafil citrate (generic Revatio)]
- Adempas

AND

2.2.2.2 An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

AND

2.3 Patient is not taking the requested medication in combination with a

prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil) as long-term concomitant therapy*	
Notes	*Concomitant use will be allowable for patients to transition from one of these agents to the other.

Product Name: Brand Adcirca, Alyq, generic tadalafil (PAH, generic of Adcirca), Tadliq, Liqrev, Opsynvi	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADCIRCA	TADALAFIL TAB 20 MG (PAH)	40143080000320	Brand
ALYQ	TADALAFIL TAB 20 MG (PAH)	40143080000320	Generic
TADALAFIL	TADALAFIL TAB 20 MG (PAH)	40143080000320	Generic
TADLIQ	TADALAFIL ORAL SUSP 20 MG/5ML (PAH)	40143080001820	Brand
LIQREV	SILDENAFIL CITRATE ORAL SUSP 10 MG/ML	40143060101825	Brand
OPSYNVI	MACITENTAN-TADALAFIL TAB 10-20 MG	40995502500310	Brand
OPSYNVI	MACITENTAN-TADALAFIL TAB 10-40 MG	40995502500320	Brand

Approval Criteria

1 - Documentation the patient is receiving clinical benefit to therapy

Product Name: Orenitram, Tyvaso DPI, Uptravi titration pack, Uptravi tabs	
Diagnosis	Pulmonary Arterial Hypertension (PAH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 0.125 MG (BASE EQUIV)	40170080050410	Brand
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 0.25 MG (BASE EQUIV)	40170080050415	Brand
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 1 MG (BASE EQUIV)	40170080050420	Brand
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 2.5 MG (BASE EQUIV)	40170080050425	Brand
ORENITRAM	TREPROSTINIL DIOLAMINE TAB ER 5 MG (BASE EQUIV)	40170080050435	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG	40170080002970	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG	40170080002980	Brand
UPTRAVI TITRATION PACK	SELEXIPAG TAB THERAPY PACK 200 MCG (140) & 800 MCG (60)	4012007000B720	Brand
UPTRAVI	SELEXIPAG TAB 200 MCG	40120070000310	Brand
UPTRAVI	SELEXIPAG TAB 400 MCG	40120070000315	Brand
UPTRAVI	SELEXIPAG TAB 600 MCG	40120070000320	Brand
UPTRAVI	SELEXIPAG TAB 800 MCG	40120070000325	Brand
UPTRAVI	SELEXIPAG TAB 1000 MCG	40120070000330	Brand
UPTRAVI	SELEXIPAG TAB 1200 MCG	40120070000335	Brand
UPTRAVI	SELEXIPAG TAB 1400 MCG	40120070000340	Brand
UPTRAVI	SELEXIPAG TAB 1600 MCG	40120070000345	Brand
ORENITRAM TITRATION KIT MONTH 1	TREPROSTINIL TAB ER TITR PK (MO1) 126 X0.125MG & 42 X0.25MG	4017008005C110	Brand
ORENITRAM TITRATION KIT MONTH 2	TREPROSTINIL TAB ER TITR PK (MO2) 126 X0.125MG & 210 X0.25MG	4017008005C120	Brand

ORENITRAM TITRATION KIT MONTH 3	TREPROSTINIL TAB ER TITR PK(MO3)126X0.125MG&42X0.25MG&84X1MG	4017008005C130	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand

Approval Criteria

1 - Documentation the patient is receiving clinical benefit to therapy

AND

2 - Patient is not taking the requested medication in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

Product Name: Adempas	
Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ADEMPAS	RIOCIGUAT TAB 0.5 MG	40134050000310	Brand
ADEMPAS	RIOCIGUAT TAB 1 MG	40134050000320	Brand
ADEMPAS	RIOCIGUAT TAB 1.5 MG	40134050000330	Brand
ADEMPAS	RIOCIGUAT TAB 2 MG	40134050000340	Brand
ADEMPAS	RIOCIGUAT TAB 2.5 MG	40134050000350	Brand

Approval Criteria

1 - Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)

Product Name: Tyvaso DPI	
Diagnosis	Pulmonary Hypertension Associated with Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG	40170080002970	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG	40170080002980	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of pulmonary hypertension associated with interstitial lung disease [WHO (World Health Organization) group 3] confirmed by right heart catheterization

AND

1.2 Interstitial lung disease is diagnosed based on evidence of diffuse parenchymal lung disease on computed tomography of the chest

AND

1.3 Pulmonary hypertension is symptomatic

AND

2 - Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist

Product Name: Tyvaso DPI	
Diagnosis	Pulmonary Hypertension Associated with Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand

TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI MAINTENANCE KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWDER 112 X 16MCG & 84 X 32MCG	40170080002970	Brand
TYVASO DPI TITRATION KIT	TREPROSTINIL INH POWD 112 X 16MCG & 112 X 32MCG & 28 X 48MCG	40170080002980	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 16 MCG/CARTRIDGE	40170080002920	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 32 MCG/CARTRIDGE	40170080002930	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 48 MCG/CARTRIDGE	40170080002940	Brand
TYVASO DPI INSTITUTIONAL KIT	TREPROSTINIL INH POWDER 64 MCG/CARTRIDGE	40170080002950	Brand

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy (e.g., improved exercise ability)

2 . Revision History

Date	Notes
8/6/2024	Copy core

Palforzia

Prior Authorization Guideline

Guideline ID	GL-146614
Guideline Name	Palforzia
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PALFORZIA INITIAL DOSE ESCALATION	PEANUT POWDER-DNFP STARTER PACK 0.5 & 1 & 1.5 & 3 & 6 MG	2010004020H510	Brand
PALFORZIA LEVEL 1	PEANUT POWDER-DNFP CAP SPRINKLE PACK 3 X 1 MG (3 MG DOSE)	2010004020H525	Brand
PALFORZIA LEVEL 2	PEANUT POWDER-DNFP CAP SPRINKLE PACK 6 X 1 MG (6 MG DOSE)	2010004020H530	Brand

PALFORZIA LEVEL 3	PEANUT POWDER-DNFP PACK 2 X 1 MG & 10 MG (12 MG DOSE)	2010004020H535	Brand
PALFORZIA LEVEL 4	PEANUT POWDER-DNFP CAP SPRINKLE PACK 20 MG (20 MG DOSE)	2010004020H540	Brand
PALFORZIA LEVEL 5	PEANUT POWDER-DNFP CAP SPRINKLE PACK 2 X 20 MG (40 MG DOSE)	2010004020H545	Brand
PALFORZIA LEVEL 6	PEANUT POWDER-DNFP CAP SPRINKLE PACK 4 X 20 MG (80 MG DOSE)	2010004020H550	Brand
PALFORZIA LEVEL 7	PEANUT POWDER-DNFP PACK 20 MG & 100 MG (120 MG DOSE)	2010004020H555	Brand
PALFORZIA LEVEL 8	PEANUT POWDER-DNFP PACK 3 X 20 MG & 100 MG (160 MG DOSE)	2010004020H560	Brand
PALFORZIA LEVEL 9	PEANUT POWDER-DNFP PACK 2 X 100 MG (200 MG DOSE)	2010004020H565	Brand
PALFORZIA LEVEL 10	PEANUT POWDER-DNFP PACK 2 X 20 MG & 2 X 100 MG (240 MG DOSE)	2010004020H570	Brand
PALFORZIA LEVEL 11 (TITRATION)	PEANUT ALLERGEN POWDER-DNFP TITRATION PACKET 300 MG	20100040203030	Brand
PALFORZIA LEVEL 11 (MAINTENANCE)	PEANUT ALLERGEN POWDER-DNFP MAINTENANCE PACKET 300 MG	20100040203050	Brand

Approval Criteria

1 - Diagnosis and clinical history of peanut allergy as documented by BOTH of the following:

1.1 A serum peanut-specific IgE (immunoglobulin E) level of greater than or equal to 0.35 kUA/L (kilounits of allergen/liter)

AND

1.2 A mean wheal diameter that is at least 3 mm (millimeters) larger than the negative control on skin-prick testing for peanut

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is 4 to 17 years of age

- Patient is in the initial dose escalation phase of therapy

OR

2.2 BOTH of the following:

- Patient is 4 years of age and older
- Patient is in the up-dosing or maintenance phase of therapy

AND

3 - Used in conjunction with a peanut-avoidant diet

AND

4 - Patient does not have any of the following:

- History of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease
- History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months
- Severe or poorly controlled asthma

AND

5 - Prescribed by or in consultation with an allergist/immunologist

AND

6 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PALFORZIA INITIAL DOSE ESCALATION	PEANUT POWDER-DNFP STARTER PACK 0.5 & 1 & 1.5 & 3 & 6 MG	2010004020H510	Brand
PALFORZIA LEVEL 1	PEANUT POWDER-DNFP CAP SPRINKLE PACK 3 X 1 MG (3 MG DOSE)	2010004020H525	Brand
PALFORZIA LEVEL 2	PEANUT POWDER-DNFP CAP SPRINKLE PACK 6 X 1 MG (6 MG DOSE)	2010004020H530	Brand
PALFORZIA LEVEL 3	PEANUT POWDER-DNFP PACK 2 X 1 MG & 10 MG (12 MG DOSE)	2010004020H535	Brand
PALFORZIA LEVEL 4	PEANUT POWDER-DNFP CAP SPRINKLE PACK 20 MG (20 MG DOSE)	2010004020H540	Brand
PALFORZIA LEVEL 5	PEANUT POWDER-DNFP CAP SPRINKLE PACK 2 X 20 MG (40 MG DOSE)	2010004020H545	Brand
PALFORZIA LEVEL 6	PEANUT POWDER-DNFP CAP SPRINKLE PACK 4 X 20 MG (80 MG DOSE)	2010004020H550	Brand
PALFORZIA LEVEL 7	PEANUT POWDER-DNFP PACK 20 MG & 100 MG (120 MG DOSE)	2010004020H555	Brand
PALFORZIA LEVEL 8	PEANUT POWDER-DNFP PACK 3 X 20 MG & 100 MG (160 MG DOSE)	2010004020H560	Brand
PALFORZIA LEVEL 9	PEANUT POWDER-DNFP PACK 2 X 100 MG (200 MG DOSE)	2010004020H565	Brand
PALFORZIA LEVEL 10	PEANUT POWDER-DNFP PACK 2 X 20 MG & 2 X 100 MG (240 MG DOSE)	2010004020H570	Brand
PALFORZIA LEVEL 11 (TITRATION)	PEANUT ALLERGEN POWDER-DNFP TITRATION PACKET 300 MG	20100040203030	Brand
PALFORZIA LEVEL 11 (MAINTENANCE)	PEANUT ALLERGEN POWDER-DNFP MAINTENANCE PACKET 300 MG	20100040203050	Brand

Approval Criteria

1 - Documentation of positive clinical response to Palforzia therapy

AND

2 - Used in conjunction with a peanut-avoidant diet

AND

3 - Prescribed by or in consultation with an allergist/immunologist

AND

4 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

Palynziq

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155065
Guideline Name	Palynziq
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PALYNZIQ	PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 2.5 MG/0.5ML	3090855040E510	Brand
PALYNZIQ	PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 10 MG/0.5ML	3090855040E520	Brand
PALYNZIQ	PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 20 MG/ML	3090855040E530	Brand

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Patient is actively on a phenylalanine-restricted diet

AND

3 - ONE of the following:

3.1 Failure to a one- to four-week trial of sapropterin as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to sapropterin therapy (please specify contraindication or intolerance)

AND

4 - Physician attestation that the patient will not be receiving Palynziq in combination with sapropterin dihydrochloride

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration greater than 600 micromoles/liter

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PALYNZIQ	PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 2.5 MG/0.5ML	3090855040E510	Brand
PALYNZIQ	PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 10 MG/0.5ML	3090855040E520	Brand
PALYNZIQ	PEGVALIASE-PQPZ SUBCUTANEOUS SOLN PREF SYRINGE 20 MG/ML	3090855040E530	Brand

Approval Criteria

1 - Patient is actively on a phenylalanine-restricted diet

AND

2 - ONE of the following:

2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration less than 600 micromoles/liter

OR

2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has achieved a 20% reduction in blood phenylalanine concentration from pre-treatment baseline

OR

2.3 Patient is in initial titration/maintenance phase of dosing regimen and dose is being titrated based on blood phenylalanine concentration response up to maximum labeled dosage of 60 milligrams once daily

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Palynziq in combination with sapropterin dihydrochloride (Prescription

claim history that does not show any concomitant sapropterin dihydrochloride claim within 60 days of reauthorization request may be used as documentation)

2 . Revision History

Date	Notes
9/17/2024	Updated authorization durations to 12 months

Panretin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146389
Guideline Name	Panretin
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Panretin	
Diagnosis	Kaposi’s Sarcoma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PANRETIN	ALITRETINOIN GEL 0.1%	90376015004020	Brand

Approval Criteria

1 - Diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi’s Sarcoma (KS)

AND

2 - Patient is not receiving systemic anti-KS treatment

Product Name: Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PANRETIN	ALITRETINOIN GEL 0.1%	90376015004020	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PANRETIN	ALITRETINOIN GEL 0.1%	90376015004020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Panretin therapy

Pemazyre

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146616
Guideline Name	Pemazyre
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Pemazyre	
Diagnosis	Cholangiocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PEMAZYRE	PEMIGATINIB TAB 4.5 MG	21532260000320	Brand
PEMAZYRE	PEMIGATINIB TAB 9 MG	21532260000330	Brand
PEMAZYRE	PEMIGATINIB TAB 13.5 MG	21532260000340	Brand

Approval Criteria

1 - Diagnosis of cholangiocarcinoma

AND

2 - Disease is ONE of the following:

- Unresectable locally advanced
- Metastatic

AND

3 - Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement

AND

4 - Patient has been previously treated

Product Name: Pemazyre	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PEMAZYRE	PEMIGATINIB TAB 4.5 MG	21532260000320	Brand
PEMAZYRE	PEMIGATINIB TAB 9 MG	21532260000330	Brand
PEMAZYRE	PEMIGATINIB TAB 13.5 MG	21532260000340	Brand

Approval Criteria

1 - Diagnosis of myeloid/lymphoid/mixed lineage neoplasms with eosinophilia

AND

2 - Disease has presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement

Product Name: Pemazyre	
Diagnosis	Cholangiocarcinoma, Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PEMAZYRE	PEMIGATINIB TAB 4.5 MG	21532260000320	Brand
PEMAZYRE	PEMIGATINIB TAB 9 MG	21532260000330	Brand
PEMAZYRE	PEMIGATINIB TAB 13.5 MG	21532260000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Pemazyre therapy

Product Name: Pemazyre	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PEMAZYRE	PEMIGATINIB TAB 4.5 MG	21532260000320	Brand
PEMAZYRE	PEMIGATINIB TAB 9 MG	21532260000330	Brand

PEMAZYRE	PEMIGATINIB TAB 13.5 MG	21532260000340	Brand

Approval Criteria

1 - Pemazyre will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Pemazyre	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PEMAZYRE	PEMIGATINIB TAB 4.5 MG	21532260000320	Brand
PEMAZYRE	PEMIGATINIB TAB 9 MG	21532260000330	Brand
PEMAZYRE	PEMIGATINIB TAB 13.5 MG	21532260000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Pemazyre therapy

Piqray

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147150
Guideline Name	Piqray
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Piqray	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PIQRAY 200MG DAILY DOSE	ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE	2153801000B720	Brand
PIQRAY 250MG	ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS)	2153801000B725	Brand

DAILY DOSE			
PIQRAY 300MG DAILY DOSE	ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB)	2153801000B730	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - ONE of the following:

- Advanced
- Metastatic

AND

3 - Disease is hormone receptor (HR)-positive

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - Presence of one or more PIK3CA mutations

AND

6 - Used in combination with fulvestrant

AND

7 - Disease has progressed on or after an endocrine-based regimen

Product Name: Piqray	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PIQRAY 200MG DAILY DOSE	ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE	2153801000B720	Brand
PIQRAY 250MG DAILY DOSE	ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS)	2153801000B725	Brand
PIQRAY 300MG DAILY DOSE	ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB)	2153801000B730	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Piqray therapy

Product Name: Piqray	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

PIQRAY 200MG DAILY DOSE	ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE	2153801000B720	Brand
PIQRAY 250MG DAILY DOSE	ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS)	2153801000B725	Brand
PIQRAY 300MG DAILY DOSE	ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB)	2153801000B730	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Piqray	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PIQRAY 200MG DAILY DOSE	ALPELISIB TAB THERAPY PACK 200 MG DAILY DOSE	2153801000B720	Brand
PIQRAY 250MG DAILY DOSE	ALPELISIB TAB PACK 250 MG DAILY DOSE (200 MG & 50 MG TABS)	2153801000B725	Brand
PIQRAY 300MG DAILY DOSE	ALPELISIB TAB PACK 300 MG DAILY DOSE (2X150 MG TAB)	2153801000B730	Brand

Approval Criteria

1 - Documentation of positive clinical response to Piqray therapy

2 . Revision History

Date	Notes
5/7/2024	Removed requirement for postmenopausal, premenopausal with ova rian ablation/suppression, or male under BC initial auth section; Mino r verbiage update to NCCN Recommended Regimens initial auth sec tion (with no changes to clinical intent).

Pomalyst

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150857
Guideline Name	Pomalyst
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/2/2024

1 . Criteria

Product Name: Pomalyst	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	Brand
POMALYST	POMALIDOMIDE CAP 2 MG	21450080000115	Brand
POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	Brand
POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	Brand

Approval Criteria

1 - Diagnosis of multiple myeloma

AND

2 - ONE of the following:

2.1 Failure of ONE of the following, confirmed by claims history or submitted medical records:

- Immunomodulatory agent [e.g., Revlimid (lenalidomide)]
- Proteasome inhibitor [e.g., Velcade (bortezomib)]

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Immunomodulatory agent [e.g., Revlimid (lenalidomide)]
- Proteasome inhibitor [e.g., Velcade (bortezomib)]

OR

2.3 Induction therapy for the management of POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome

Product Name: Pomalyst	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	Brand
POMALYST	POMALIDOMIDE CAP 2 MG	21450080000115	Brand
POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	Brand
POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	Brand

Approval Criteria

1 - Diagnosis of systemic light chain amyloidosis

AND

2 - Used in combination with dexamethasone

Product Name: Pomalyst	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	Brand
POMALYST	POMALIDOMIDE CAP 2 MG	21450080000115	Brand
POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	Brand
POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	Brand

Approval Criteria

1 - Diagnosis of HIV (human immunodeficiency virus)-negative Kaposi Sarcoma

OR

2 - BOTH of the following:

2.1 Diagnosis of AIDS (acquired immunodeficiency syndrome)-related Kaposi Sarcoma

AND

2.2 Patient is currently being treated with antiretroviral therapy (ART), confirmed by claims history or submitted medical records

Product Name: Pomalyst	
Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	Brand
POMALYST	POMALIDOMIDE CAP 2 MG	21450080000115	Brand
POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	Brand
POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	Brand

Approval Criteria

1 - Diagnosis of primary central nervous system (CNS) lymphoma

AND

2 - Used as second-line or subsequent therapy

Product Name: Pomalyst	
Diagnosis	Multiple Myeloma, Systemic Light Chain Amyloidosis, Kaposi Sarcoma, Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	Brand
POMALYST	POMALIDOMIDE CAP 2 MG	21450080000115	Brand
POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	Brand
POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Pomalyst therapy

Product Name: Pomalyst	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	Brand
POMALYST	POMALIDOMIDE CAP 2 MG	21450080000115	Brand
POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	Brand
POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Pomalyst	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	Brand
POMALYST	POMALIDOMIDE CAP 2 MG	21450080000115	Brand
POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	Brand
POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	Brand

Approval Criteria

1 - Documentation of positive clinical response to Pomalyst therapy

2 . Revision History

Date	Notes
8/2/2024	Annual review. Updated criteria for multiple myeloma and Kaposi sar coma. Updated background and references.

PPI (Proton Pump Inhibitors)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152613
Guideline Name	PPI (Proton Pump Inhibitors)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: generic lansoprazole ODT, generic esomeprazole magnesium susp packets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic

ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Generic

Approval Criteria

1 - The patient is less than 2 years of age

OR

2 - ONE of the following:

2.1 Failure to lansoprazole DR capsule as sprinkle administration, as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to lansoprazole DR capsule as sprinkle administration (please specify contraindication or intolerance)

Product Name: generic esomeprazole magnesium caps (OTC)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
EQ ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM DR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic

GNP ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GOODSENSE ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
KLS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
QC ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RA ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
SM ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic

Approval Criteria

1 - Failure to at least a 30 day trial of TWO of the following as confirmed by claims history or submission of medical records:

- Omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)

Product Name: Prilosec OTC, omeprazole tabs, Brand Protonix tabs, Brand Prevacid, Prevacid 24HR, Nexium caps, Brand Aciphex, generic rabeprazole tabs, Brand Dexilant, Esomeprazole Strontium, generic dexlansoprazole, Brand Nexium caps, Brand Nexium 24HR, generic esomeprazole magnesium tabs (OTC)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRILOSEC OTC	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Brand
CVS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQ OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQL OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
GNP OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
HM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
KLS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PX OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
RA OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SB OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Brand
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Brand
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Brand
ACIPHEX	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Brand

RABEPRAZOLE SODIUM	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Generic
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Brand
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Brand
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
ESOMEPRAZOLE STRONTIUM	ESOMEPRAZOLE STRONTIUM CAP DELAYED RELEASE 49.3 MG	49270025306550	Brand
ACID REDUCER	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
OMEPRAZOLE DR	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
QC OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
ESOMEPRAZOLE MAGNESIUM DR24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Generic
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Brand

Approval Criteria

1 - Failure to at least a 30 day trial of THREE of the following as confirmed by claims history or submission of medical records:

- Omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole delayed release (DR) capsule (generic Prevacid)
- Esomeprazole magnesium OTC capsule (Prior authorization required)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Omeprazole capsule (generic Prilosec)
- Pantoprazole tablet (generic Protonix)
- Lansoprazole DR capsule (generic Prevacid)
- Esomeprazole magnesium OTC capsule

Product Name: Prilosec, Brand Protonix susp packets, Brand Prevacid Solutab, Nexium susp packets, Brand Nexium susp packets, generic pantoprazole susp packets, Rabeprazole Sprinkle	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG	49270060103020	Brand
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270060103030	Brand
PROTONIX	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Brand
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Brand
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG	49270025103004	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG	49270025103007	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand

Approval Criteria

1 - Failure to at least a 30 day trial to ALL of the following products as confirmed by claims history or submission of medical records:

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab) (Prior authorization required)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension) (Prior authorization required)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Lansoprazole DR capsule as sprinkle administration (generic Prevacid)
- Lansoprazole oral disintegrating tablet (generic Prevacid Solutab)
- Esomeprazole magnesium granule suspension (generic Nexium granule suspension)

Product Name: omeprazole caps, Prilosec, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic esomeprazole magnesium caps, Nexium, Brand Aciphex, generic rabeprazole, Brand Dexilant, generic esomeprazole magnesium susp packets, Esomeprazole Strontium, generic dexlansoprazole, Brand Nexium, Brand Nexium 24HR, Rabeprazole Sprinkle, generic esomeprazole magnesium tabs (OTC)

Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 20 MG	49270060006520	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic
OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG	49270060103020	Brand

PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270060103030	Brand
PRILOSEC OTC	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Brand
CVS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQ OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQL OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
GNP OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
HM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
KLS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PX OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
RA OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SB OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Brand
PROTONIX	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Brand
CVS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
EQ LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
GNP LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
GOODSENSE LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic

HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
SM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG	49270025103004	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG	49270025103007	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Brand
ACIPHEX	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Brand
RABEPRAZOLE SODIUM	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Generic
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Brand

DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
ESOMEPRAZOLE STRONTIUM	ESOMEPRAZOLE STRONTIUM CAP DELAYED RELEASE 49.3 MG	49270025306550	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
QC LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
CVS LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
OMEPRAZOLE DR	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
QC OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
CVS OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
EQ OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
GNP OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
KP OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
QC OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic

CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
EQ ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM DR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GNP ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GOODSENSE ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
KLS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
QC ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RA ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
SM ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand
ESOMEPRAZOLE MAGNESIUM DR24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Generic
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Brand

Approval Criteria

1 - The patient did not exhibit an adequate response to treatment within the quantity limit*

OR

2 - The patient has documented erosive disease*

OR

3 - The patient has documented symptoms of complicated disease (e.g., dysphagia, bleeding, weight loss, choking, chest pain)*

OR

4 - The patient has a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple endocrine adenomas, or systemic mastocytosis**

Notes	Authorization will be issued based on circumstance. *Authorization will be issued for 8 weeks. **Authorization of therapy will be issued for 12 months.

Product Name: omeprazole caps, Prilosec, Prilosec OTC, omeprazole tabs, generic pantoprazole tabs/susp packets, Brand Protonix tabs/susp packets, generic lansoprazole, Brand Prevacid, Prevacid 24HR, generic lansoprazole ODT, Brand Prevacid Solutab, generic esomeprazole magnesium caps, Nexium, Brand Aciphex, generic rabeprazole, Brand Dexilant, generic esomeprazole magnesium susp packets, Esomeprazole Strontium, generic dexlansoprazole, Brand Nexium, Brand Nexium 24HR, Rabeprazole Sprinkle, generic esomeprazole magnesium tabs (OTC)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 10 MG	49270060006510	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 20 MG	49270060006520	Generic
OMEPRAZOLE	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic

OMEPRAZOLE DR	OMEPRAZOLE CAP DELAYED RELEASE 40 MG	49270060006530	Generic
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 2.5 MG	49270060103020	Brand
PRILOSEC	OMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270060103030	Brand
PRILOSEC OTC	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Brand
CVS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQ OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
EQL OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
GNP OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
HM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
KLS OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PX OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
RA OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SB OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
SM OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 20 MG (BASE EQUIV)	49270070100610	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
PROTONIX	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Brand
PROTONIX	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Brand
CVS LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
EQ LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic

GNP LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
GOODSENSE LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
HM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
PREVACID 24HR	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Brand
SM LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Generic
PREVACID	LANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270040006520	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Brand
LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
LANSOPRAZOLE ODT	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Generic
PREVACID SOLUTAB	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 30 MG	4927004000H330	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 40 MG (BASE EQ)	49270025106540	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACK 2.5 MG	49270025103004	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 5 MG	49270025103007	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Brand
NEXIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Brand
ACIPHEX	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Brand

RABEPRAZOLE SODIUM	RABEPRAZOLE SODIUM EC TAB 20 MG	49270076100620	Generic
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Brand
DEXILANT	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Brand
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 10 MG	49270025103010	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 20 MG	49270025103020	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270025103040	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
ESOMEPRAZOLE STRONTIUM	ESOMEPRAZOLE STRONTIUM CAP DELAYED RELEASE 49.3 MG	49270025306550	Brand
PANTOPRAZOLE SODIUM	PANTOPRAZOLE SODIUM FOR DELAYED RELEASE SUSP PACKET 40 MG	49270070103020	Generic
QC LANSOPRAZOLE	LANSOPRAZOLE CAP DELAYED RELEASE 15 MG	49270040006510	Generic
CVS LANSOPRAZOLE	LANSOPRAZOLE TAB DELAYED RELEASE ORALLY DISINTEGRATING 15 MG	4927004000H315	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
OMEPRAZOLE DR	OMEPRAZOLE MAGNESIUM DELAYED RELEASE TAB 20 MG (BASE EQUIV)	49270060100620	Generic
PANTOPRAZOLE SODIUM DR	PANTOPRAZOLE SODIUM EC TAB 40 MG (BASE EQUIV)	49270070100620	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG	49270020006520	Generic
DEXLANSOPRAZOLE	DEXLANSOPRAZOLE CAP DELAYED RELEASE 60 MG	49270020006530	Generic
QC OMEPRAZOLE	OMEPRAZOLE DELAYED RELEASE TAB 20 MG	49270060000620	Generic
ACID REDUCER	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
CVS OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
EQ OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
GNP OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
KP OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
OMEPRAZOLE	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic

OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
QC OMEPRAZOLE MAGNESIUM	OMEPRAZOLE MAGNESIUM CAP DR 20.6 MG (20 MG BASE EQUIV)	49270060106520	Generic
CVS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
EQ ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
ESOMEPRAZOLE MAGNESIUM DR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GNP ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
GOODSENSE ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
HM ESOMEPRAZOLE MAGNESIUM DELAYED RELEASE	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
KLS ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
NEXIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
NEXIUM 24HR CLEAR MINIS	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Brand
QC ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RA ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
SM ESOMEPRAZOLE MAGNESIUM	ESOMEPRAZOLE MAGNESIUM CAP DELAYED RELEASE 20 MG (BASE EQ)	49270025106520	Generic
RABEPRAZOLE SODIUM DR SPRINKLE	RABEPRAZOLE SODIUM CAPSULE SPRINKLE DR 10 MG	49270076106810	Brand
ESOMEPRAZOLE MAGNESIUM DR24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Generic
NEXIUM 24HR	ESOMEPRAZOLE MAGNESIUM TAB DELAYED RELEASE 20 MG	49270025100620	Brand

Approval Criteria

1 - The patient is continuing therapy for a pathological hypersecretory condition such as Zollinger-Ellison syndrome, Barrett's Esophagus, multiple adenomas, or systemic mastocytosis

2 . Revision History

Date	Notes
8/26/2024	Updated GPIs and product names.

Pradaxa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146391
Guideline Name	Pradaxa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Continuation of Therapy Upon Hospital Discharge
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand

DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - For continuation of therapy upon hospital discharge

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Stroke and Systemic Embolism Prevention in an Adult Patient with Non-Valvular Atrial Fibrillation (AF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand

PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of atrial fibrillation (AF)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Eliquis
- Savaysa

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Eliquis
- Savaysa

OR

3.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) and Pulmonary Embolism (PE) after Orthopedic Surgery in an Adult Patient (Hip Replacement: Labeled; Knee Replacement: Off-Label)
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - ONE of the following:

- Patient has or is scheduled to have total knee replacement surgery
- Patient has or is scheduled to have total hip replacement surgery

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure of Eliquis confirmed by claims history or submitted medical records

OR

3.2 History of intolerance or contraindication to Eliquis (please specify intolerance or contraindication)

OR

3.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) in an Adult Patient
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand

PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Eliquis
- Savaysa

OR

3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Eliquis

- Savaysa

OR

3.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Reduction in the Risk of Recurrence of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) in an Adult Patient
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Previous diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient must have been treated with an anticoagulant [e.g., warfarin, Eliquis (apixiban)] for at least 3 months prior to request

AND

4 - ONE of the following:

4.1 Failure of Eliquis confirmed by claims history or submitted medical records

OR

4.2 History of intolerance or contraindication to Eliquis (please specify intolerance or contraindication)

OR

4.3 Continuation of prior Pradaxa therapy

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Treatment of Venous Thromboembolic Events (VTE) in a Pediatric Patient
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of venous thromboembolic events (VTE)

AND

2 - Patient does not have an artificial heart valve

Product Name: dabigatran etexilate, Pradaxa	
Diagnosis	Reduction in the Risk of Recurrence of VTE in a Pediatric Patient
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic

PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand

Approval Criteria

1 - Diagnosis of venous thromboembolic events (VTE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient must have been treated with an anticoagulant (e.g., warfarin) for at least 3 months prior to request

Praluent

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146834
Guideline Name	Praluent
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Praluent (all labelers)	
Diagnosis	Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia (HeFH) and Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

1.1.1 BOTH of the following:

1.1.1.1 Pre-treatment low density lipoprotein cholesterol (LDL-C) of ONE of the following:

- Greater than or equal to 190 milligrams/deciliter (mg/dL)
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second degree relative

OR

1.1.2 BOTH of the following:

1.1.2.1 Pre-treatment LDL-C of ONE of the following:

- Greater than or equal to 190 mg/dL
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low density lipoprotein), apoB (apolipoprotein B), or PCSK9 (proprotein convertase subtilisin/kexin type 9) gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

OR

1.3 Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy [i.e., atorvastatin 40-80 milligrams (mg), rosuvastatin 20-40 mg] and will continue to receive high intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]

- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily, or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication or intolerance to ezetimibe (please specify intolerance or contraindication)

AND

4 - Patient has received comprehensive counseling regarding appropriate diet

AND

5 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

AND

6 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

7 - Not used in combination with Leqvio (inclisiran)

Product Name: Praluent (all labelers)	
Diagnosis	Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia (HeFH) and Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Product Name: Praluent (all labelers)	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 BOTH of the following:

1.2.1 Pre-treatment low density lipoprotein cholesterol (LDL-C) greater than 400 milligrams/deciliter (mg/dL)

AND

1.2.2 ONE of the following:

1.2.2.1 Xanthoma before 10 years of age

OR

1.2.2.2 Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diets

AND

3 - Patient is receiving other lipid-lowering therapy confirmed by claims history or submitted medical records (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

6 - Not used in combination with Juxtapid (lomitapide)

Product Name: Praluent (all labelers)	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Praluent therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

Product Name: Praluent (Non-72733 labelers)	
Diagnosis	Non-Preferred*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/ML	3935001000D520	Brand
PRALUENT	ALIROCUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	3935001000D530	Brand

Approval Criteria

1 - History of failure to at least THREE preferred alternatives as confirmed by claims history or submission of medical records.* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure to all of the preferred products.

OR

2 - History of contraindication or intolerance to THREE preferred alternatives (please specify contraindication or intolerance).* NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to all of the preferred products.

Notes	*Reference Non-Preferred Drugs policy. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Preferred Non-Solid Dosage Forms

Prior Authorization Guideline

Guideline ID	GL-146840
Guideline Name	Preferred Non-Solid Dosage Forms
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Diagnosis	Requests for Non-Solid Dosage Forms
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Non-solid dosage forms			
Non solid dosage forms			
Solid oral dosage forms			

Approval Criteria

1 - ONE of the following:

1.1 Requested drug must be used for an FDA (Food and Drug Administration)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 The patient is able to swallow a solid dosage form

AND

3.1.2 ONE of the following:

3.1.2.1 History of failure, contraindication, or intolerance to at least THREE preferred* solid oral dosage forms (Prior trials of formulary/PDL (preferred drug list) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request. NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of failure, contraindication, or intolerance to ALL of the preferred products.)

OR **3.1.2.2** There are no preferred formulary alternatives for the requested drug **OR** **3.2** Patient is unable to swallow a solid dosage form **OR** **3.3** Patient utilizes a feeding tube for medication administration **OR** **3.4** Request is for a nebulized formulation of an inhaled medication for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Pretomanid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146395
Guideline Name	Pretomanid
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Pretomanid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PRETOMANID	PRETOMANID TAB 200 MG	09000063000320	Brand

Approval Criteria

1 - One of the following:

1.1 Diagnosis of pulmonary extensively drug resistant (XDR) tuberculosis (TB)

OR

1.2 Treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB)

AND

2 - Pretomanid will be used in combination with bedaquiline and linezolid

Prevymis

Prior Authorization Guideline

Guideline ID	GL-146619
Guideline Name	Prevymis
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Prevymis tabs	
Diagnosis	Cytomegalovirus Prophylaxis
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PREVYMIS	LETERMOVIR TAB 240 MG	12200045000320	Brand
PREVYMIS	LETERMOVIR TAB 480 MG	12200045000340	Brand

Approval Criteria

1 - ALL of the following:

1.1 Patient is a recipient of an allogeneic hematopoietic stem cell transplant

AND

1.2 Patient is cytomegalovirus (CMV)-seropositive

AND

1.3 Provider attests that Prevymis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

OR

2 - ALL of the following:

2.1 Patient is a recipient of a kidney transplant

AND

2.2 Patient is CMV-seronegative

AND

2.3 Donor is CMV-seropositive

AND

2.4 Provider attests that Prevymis will be initiated between Day 0 and Day 7 post-transplantation (before or after engraftment) and is being prescribed as prophylaxis and not treatment of CMV infection

Procysbi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146620
Guideline Name	Procysbi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Procysbi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROCYSBI	CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 75 MG	56400030103020	Brand
PROCYSBI	CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 300 MG	56400030103040	Brand
PROCYSBI	CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 25 MG (BASE EQUIV)	56400030106520	Brand

PROCYSBI	CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 75 MG (BASE EQUIV)	56400030106530	Brand

Approval Criteria

1 - Diagnosis of nephropathic cystinosis

AND

2 - Patient is 1 year of age or older

AND

3 - ONE of the following*:

3.1 Failure to immediate-release cysteamine bitartrate (generic Cystagon), as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to immediate-release cysteamine bitartrate (generic Cystagon) (please specify intolerance or contraindication)

Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity.

Product Name: Procysbi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROCYSBI	CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 75 MG	56400030103020	Brand
PROCYSBI	CYSTEAMINE BITARTRATE DELAYED RELEASE GRANULES PACKET 300 MG	56400030103040	Brand

PROCYSBI	CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 25 MG (BASE EQUIV)	56400030106520	Brand
PROCYSBI	CYSTEAMINE BITARTRATE CAP DELAYED RELEASE 75 MG (BASE EQUIV)	56400030106530	Brand

Approval Criteria

1 - Documentation of positive clinical response to Procysbi therapy

Progesterone - Non-Oral

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146396
Guideline Name	Progesterone - Non-Oral
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Crinone, Endometrin	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CRINONE	PROGESTERONE VAGINAL GEL 4%	55370060004010	Brand
CRINONE	PROGESTERONE VAGINAL GEL 8%	55370060004020	Brand
ENDOMETRIN	PROGESTERONE VAGINAL INSERT 100 MG	55370060009910	Brand

Approval Criteria

1 - Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)

Progesterone - Oral

Prior Authorization Guideline

Guideline ID	GL-146397
Guideline Name	Progesterone - Oral
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Prometrium, generic progesterone caps	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROGESTERONE	PROGESTERONE CAP 100 MG	26000040000120	Generic
PROMETRIUM	PROGESTERONE CAP 100 MG	26000040000120	Brand
PROGESTERONE	PROGESTERONE CAP 200 MG	26000040000140	Generic
PROMETRIUM	PROGESTERONE CAP 200 MG	26000040000140	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Amenorrhea
- Endometrial hyperplasia or prevention of endometrial hyperplasia
- Abnormal uterine or vaginal bleeding
- History of preterm birth
- Prevention of preterm delivery for current pregnancy

Promacta, Alvaiz

Prior Authorization Guideline

Guideline ID	GL-156834
Guideline Name	Promacta, Alvaiz
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Promacta, Alvaiz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROMACTA	ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV)	82405030100310	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV)	82405030100320	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV)	82405030100330	Brand

PROMACTA	ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV)	82405030100340	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV)	82405030103020	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ)	82405030103030	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV)	82405030050310	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV)	82405030050320	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV)	82405030050330	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV)	82405030050340	Brand

Approval Criteria

1 - Diagnosis of chronic idiopathic thrombocytopenic purpura (ITP)

AND

2 - ONE of the following:

2.1 Failure to at least ONE of the following as confirmed by claims history or submission of medical records:

- Corticosteroids
- Immunoglobulins
- Splenectomy

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- Corticosteroids
- Immunoglobulins
- Splenectomy

AND

3 - If the request is for Alvaiz, one of the following:

3.1 Failure to Promacta as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to Promacta (please specify intolerance or contraindication)

Product Name: Promacta, Alvaiz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROMACTA	ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV)	82405030100310	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV)	82405030100320	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV)	82405030100330	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV)	82405030100340	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV)	82405030103020	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ)	82405030103030	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV)	82405030050310	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV)	82405030050320	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV)	82405030050330	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV)	82405030050340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Promacta or Alvaiz therapy

Product Name: Promacta, Alvaiz

Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROMACTA	ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV)	82405030100310	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV)	82405030100320	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV)	82405030100330	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV)	82405030100340	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV)	82405030103020	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ)	82405030103030	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV)	82405030050310	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV)	82405030050320	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV)	82405030050330	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV)	82405030050340	Brand

Approval Criteria

1 - Diagnosis of chronic hepatitis C-associated thrombocytopenia

AND

2 - ONE of the following:

- Planning to initiate and maintain interferon-based treatment
- Currently receiving interferon-based treatment

AND

3 - If the request is for Alvaiz, one of the following:

3.1 Failure to Promacta as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to Promacta (please specify intolerance or contraindication)

Product Name: Promacta, Alvaiz	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROMACTA	ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV)	82405030100310	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV)	82405030100320	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV)	82405030100330	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV)	82405030100340	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV)	82405030103020	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ)	82405030103030	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV)	82405030050310	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV)	82405030050320	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV)	82405030050330	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV)	82405030050340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Promacta or Alvaiz therapy

AND

2 - Patient is currently on antiviral interferon therapy for treatment of chronic hepatitis C

Product Name: Promacta, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROMACTA	ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV)	82405030100310	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV)	82405030100320	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV)	82405030100330	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV)	82405030100340	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV)	82405030103020	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ)	82405030103030	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV)	82405030050310	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV)	82405030050320	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV)	82405030050330	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV)	82405030050340	Brand

Approval Criteria

1 - Diagnosis of severe aplastic anemia

AND

2 - ONE of the following:

2.1 Used in combination with standard immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

OR

2.2 History of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

AND

3 - If the request is for Alvaiz, one of the following:

3.1 Failure to Promacta as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to Promacta (please specify intolerance or contraindication)

Product Name: Promacta, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PROMACTA	ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV)	82405030100310	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV)	82405030100320	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV)	82405030100330	Brand
PROMACTA	ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV)	82405030100340	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 25 MG (BASE EQUIV)	82405030103020	Brand
PROMACTA	ELTROMBOPAG OLAMINE POWDER PACK FOR SUSP 12.5 MG (BASE EQ)	82405030103030	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 9 MG (BASE EQUIV)	82405030050310	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 18 MG (BASE EQUIV)	82405030050320	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 36 MG (BASE EQUIV)	82405030050330	Brand
ALVAIZ	ELTROMBOPAG CHOLINE TAB 54 MG (BASE EQUIV)	82405030050340	Brand

Approval Criteria **1** - Documentation of positive clinical response to Promacta or Alvaiz therapy

2 . Revision History

Date	Notes
10/1/2024	Updated approval durations to 12 months

Provigil, Nuvigil

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146398
Guideline Name	Provigil, Nuvigil
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
MODAFINIL	MODAFINIL TAB 100 MG	61400024000310	Generic
PROVIGIL	MODAFINIL TAB 100 MG	61400024000310	Brand
MODAFINIL	MODAFINIL TAB 200 MG	61400024000320	Generic
PROVIGIL	MODAFINIL TAB 200 MG	61400024000320	Brand
ARMODAFINIL	ARMODAFINIL TAB 50 MG	61400010000310	Generic
NUVIGIL	ARMODAFINIL TAB 50 MG	61400010000310	Brand

ARMODAFINIL	ARMODAFINIL TAB 150 MG	61400010000330	Generic
NUVIGIL	ARMODAFINIL TAB 150 MG	61400010000330	Brand
ARMODAFINIL	ARMODAFINIL TAB 200 MG	61400010000335	Generic
NUVIGIL	ARMODAFINIL TAB 200 MG	61400010000335	Brand
ARMODAFINIL	ARMODAFINIL TAB 250 MG	61400010000340	Generic
NUVIGIL	ARMODAFINIL TAB 250 MG	61400010000340	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Narcolepsy
- Excessive sleepiness due to obstructive sleep apnea
- Excessive sleepiness due to shift work disorder (circadian rhythm sleep disorder, shift work type)
- Idiopathic hypersomnia
- Diagnosis of multiple sclerosis (MS)
- Diagnosis of major depressive disorder or bipolar depression

Pulmozyme

Prior Authorization Guideline

Guideline ID	GL-146622
Guideline Name	Pulmozyme
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Pulmozyme	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PULMOZYME	DORNASE ALFA INHAL SOLN 2.5 MG/2.5ML	45304020002010	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis

Pyrukynd

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150405
Guideline Name	Pyrukynd
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name: Pyrukynd Taper Pack, Pyrukynd	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PYRUKYND TAPER PACK	MITAPIVAT SULFATE TAB THERAPY PACK 5 MG	8587005070B710	Brand
PYRUKYND TAPER PACK	MITAPIVAT SULFATE TAB THERAPY PACK 7 X 20 MG & 7 X 5 MG	8587005070B720	Brand

PYRUKYND TAPER PACK	MITAPIVAT SULFATE TAB THERAPY PACK 7 X 50 MG & 7 X 20 MG	8587005070B735	Brand
PYRUKYND	MITAPIVAT SULFATE TAB 5 MG	85870050700310	Brand
PYRUKYND	MITAPIVAT SULFATE TAB 20 MG	85870050700325	Brand
PYRUKYND	MITAPIVAT SULFATE TAB 50 MG	85870050700340	Brand

Approval Criteria

1 - Diagnosis of pyruvate kinase (PK) deficiency based on ALL of the following:

1.1 Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 is a missense variant

AND

1.2 Patient is not homozygous for the c.1436G > A (p.R479H) variant

AND

1.3 Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene

AND

2 - Used for the treatment of hemolytic anemia

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Baseline hemoglobin less than or equal to 10 grams/deciliter (g/dL)

AND

3.1.2 Patient has had no more than 4 transfusions in the previous 52 weeks and no transfusions in the preceding 3-month period

OR

3.2 Patient has had a minimum of 6 transfusion episodes in the preceding 52 weeks

AND

4 - Prescribed by a nephrologist or hematologist

Product Name: Pyrukynd Taper Pack, Pyrukynd	
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
PYRUKYND TAPER PACK	MITAPIVAT SULFATE TAB THERAPY PACK 5 MG	8587005070B710	Brand
PYRUKYND TAPER PACK	MITAPIVAT SULFATE TAB THERAPY PACK 7 X 20 MG & 7 X 5 MG	8587005070B720	Brand
PYRUKYND TAPER PACK	MITAPIVAT SULFATE TAB THERAPY PACK 7 X 50 MG & 7 X 20 MG	8587005070B735	Brand
PYRUKYND	MITAPIVAT SULFATE TAB 5 MG	85870050700310	Brand
PYRUKYND	MITAPIVAT SULFATE TAB 20 MG	85870050700325	Brand
PYRUKYND	MITAPIVAT SULFATE TAB 50 MG	85870050700340	Brand

Approval Criteria

1 - BOTH of the following*:

1.1 Documentation of positive clinical response to Pyrukynd therapy **AND** **1.2** Prescribed by, or in consultation with, a nephrologist or hematologist **OR** **2** - Documentation does not provide evidence of positive clinical response to Pyrukynd therapy, allow for dose titration with discontinuation of therapy**	
Notes	*If criteria is met under step 1, authorization length is 12 months. **If criteria is met under step 2, authorization length is 4 weeks.

2 . Revision History

Date	Notes
7/24/2024	Updated initial approval duration from 6 months to 12 months. Simplified reauthorization criteria.

Qbrexza

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146399
Guideline Name	Qbrexza
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Qbrexza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QBREXZA	GLYCOPYRRONIUM TOSYLATE PAD 2.4% (BASE EQUIVALENT)	90970030204320	Brand

Approval Criteria

1 - Diagnosis of primary axillary hyperhidrosis

AND

2 - ONE of the following:

2.1 Failure to Xerac-AC as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to Xerac-AC (please specify contraindication or intolerance)

Qinlock

Prior Authorization Guideline

Guideline ID	GL-154753
Guideline Name	Qinlock
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Qinlock	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QINLOCK	RIPRETINIB TAB 50 MG	21533053000320	Brand

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST)

AND

2 - ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Recurrent/Metastatic

AND

3 - ONE of the following:

3.1 History of failure to ALL of the following as confirmed by claims history or submission of medical records:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- regorafenib (generic Stivarga)

OR

3.2 ALL of the following:

3.2.1 Performance status 0-2

AND

3.2.2 History of progression on imatinib (Gleevec) as confirmed by claims history or submission of medical records

AND

3.2.3 History of intolerance to sunitinib (Sutent) (please specify intolerance) as confirmed by claims history or submission of medical records

OR

3.3 ALL of the following:

3.3.1 PDGFRA exon 18 mutations that are insensitive to imatinib (Gleevec) (including PDGFRA D842V)

AND

3.3.2 History of progression on avapritinib (Ayvakit) as confirmed by claims history or submission of medical records

AND

3.3.3 History of progression on dasatinib (Sprycel) as confirmed by claims history or submission of medical records

Product Name: Qinlock	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QINLOCK	RIPRETINIB TAB 50 MG	21533053000320	Brand

Approval Criteria

1 - Diagnosis of cutaneous melanoma

AND

2 - Disease is unresectable or metastatic

AND

3 - Disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy

AND

4 - Positive for activating mutations of KIT

Product Name: Qinlock	
Diagnosis	Gastrointestinal Stromal Tumor (GIST), Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QINLOCK	RIPRETINIB TAB 50 MG	21533053000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Qinlock therapy

Product Name: Qinlock	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

QINLOCK	RIPRETINIB TAB 50 MG	21533053000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Qinlock	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
QINLOCK	RIPRETINIB TAB 50 MG	21533053000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Qinlock therapy

Qlosi, Vuity

Prior Authorization Guideline

Guideline ID	GL-146400
Guideline Name	Qlosi, Vuity
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vuity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VUITY	PILOCARPINE HCL OPHTH SOLN 1.25%	86501030102017	Brand

Approval Criteria

1 - Diagnosis of presbyopia

AND

2 - Patient is between the ages of 40 to 55

AND

3 - Patient is unable to use corrective lenses (e.g., glasses, contacts) (document medical rationale why patient is unable to use corrective lenses)

AND

4 - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

Product Name: Vuity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VUITY	PILOCARPINE HCL OPHTH SOLN 1.25%	86501030102017	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Age less than 55

AND

3 - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

Product Name: Qlosi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
Qlosi			

Approval Criteria

1 - Diagnosis of presbyopia

AND

2 - Patient is between the ages of 45 to 64

AND

3 - Patient is unable to use corrective lenses (e.g., glasses, contacts) (document medical rationale why patient is unable to use corrective lenses)

AND

4 - Prescribed by ONE of the following:

- Optometrist

- Ophthalmologist

Product Name: Qlosi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
Qlosi			

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Age less than 64

AND

3 - Prescribed by ONE of the following:

- Optometrist
- Ophthalmologist

Quantity Limits

Prior Authorization Guideline

Guideline ID	GL-146401
Guideline Name	Quantity Limits
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review (General)
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - ONE of the following:

1.1 The requested drug must be used for an FDA (Food and Drug Administration)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - ONE of the following:

2.1 The drug is being prescribed within the manufacturer's published dosing guidelines

OR

2.2 The request falls within dosing guidelines found in ONE of the following compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation.

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program.

Product Name: Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review for the treatment of gender dysphoria*
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for an indication that is recognized as a covered benefit by the applicable health plans' program.

Notes	* If the above criteria are not met, then refer for clinical review by an appropriate trained professional (physician or pharmacist) based on the applicable regulatory requirement.

Product Name: Quantity Limit, Prescription Limit

Diagnosis	Monthly prescription limit review for migraine therapy, benzodiazepines, or muscle relaxants
Approval Length	1 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - Medical necessity rationale provided for why the member requires 5 or more fills of the same drug or drug class within a month.

Notes	*If deemed medically necessary, longer authorization duration is perm itted

Product Name: Quantity Limit, Prescription Limit	
Diagnosis	Topical products exceeding the allowable package size per fill OR the allowable quantity per month
Approval Length	12 month(s)
Guideline Type	Administrative

Product Name	Generic Name	GPI	Brand/Generic
Quantity Limit			
Prescription Limit			

Approval Criteria

1 - The physician attests that a larger quantity is needed for treatment of a larger surface area.

Radicava ORS

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155393
Guideline Name	Radicava ORS
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RADICAVA ORS STARTER KIT	EDARAVONE ORAL SUSP 105 MG/5ML	74509030001820	Brand
RADICAVA ORS	EDARAVONE ORAL SUSP 105 MG/5ML	74509030001820	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Patient has been established on therapy with Radicava for amyotrophic lateral sclerosis (ALS) under an active UnitedHealthcare medical benefit prior authorization

AND

1.2 ALL of the following:

1.2.1 Diagnosis of “definite” or “probable” ALS per the El Escorial/revised Airlie House diagnostic criteria

AND

1.2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

1.2.3 Patient is currently receiving Radicava therapy

AND

1.2.4 Patient is not dependent on invasive ventilation or tracheostomy

OR

2 - ALL of the following:

2.1 Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support the diagnosis of “definite” or “probable” ALS per the El Escorial/revised Airlie House diagnostic criteria

AND

2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

2.3 Submission of the most recent ALS Functional Rating Scale-Revised (ALSFRS-R) score confirming that the patient has scores greater than or equal to 2 in all items of the ALSFRS-R criteria at the start of treatment

AND

2.4 Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a % forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment

Product Name: Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RADICAVA ORS STARTER KIT	EDARAVONE ORAL SUSP 105 MG/5ML	74509030001820	Brand
RADICAVA ORS	EDARAVONE ORAL SUSP 105 MG/5ML	74509030001820	Brand

Approval Criteria

1 - Diagnosis of “definite” or “probable” amyotrophic lateral sclerosis (ALS) per the El Escorial/revised Airlie House diagnostic criteria

AND **2** - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS **AND** **3** - Patient is currently receiving Radicava ORS therapy **AND** **4** - Patient is not dependent on invasive ventilation or tracheostomy

2 . Revision History

Date	Notes
9/20/2024	Clarified criteria for existing prior authorization to be under the medic al benefit. Updated initial and reauth durations to 12 months.

Ravicti

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146626
Guideline Name	Ravicti
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ravicti	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAVICTI	GLYCEROL PHENYLBUTYRATE LIQUID 1.1 GM/ML	30908030000920	Brand

Approval Criteria

1 - Diagnosis of urea cycle disorders (UCDs)

AND

2 - Inadequate response to ONE of the following:

- Dietary protein restriction
- Amino acid supplementation

AND

3 - Will be used concomitantly with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

AND

4 - ONE of the following:

4.1 Failure to sodium phenylbutyrate (Buphenyl) as confirmed by claims history or submission of medical records*

OR

4.2 History of intolerance or contraindication to sodium phenylbutyrate (Buphenyl) (please specify contraindication or intolerance)*

Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens an indication of medical necessity

Product Name: Ravicti	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAVICTI	GLYCEROL PHENYLBUTYRATE LIQUID 1.1 GM/ML	30908030000920	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ravicti therapy

AND

2 - Patient is actively on dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

Rayos

Prior Authorization Guideline

Guideline ID	GL-146402
Guideline Name	Rayos
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rayos	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAYOS	PREDNISONE TAB DELAYED RELEASE 1 MG	22100045000610	Brand
RAYOS	PREDNISONE TAB DELAYED RELEASE 2 MG	22100045000620	Brand
RAYOS	PREDNISONE TAB DELAYED RELEASE 5 MG	22100045000630	Brand

Approval Criteria

1 - ONE of the following:

1.1 Rayos must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 The intended use of Rayos is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - Rayos is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting an intolerance to generic prednisone tablets which is unable to be resolved with attempts to minimize the adverse effects where appropriate

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Dexamethasone tablet/oral solution
- Hydrocortisone tablet
- Methylprednisolone tablet
- Prednisolone tablet/oral solution

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Dexamethasone tablet/oral solution
- Hydrocortisone tablet
- Methylprednisolone tablet
- Prednisolone tablet/oral solution

Rectiv

Prior Authorization Guideline

Guideline ID	GL-146403
Guideline Name	Rectiv
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rectiv	
Diagnosis	Pain Associated with Chronic Anal Fissures
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RECTIV	NITROGLYCERIN OINT 0.4%	89254060004220	Brand

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with chronic anal fissures

Regranex

Prior Authorization Guideline

Guideline ID	GL-146404
Guideline Name	Regranex
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Regranex	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REGRANEX	BECAPLERMIN GEL 0.01%	90945020004020	Brand

Approval Criteria

1 - Patient has a lower extremity diabetic neuropathic ulcer

Relistor

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146405
Guideline Name	Relistor
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Relistor Injection	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELISTOR	METHYLNALTREXONE BROMIDE INJ 8 MG/0.4ML (20 MG/ML)	52580050102015	Brand
RELISTOR	METHYLNALTREXONE BROMIDE INJ 12 MG/0.6ML (20 MG/ML)	52580050102020	Brand

Approval Criteria

1 - Documentation (e.g. chart notes) demonstrating a diagnosis of opioid induced constipation in a patient with advanced illness receiving palliative care

OR

2 - Documentation (e.g. chart notes) demonstrating BOTH of the following:

2.1 ONE of the following:

2.1.1 Diagnosis of opioid induced constipation with chronic, non-cancer pain

OR

2.1.2 Diagnosis of opioid induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation

AND

2.2 ONE of the following:

2.2.1 The patient is not able to swallow oral medications

OR

2.2.2 ALL of the following:

2.2.2.1 ONE of the following:

2.2.2.1.1 Failure to ONE of the following as confirmed by claims history or submitted medical records

- Lactulose
- Polyethylene glycol (Miralex)

OR

2.2.2.1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication)

- Lactulose
- Polyethylene glycol (Miralex)

AND

2.2.2.2 ONE of the following:

2.2.2.2.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.2.2.2.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

2.2.2.3 ONE of the following:

2.2.2.3.1 Failure to Movantik as confirmed by claims history or submitted medical records

OR

2.2.2.3.2 History of contraindication or intolerance to Movantik (please specify intolerance or contraindication)

Product Name: Relistor Injection	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

RELISTOR	METHYLNALTREXONE BROMIDE INJ 8 MG/0.4ML (20 MG/ML)	52580050102015	Brand
RELISTOR	METHYLNALTREXONE BROMIDE INJ 12 MG/0.6ML (20 MG/ML)	52580050102020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Relistor Injection therapy

Product Name: Relistor tablet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELISTOR	METHYLNALTREXONE BROMIDE TAB 150 MG	52580050100320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of opioid induced constipation with chronic, non-cancer pain

OR

1.2 Diagnosis of opioid induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 Failure to ONE of the following as confirmed by claims history or submitted medical records

- Lactulose
- Polyethylene glycol (Miralex)

OR

2.1.2 History of contraindication or intolerance to BOTH of the following (please specify intolerance or contraindication)

- Lactulose
- Polyethylene glycol (Miralex)

AND

2.2 ONE of the following:

2.2.1 Failure to lubiprostone (generic of Amitiza) as confirmed by claims history or submission of medical records

OR

2.2.2 History of intolerance or contraindication to lubiprostone (generic of Amitiza) (please specify intolerance or contraindication)

AND

2.3 ONE of the following:

2.3.1 Failure to Movantik as confirmed by claims history or submitted medical records

OR

2.3.2 History of contraindication or intolerance to Movantik (please specify intolerance or contraindication)

Product Name: Relistor tablet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELISTOR	METHYLNALTREXONE BROMIDE TAB 150 MG	52580050100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Relistor Tablet therapy

Relyvrio

Prior Authorization Guideline

Guideline ID	GL-146627
Guideline Name	Relyvrio
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Relyvrio	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELYVRIO	SODIUM PHENYLBUTYRATE-TAURURSODIOL POWD PACK 3-1 GM	74509902703020	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support the diagnosis of amyotrophic lateral sclerosis (ALS)

AND

2 - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

3 - Provider attestation that the patient's baseline functional ability has been documented prior to initiating treatment (e.g., speech, walking, climbing stairs, etc.)

AND

4 - Patient is not dependent on invasive ventilation or tracheostomy

Product Name: Relyvrio	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RELYVRIO	SODIUM PHENYLBUTYRATE-TAURURSODIOL POWD PACK 3-1 GM	74509902703020	Brand

Approval Criteria

1 - Diagnosis of amyotrophic lateral sclerosis (ALS)

AND

2 - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

3 - Patient is currently receiving Relyvrio therapy

AND

4 - Provider attestation that the patient has slowed disease progression from baseline

AND

5 - Patient is not dependent on invasive ventilation or tracheostomy

Repatha

Prior Authorization Guideline

Guideline ID	GL-146407
Guideline Name	Repatha
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Repatha	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand

REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - ONE of the following diagnoses:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

1.1.1 BOTH of the following:

1.1.1.1 Pre-treatment LDL-C (low-density lipoprotein cholesterol) is ONE of the following:

- Greater than or equal to 190 milligrams/deciliter (mg/dL)
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 BOTH of the following:

1.1.2.1 Pre-treatment LDL-C is ONE of the following:

- Greater than or equal to 190 mg/dL
- Greater than or equal to 155 mg/dL if less than 16 years of age

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL (low-density lipoprotein), apoB (Apolipoprotein B), or PCSK9 (Proprotein convertase subtilisin/kexin type 9) gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

OR

1.3 Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

2.1 Patient has been receiving at least 12 consecutive weeks of high-intensity statin therapy (i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg) and will continue to receive high-intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than or equal to 10 mg, pravastatin greater than or equal to 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40 mg twice daily or Livalo (pitavastatin) greater than or equal to 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis [muscle symptoms with CK elevations less than 10 times upper limit of normal (ULN)]

OR

2.3.2 Patient has a labeled contraindication to all statins as confirmed by medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

3.2.2.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2.2.2 Patient has a history of contraindication or intolerance to ezetimibe (please specify intolerance or contraindication)

AND

4 - Patient has received comprehensive counseling regarding appropriate diet

AND

5 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

6 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

7 - Not used in combination with Leqvio (inclisiran)

Product Name: Repatha	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

AND

2 - Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Product Name: Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.1 Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 BOTH of the following:

1.2.1 Pre-treatment LDL-C (low-density lipoprotein cholesterol) greater than 400 mg/dL (milligrams/deciliter)

AND

1.2.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diet

AND

3 - Patient is receiving other lipid-lowering therapy confirmed by claims history or submitted medical records (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

6 - Not used in combination with Juxtapid (lomitapide)

Product Name: Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REPATHA	EVOLOCUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 140 MG/ML	3935002000E520	Brand
REPATHA PUSHTRONEX SYSTEM	EVOLOCUMAB SUBCUTANEOUS SOLN CARTRIDGE/INFUSOR 420 MG/3.5ML	3935002000E230	Brand
REPATHA SURECLICK	EVOLOCUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 140 MG/ML	3935002000D520	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C (low-density lipoprotein cholesterol) reduction while on Repatha therapy

AND

2 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid Specialist

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)

Repository Corticotropins

Prior Authorization Guideline

Guideline ID	GL-146628
Guideline Name	Repository Corticotropins
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Acthar, Cortrophin	
Diagnosis	Infantile spasm (i.e., West Syndrome)*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTHAR	CORTICOTROPIN INJ GEL 80 UNIT/ML	30300010004010	Brand
CORTROPHIN	CORTICOTROPIN INJ GEL 80 UNIT/ML	30300010004010	Brand

Approval Criteria

1 - Diagnosis of infantile spasms (i.e., West Syndrome)*

AND

2 - Patient is less than 2 years old

AND

3 - Both of following:

3.1 Initial dose: 75 U/m^2 (units/square meters) intramuscular (IM) twice daily for 2 weeks

AND

3.2 After 2 weeks, dose should be tapered according to the following schedule: 30 U/m^2 IM in the morning for 3 days; 15 U/m^2 IM in the morning for 3 days; 10 U/m^2 IM in the morning for 3 days; 10 U/m^2 IM every other morning for 6 days (3 doses)

Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. See Background for more information.

Product Name: Acthar, Cortrophin	
Diagnosis	Opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome)*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTHAR	CORTICOTROPIN INJ GEL 80 UNIT/ML	30300010004010	Brand
CORTROPHIN	CORTICOTROPIN INJ GEL 80 UNIT/ML	30300010004010	Brand

Approval Criteria

1 - Diagnosis of opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome)*

AND **2** - If the request is for Acthar gel, provider submits documentation of reason or special circumstance patient cannot use Cortrophin Gel	
Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatm ent of acute exacerbations of multiple sclerosis. See Background for more information.

2 . Background

Benefit/Coverage/Program Information
More Information: The Acthar Gel and Purified Cortrophin Gel package inserts have listed other conditions in which it may be used. UHCP has determined that use of Acthar Gel and Purified Cortrophin Gel is not medically necessary for treatment of the following disorders and diseases: multiple sclerosis; rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state.

Retevmo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146629
Guideline Name	Retevmo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Retevmo	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETEVMO	SELPERCATINIB CAP 40 MG	21535779000120	Brand
RETEVMO	SELPERCATINIB CAP 80 MG	21535779000140	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

AND

3 - Presence of RET gene fusion-positive or RET rearrangement positive tumors

Product Name: Retevmo	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETEVMO	SELPERCATINIB CAP 40 MG	21535779000120	Brand
RETEVMO	SELPERCATINIB CAP 80 MG	21535779000140	Brand

Approval Criteria

1 - All of the following:

1.1 Diagnosis of medullary thyroid cancer (MTC)

AND

1.2 Disease is one of the following:

- Advanced
- Metastatic

AND

1.3 Disease has presence of RET gene mutation

AND

1.4 Disease requires treatment with systemic therapy

OR

2 - All of the following:

2.1 Diagnosis of thyroid cancer

AND

2.2 Disease is one of the following:

- Advanced
- Metastatic

AND

2.3 Disease is RET gene fusion-positive

AND

2.4 Disease requires treatment with systemic therapy

AND

2.5 One of the following:

- Patient is radioactive iodine-refractory
- Treatment with radioactive iodine is not appropriate

Product Name: Retevmo	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETEVMO	SELPERCATINIB CAP 40 MG	21535779000120	Brand
RETEVMO	SELPERCATINIB CAP 80 MG	21535779000140	Brand

Approval Criteria

1 - Diagnosis of ONE of the following histiocytic neoplasms:

- Langerhans Cell Histiocytosis
- Erdheim-Chester disease
- Rosai-Dorfman disease

AND

2 - Used for RET fusion target as a single agent

Product Name: Retevmo	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETEVMO	SELPERCATINIB CAP 40 MG	21535779000120	Brand
RETEVMO	SELPERCATINIB CAP 80 MG	21535779000140	Brand

Approval Criteria

1 - Presence of RET gene fusion-positive solid tumor

AND

2 - Disease is one of the following:

- Recurrent
- Advanced
- Metastatic

Product Name: Retevmo	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Thyroid Cancer, Histiocytic Neoplasms, Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETEVMO	SELPERCATINIB CAP 40 MG	21535779000120	Brand
RETEVMO	SELPERCATINIB CAP 80 MG	21535779000140	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Retevmo therapy

Product Name: Retevmo

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETEVMO	SELPERCATINIB CAP 40 MG	21535779000120	Brand
RETEVMO	SELPERCATINIB CAP 80 MG	21535779000140	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Retevmo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RETEVMO	SELPERCATINIB CAP 40 MG	21535779000120	Brand
RETEVMO	SELPERCATINIB CAP 80 MG	21535779000140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Retevmo therapy

Revlimid

Prior Authorization Guideline

Guideline ID	GL-151139
Guideline Name	Revlimid
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/7/2024

1 . Criteria

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand

REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of multiple myeloma

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Myelodysplastic Syndromes (MDS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) associated with a deletion 5q

OR

2 - BOTH of the following:

2.1 Patient has a diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) WITHOUT deletion 5q

AND

2.2 ONE of the following:

2.2.1 ALL of the following:

2.2.1.1 Serum erythropoietin levels less than or equal to 500 mU/mL

AND

2.2.1.2 One of the following:

- Ring sideroblasts < 15%
- Ring sideroblasts < 5% with an SF3B1 mutation

AND

2.2.1.3 History of failure, contraindication or intolerance to one of the following:

- Erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa
- Reblozyl (luspatercept-aamt)

AND

2.2.1.4 Used in combination with an erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa

OR

2.2.2 ALL of the following:

2.2.2.1 Serum erythropoietin levels less than or equal to 500 mU/mL

AND

2.2.2.2 One of the following:

- Ring sideroblasts ≥ 15%
- Ring sideroblasts ≥ 5% with an SF3B1 mutation

AND

2.2.2.3 History of failure, contraindication or intolerance to both of the following:

- Erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa
- Reblozyl (luspatercept-aamt)

OR

2.2.3 All of the following:

2.2.3.1 Serum erythropoetin levels > 500 mU/mL

AND

2.2.3.2 One of the following:

- Ring sideroblasts < 15%
- Ring sideroblasts < 5% with an SF3B1 mutation

AND

2.2.3.3 One of the following:

- Poor probability to respond to immunosuppressive therapy (e.g., azacitidine, decitabine)
- History of failure, contraindication, or intolerance to immunosuppressive therapy (e.g., azacitidine, decitabine)

OR

2.2.4 All of the following:

2.2.4.1 Serum erythropoetin levels > 500 mU/mL

AND

2.2.4.2 One of the following:

- Ring sideroblasts ≥ 15%
- Ring sideroblasts ≥ 5% with an SF3B1 mutation

AND

2.2.4.3 History of failure, contraindication or intolerance to Reblozyl (luspatercept-aamt)

OR

3 - BOTH of the following:

3.1 Diagnosis of myelodysplastic/myeloproliferative neoplasms (MDS/MPN) overlap neoplasm

AND

3.2 One of the following:

- Patient has SF3B1 mutation and thrombocytosis
- Patient has ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - ONE of the following diagnoses:

- Mantle cell lymphoma (MCL)
- Extranodal marginal zone lymphoma of nongastric sites (noncutaneous)
- Extranodal marginal zone lymphoma (EMZL) of the stomach
- Classic follicular lymphoma
- Nodal marginal zone lymphoma
- Splenic marginal zone lymphoma

OR

2 - BOTH of the following:

2.1 ONE of the following diagnoses:

- HIV-related B-cell lymphoma
- Diffuse large B-cell lymphoma
- High-grade B-cell lymphoma
- Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
- Post-transplant lymphoproliferative disorders

AND

2.2 Used as second line or subsequent therapy

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic

LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of Hodgkin lymphoma

AND

2 - Disease is refractory to at least 3 prior lines of therapy

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of systemic light chain amyloidosis

AND

2 - Used in combination with ONE of the following:

- Dexamethasone
- Dexamethasone and cyclophosphamide
- Dexamethasone and Ninlaro® (ixazomib)

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)

AND

2 - Disease is relapsed or refractory

AND

3 - Used after prior therapy with Bruton Tyrosine Kinase (BTK) inhibitor and venetoclax-based regimens

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	T-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Peripheral T-cell lymphoma
- T-cell leukemia/lymphoma
- Hepatosplenic gamma-delta T-cell lymphoma

AND

2 - Used as second-line or subsequent therapy

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of primary central nervous system lymphoma

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Patient has a diagnosis of human immunodeficiency virus (HIV)-negative Kaposi Sarcoma

OR

1.1.2 BOTH of the following:

1.1.2.1 Diagnosis of HIV-related Kaposi Sarcoma

AND

1.1.2.2 Patient is currently being treated with antiretroviral therapy (ART) confirmed by claims history or submission of medical records

AND

1.2 Disease has progressed or not responded to two different systemic first-line systemic therapies (e.g., liposomal doxorubicin, sirolimus, paclitaxel)

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Langerhans Cell Histiocytosis, Rosai-Dorfman disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic

LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Langerhans cell histiocytosis
- Rosai-Dorfman disease

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Multicentric Castleman Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of multicentric castleman disease

AND

2 - One of the following:

- Progressed following treatment of relapsed/refractory disease
- Considered progressive disease

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Revlimid therapy

Notes	*Multiple Myeloma, Myelodysplastic Syndromes (MDS), B-Cell Lymphomas, Hodgkin Lymphoma, Systemic Light Chain Amyloidosis, Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma, T-Cell Lymphomas, Primary CNS Lymphomas, Kaposi Sarcoma, Langerhans Cell Histiocytosis, Rosai-Dorfman disease, Multicentric Castleman Disease

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Patient has a diagnosis of myelofibrosis-associated anemia

AND

2 - Presence of del(5q) mutation

AND

3 - No symptomatic splenomegaly and/or constitutional symptoms

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Documentation of positive clinical response while on Revlimid

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Revlimid will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Revlimid, generic lenalidomide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Brand
REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	Brand
REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	Brand
REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	Brand
REVLIMID	LENALIDOMIDE CAP 20 MG	99394050000145	Brand
REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	Brand
LENALIDOMIDE	LENALIDOMIDE CAP 5 MG	99394050000120	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 10 MG	99394050000130	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 15 MG	99394050000140	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 25 MG	99394050000150	Generic
LENALIDOMIDE	LENALIDOMIDE CAPS 2.5 MG	99394050000110	Generic
LENALIDOMIDE	LENALIDOMIDE CAP 20 MG	99394050000145	Generic

Approval Criteria

1 - Documentation of positive clinical response to Revlimid therapy

Reyvow

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146408
Guideline Name	Reyvow
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Reyvow	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REYVOW	LASMIDITAN SUCCINATE TAB 50 MG	67406540600310	Brand
REYVOW	LASMIDITAN SUCCINATE TAB 100 MG	67406540600320	Brand

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 History of a therapeutic failure (after at least 3 migraine episodes and a minimum of a 30-day trial), to BOTH of the following as confirmed by claims history or submission of medical records:

3.1.1 TWO of the following:

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)

AND

3.1.2 ONE of the following:

- Nurtec ODT
- Ubrelvy

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt/Maxalt MLT)
- sumatriptan (generic Imitrex)
- Nurtec ODT
- Ubrelvy

AND

4 - Prescribed by or in consultation with ONE of the following specialists with expertise in the acute treatment of migraine:

- Neurologist
- Pain Specialist
- Headache Specialist [Headache specialists are physicians certified by the United Council for Neurologic Subspecialties (UCNS)]

AND

5 - Prescriber attests to BOTH of the following:

5.1 Patient has been informed the use of Reyvow may result in significant CNS (central nervous system) impairment, and may impact the patient's ability to drive or operate machinery for 8 hours after each dose

AND

5.2 If used concurrently with a benzodiazepine or other drugs that could potentially cause CNS depression, the prescriber has acknowledged that they have completed an assessment of increased risk for sedation and other cognitive and/or neuropsychiatric adverse events

AND

6 - ONE of the following:

6.1 Patient is currently treated with ONE of the following prophylactic therapies:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- A calcitonin gene-related peptide receptor (CGRP) antagonist for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab)*, Emgality (galcanezumab), Nurtec ODT, Qulipta*, Vyepti (eptinezumab-jjmr)**]***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

OR

6.2 Patient has less than 4 migraine days per month

OR

6.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ONE of the following prophylactic therapies:

- Amitriptyline (generic Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol*)
- Candesartan (generic Atacand)*
- A calcitonin gene-related peptide receptor (CGRP) antagonist for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab)*, Emgality (galcanezumab), Nurtec ODT, Qulipta*, Vyepti (eptinezumab-jjmr)**]***
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)

Notes	*Timolol, candesartan, Ajovy, and Qulipta are non-preferred and shoul d not be included in denial to provider. **Vyepti and OnabotulinumtoxinA (generic Botox) are medical benefit, should not be included in denial to provider. ***CGRP antagonists for preventive treatment of migraines require a p rior authorization.

Product Name: Reyvow	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REYVOW	LASMIDITAN SUCCINATE TAB 50 MG	67406540600310	Brand
REYVOW	LASMIDITAN SUCCINATE TAB 100 MG	67406540600320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Rezdiffra

Prior Authorization Guideline

Guideline ID	GL-147405
Guideline Name	Rezdiffra
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rezdiffra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REZDIFFRA	RESMETIROM 60 MG TAB	52601060000320	Brand
REZDIFFRA	RESMETIROM 80 MG TAB	52601060000330	Brand
REZDIFFRA	RESMETIROM 100 MG TAB	52601060000340	Brand

Approval Criteria

1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)]

AND

2 - Disease is fibrosis stage F2 or F3 as confirmed by one of the following:

2.1 FAST [FibroScan-aspartate aminotransferase (AST)]

OR

2.2 MAST [derived from magnetic resonance imaging–proton density fat fraction, magnetic resonance elastography (MRE), and AST]

OR

2.3 MEFIB [MRE combined with fibrosis-4 index (FIB-4)]

OR

2.4 Liver biopsy

AND

3 - Patient has received comprehensive counseling regarding lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

4 - Prescribed by or in consultation with a gastroenterologist or hepatologist

Product Name: Rezdiffra	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REZDIFFRA	RESMETIROM 60 MG TAB	52601060000320	Brand
REZDIFFRA	RESMETIROM 80 MG TAB	52601060000330	Brand
REZDIFFRA	RESMETIROM 100 MG TAB	52601060000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rezdiffra therapy (e.g., improvement in or stabilization of fibrosis)

AND

2 - Prescribed by or in consultation with a gastroenterologist or hepatologist

2 . Revision History

Date	Notes
5/14/2024	New guideline

Rezlidhia

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146631
Guideline Name	Rezlidhia
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rezlidhia	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REZLIDHIA	OLUTASIDENIB CAP 150 MG	21534960000120	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - Positive for a susceptible isocitrate dehydrogenase-1 (IDH1) mutation (e.g., R132C, R132H, R132G, R132S, R132L)

AND

3 - Disease is relapsed or refractory

Product Name: Rezlidhia	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REZLIDHIA	OLUTASIDENIB CAP 150 MG	21534960000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Rezlidhia therapy

Product Name: Rezlidhia	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

REZLIDHIA	OLUTASIDENIB CAP 150 MG	21534960000120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Rezlidhia	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REZLIDHIA	OLUTASIDENIB CAP 150 MG	21534960000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rezlidhia therapy

Rezurock

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146632
Guideline Name	Rezurock
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rezurock	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REZUROCK	BELUMOSUDIL MESYLATE TAB 200 MG	99398510500320	Brand

Approval Criteria

1 - Diagnosis of chronic graft-versus-host disease (chronic GVHD)

AND

2 - History of failure of at least TWO prior lines of systemic therapy (e.g., corticosteroids, mycophenolate, tacrolimus, etc.) confirmed by claims history or submitted medical records

AND

3 - The patient is at least 12 years of age

Product Name: Rezurock	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
REZUROCK	BELUMOSUDIL MESYLATE TAB 200 MG	99398510500320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rezurock therapy

Rinvoq

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155091
Guideline Name	Rinvoq
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses as confirmed by claims history or submission of medical records

OR

2.1.1.2 History of intolerance or contraindication to ONE non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) (please specify intolerance or contraindication)

OR

2.1.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Olumiant (baricitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to THREE of the following as confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)

- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

OR

2.1.2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Cimzia (certolizumab)
- Enbrel (etanercept)
- One of the preferred adalimumab products*
- Tyenne (tocilizumab-aazg)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

2.1.3 ONE of the following:

2.1.3.1 Failure to Olumiant as confirmed by claims history or submission of medical records

OR

2.1.3.2 History of contraindication or intolerance to Olumiant (please specify contraindication or intolerance)

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand
RINVOQ LQ	UPADACITINIB ORAL SOLN 1 MG/ML	66603072002020	Brand

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to a 3 month trial of methotrexate at maximally indicated dose as confirmed by claims history or submission of medical records

OR

2.1.1.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

2.1.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Cosentyx (secukinumab), Taltz (ixekizumab), Olumiant (baricitinib), Otezla (apremilast), Skyrizi (risankizumab-rzaa)]

AND

2.1.2 ONE of the following:

2.1.2.1 BOTH of the following:

2.1.2.1.1 ONE of the following:

2.1.2.1.1.1 Failure to at least TWO of the following as confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

OR

2.1.2.1.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

AND

2.1.2.1.2 ONE of the following:

2.1.2.1.2.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

OR

2.1.2.1.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

2.1.2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

2.2 Patient is currently on Rinvoq or Rinvoq LQ therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq or Rinvoq LQ in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Rinvoq	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to TWO of the following therapeutic classes of topical therapies, as confirmed by claims history or submission of medical records:

- One medium to very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

OR

2.1.1.2 History of intolerance or contraindication to ALL of the following therapeutic classes of topical therapies (please specify intolerance or contraindication):

- One medium to very-high potency topical corticosteroid [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)] (see Table 1 in Background)
- One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]
- Eucrisa (crisaborole)

AND

2.1.2 ONE of the following:

2.1.2.1 BOTH of the following:

2.1.2.1.1 Submission of medical records (e.g., chart notes, laboratory values) documenting a 3 month trial of a systemic drug product for the treatment of atopic dermatitis [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.]

AND

2.1.2.1.2 Physician attests that the patient was not adequately controlled with the documented systemic drug product

OR

2.1.2.2 Physician attests that systemic treatment with BOTH of the following FDA (Food and Drug Administration)-approved atopic dermatitis therapy is inadvisable (document drug and contraindication rationale):

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure [refer to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-V-TR) 300.29 for specific phobia diagnostic criteria]

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Rinvoq	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

2.1.1.2 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz/XR (tofacitinib)]

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

OR

2.1.2.2 History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Rinvoq	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active ankylosing spondylitis

AND

1.2 ONE of the following:

1.2.1 Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 ONE of the following:

1.3.1.1.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

OR

1.3.1.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

AND

1.3.1.2 ONE of the following:

1.3.1.2.1 Failure to Cosentyx (secukinumab), as confirmed by claims history or submission of medical records

OR

1.3.1.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

1.3.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Rinvoq therapy, as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Rinvoq	
Diagnosis	Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - Diagnosis of non-radiographic axial spondyloarthritis

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen,

naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

2.1.1.2 History of intolerance or contraindication to TWO NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

2.1.1.3 Patient has been previously treated with a biologic DMARD FDA-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Cosentyx (secukinumab)]

AND

2.1.2 ONE of the following:

2.1.2.1 ONE of the following:

2.1.2.1.1 Failure to Cimzia (certolizumab), as confirmed by claims history or submission of medical records

OR

2.1.2.1.2 History of contraindication or intolerance to Cimzia (certolizumab) (please specify contraindication or intolerance)

OR

2.1.2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

OR

2.2 Patient is currently on Rinvoq therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Rinvoq	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn’s Disease

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to ONE of the following conventional therapy drugs or classes at maximally indicated dose confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.1.1.2 History of intolerance or contraindication to ALL of the following conventional therapy drugs or classes (please specify intolerance or contraindication)

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.1.1.3 Patient has been previously treated with a biologic disease modifying anti-rheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab]

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to BOTH of the following confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Cimzia (certolizumab)

OR

2.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Cimzia (certolizumab)

OR

2.2 Patient is currently on Rinvoq therapy for moderately to severely active Crohn's disease as confirmed by claims history or submitted medical records

AND

3 - Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Rinvoq, Rinvoq LQ	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand
RINVOQ LQ	UPADACITINIB ORAL SOLN 1 MG/ML	66603072002020	Brand

Approval Criteria

1 - Diagnosis of active polyarticular juvenile idiopathic arthritis

AND

2 - One of the following:

2.1 One of the following:

2.1.1 Failure to ALL of the following as confirmed by claims history or submission of medical records

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

2.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria5)

OR

2.3 Patient is currently on Rinvoq or Rinvoq LQ therapy as confirmed by claims history or submission of medical records

AND

3 - Patient is not receiving Rinvoq or Rinvoq LQ in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Xeljanz (tofacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA), Ulcerative Colitis (UC), Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis (nr-axSpA), Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq therapy

AND

2 - Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)]*
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

Notes	* Examples of drug(s) may not be applicable based on the requested i ndication.

Product Name: Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA), Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand
RINVOQ LQ	UPADACITINIB ORAL SOLN 1 MG/ML	66603072002020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq or Rinvoq LQ therapy

AND

2 - Patient is NOT receiving Rinvoq or Rinvoq LQ in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)]*
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

Notes	* Examples of drug(s) may not be applicable based on the requested i ndication.

Product Name: Rinvoq	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq therapy

AND

2 - Patient is NOT receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

3 - Prescribed by or in consultation with ONE of the following:

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05

	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
9/17/2024	Removed Kevzara and added Tyenne as a step through agent for R A and PJIA

Rivfloza

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149311
Guideline Name	Rivfloza
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/2/2024

1 . Criteria

Product Name: Rivfloza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RIVFLOZA	NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 128 MG/0.8ML	5662605060E520	Brand
RIVFLOZA	NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 160 MG/ML	5662605060E530	Brand
RIVFLOZA	NEDOSIRAN SODIUM SUBCUTANEOUS SOLN 80 MG/0.5ML	56626050602020	Brand

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Rivfloza under an active UnitedHealthcare medical benefit prior authorization for the treatment of primary hyperoxaluria type 1 (PH1)

AND

1.2 Submission of medical records (e.g., chart notes, laboratory values) documenting a positive clinical response to therapy from pre-treatment baseline (e.g., decreased urinary oxalate concentrations, decreased urinary oxalate: creatinine ratio, decreased plasma oxalate concentrations)

AND

1.3 Patient has NOT received a liver transplant

AND

1.4 Patient has relatively preserved kidney function (e.g., eGFR [estimated glomerular filtration rate] greater than or equal to 30 mL/min/1.73 m^2)

AND

1.5 Patient is NOT receiving Rivfloza in combination with Oxlumo (lumasiran)

AND

1.6 Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

OR

2 - ALL of the following:

2.1 Diagnosis of primary hyperoxaluria type 1 (PH1)

AND

2.2 Confirmation of diagnosis based on BOTH of the following:

2.2.1 Metabolic testing demonstrating ONE of the following:

2.2.1.1 Increased urinary oxalate excretion (e.g., greater than 1 mmol/1.73 m^2 per day [90 mg/1.73 m^2 per day], increased urinary oxalate: creatinine ratio relative to normative values for age)

OR

2.2.1.2 Increased plasma oxalate and glyoxylate concentrations

AND

2.2.2 Genetic testing has confirmed a mutation in the alanine: glyoxylate aminotransferase (AGT or AGXT) gene

AND

2.3 Patient has NOT received a liver transplant

AND

2.4 Patient is at least 9 years of age or older

AND

2.5 Patient has relatively preserved kidney function (e.g., eGFR [estimated glomerular filtration rate] greater than or equal to 30 mL/min/1.73 m^2)

AND

2.6 Patient is NOT receiving Rivfloza in combination with Oxlumo (lumasiran)

AND

2.7 Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

Product Name: Rivfloza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RIVFLOZA	NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 128 MG/0.8ML	5662605060E520	Brand
RIVFLOZA	NEDOSIRAN SODIUM SUBCUTANEOUS SOLN PREF SYR 160 MG/ML	5662605060E530	Brand
RIVFLOZA	NEDOSIRAN SODIUM SUBCUTANEOUS SOLN 80 MG/0.5ML	56626050602020	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a positive clinical response to therapy from pre-treatment baseline (e.g., decreased urinary oxalate concentrations, decreased urinary oxalate: creatinine ratio, decreased plasma oxalate concentrations)

AND

2 - Patient has NOT received a liver transplant

AND

3 - Patient has relatively preserved kidney function (e.g., eGFR [estimated glomerular filtration rate] greater than or equal to 30 mL/min/1.73 m^2)

AND

4 - Patient is NOT receiving Rivfloza in combination with Oxlumo (lumasiran)

AND

5 - Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

2 . Revision History

Date	Notes
7/2/2024	New program.

Rozerem

Prior Authorization Guideline

Guideline ID	GL-146409
Guideline Name	Rozerem
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Rozerem, generic ramelteon	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAMELTEON	RAMELTEON TAB 8 MG	60250060000320	Generic
ROZEREM	RAMELTEON TAB 8 MG	60250060000320	Brand

Approval Criteria

1 - Failure of at least 2 weeks to ALL of the following sedative-hypnotic alternatives confirmed by claims history or submitted medical records:

- Zolpidem or zolpidem ER (generic Ambien, generic Ambien CR)
- Zaleplon (generic Sonata)
- Eszopiclone (generic Lunesta)

OR

2 - History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Zolpidem or zolpidem ER (generic Ambien, generic Ambien CR)
- Zaleplon (generic Sonata)
- Eszopiclone (generic Lunesta)

OR

3 - History of or potential for a substance abuse disorder

Rozlytrek

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146634
Guideline Name	Rozlytrek
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rozlytrek	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ROZLYTREK	ENTRECTINIB CAP 100 MG	21533820000120	Brand
ROZLYTREK	ENTRECTINIB CAP 200 MG	21533820000130	Brand
ROZLYTREK	ENTRECTINIB PELLET PACK 50 MG	21533820003020	Brand

Approval Criteria

1 - Patient has diagnosis of metastatic non-small cell lung cancer (NSCLC)

AND

2 - Disease is ROS1 (gene)-positive

Product Name: Rozlytrek	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ROZLYTREK	ENTRECTINIB CAP 100 MG	21533820000120	Brand
ROZLYTREK	ENTRECTINIB CAP 200 MG	21533820000130	Brand
ROZLYTREK	ENTRECTINIB PELLET PACK 50 MG	21533820003020	Brand

Approval Criteria

1 - Presence of solid tumors [e.g., sarcoma, non-small cell lung cancer (NSCLC), salivary, breast, thyroid, colorectal, neuroendocrine, pancreatic, gynecological, cholangiocarcinoma, etc.]

AND

2 - Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]

AND

4 - Disease is ONE of the following:

- Metastatic
- Unresectable

Product Name: Rozlytrek	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ROZLYTREK	ENTRECTINIB CAP 100 MG	21533820000120	Brand
ROZLYTREK	ENTRECTINIB CAP 200 MG	21533820000130	Brand
ROZLYTREK	ENTRECTINIB PELLET PACK 50 MG	21533820003020	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Rozlytrek therapy

Product Name: Rozlytrek	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ROZLYTREK	ENTRECTINIB CAP 100 MG	21533820000120	Brand
ROZLYTREK	ENTRECTINIB CAP 200 MG	21533820000130	Brand
ROZLYTREK	ENTRECTINIB PELLET PACK 50 MG	21533820003020	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Rozlytrek	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ROZLYTREK	ENTRECTINIB CAP 100 MG	21533820000120	Brand
ROZLYTREK	ENTRECTINIB CAP 200 MG	21533820000130	Brand
ROZLYTREK	ENTRECTINIB PELLET PACK 50 MG	21533820003020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rozlytrek therapy

Rubraca

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146635
Guideline Name	Rubraca
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rubraca	
Diagnosis	Epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUBRACA	RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT)	21535570200325	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT)	21535570200330	Brand

RUBRACA	RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT)	21535570200320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - BOTH of the following:

2.1 Cancer has a deleterious BRCA mutation

AND

2.2 To be used as maintenance therapy in individuals who are in complete or partial response to platinum-based chemotherapy

Product Name: Rubraca	
Diagnosis	Prostate cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUBRACA	RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT)	21535570200325	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT)	21535570200330	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT)	21535570200320	Brand

Approval Criteria

1 - Diagnosis of metastatic, castration-resistant prostate cancer

AND

2 - Cancer has a deleterious BRCA mutation

AND

3 - ONE of the following:

3.1 Failure to androgen receptor-directed therapy [e.g., Zytiga (abiraterone), Xtandi (enzalutamide), Erleada (apalutamide)] as confirmed by claims history or submission of medical records

OR

3.2 Contraindication or intolerance to androgen receptor-directed therapy [e.g., Zytiga (abiraterone), Xtandi (enzalutamide), Erleada (apalutamide)] (please specify intolerance or contraindication

AND

4 - History of failure, contraindication, or intolerance to taxane-based chemotherapy (e.g., docetaxel, Jevtana (cabazitaxel))

AND

5 - ONE of the following:

5.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

5.2 Patient has had bilateral orchiectomy

Product Name: Rubraca	
Diagnosis	Uterine cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUBRACA	RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT)	21535570200325	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT)	21535570200330	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT)	21535570200320	Brand

Approval Criteria

1 - Diagnosis of BRCA altered uterine leiomyosarcoma (uLMS)

AND

2 - Disease has progressed following prior treatment with ONE of the following:

- Gemcitabine plus docetaxel
- Doxorubicin

Product Name: Rubraca	
Diagnosis	Pancreatic cancer
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUBRACA	RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT)	21535570200325	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT)	21535570200330	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT)	21535570200320	Brand

Approval Criteria

1 - Diagnosis of pancreatic adenocarcinoma

AND

2 - Disease is metastatic

AND

3 - Presence of ONE of the following:

3.1 Deleterious or suspected deleterious germline or somatic BRCA1/2 mutation

OR

3.2 Deleterious or suspected deleterious germline or somatic PALB2 mutation

AND

4 - Disease has NOT progressed while receiving at least 16 weeks of a first-line platinum-based chemotherapy regimen

Product Name: Rubraca

Diagnosis	Epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, Prostate cancer, Uterine cancer, Pancreatic cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUBRACA	RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT)	21535570200325	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT)	21535570200330	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT)	21535570200320	Brand

Approval Criteria

1 - Patient does NOT show evidence of progressive disease while on Rubraca therapy

Product Name: Rubraca	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUBRACA	RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT)	21535570200325	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT)	21535570200330	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT)	21535570200320	Brand

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Rubraca	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUBRACA	RUCAPARIB CAMSYLATE TAB 250 MG (BASE EQUIVALENT)	21535570200325	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 300 MG (BASE EQUIVALENT)	21535570200330	Brand
RUBRACA	RUCAPARIB CAMSYLATE TAB 200 MG (BASE EQUIVALENT)	21535570200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rubraca therapy

Ruconest

Prior Authorization Guideline

Guideline ID	GL-148152
Guideline Name	Ruconest
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Ruconest	
Diagnosis	Hereditary Angioedema (HAE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUCONEST	C1 ESTERASE INHIBITOR (RECOMBINANT) FOR IV INJ 2100 UNIT	85802022102130	Brand

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - Prescribed for the acute treatment of HAE attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name: Ruconest

Diagnosis	Hereditary Angioedema (HAE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUCONEST	C1 ESTERASE INHIBITOR (RECOMBINANT) FOR IV INJ 2100 UNIT	85802022102130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ruconest therapy

AND

2 - Prescribed for the acute treatment of HAE attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes

6/5/2024	Update to types of genetic variant(s) and diagnostic criteria with nor mal C1 inhibitor levels in initial auth section and minor language upd ate in reauth section; Minor cosmetic updates.

Rukobia

Prior Authorization Guideline

Guideline ID	GL-146410
Guideline Name	Rukobia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rukobia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RUKOBIA	FOSTEMSAVIR TROMETHAMINE TAB ER 12HR 600 MG	12102330407420	Brand

Approval Criteria

1 - Patient has been diagnosed with multidrug-resistant HIV-1 (human immunodeficiency virus) infection

AND

2 - Patient is currently taking or will be prescribed an optimized background antiretroviral regimen

Rydapt

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146637
Guideline Name	Rydapt
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Rydapt	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RYDAPT	MIDOSTAURIN CAP 25 MG	21533030000130	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - AML is FLT3 mutation-positive

AND

3 - Rydapt will be used in combination with standard induction and consolidation therapy

Product Name: Rydapt	
Diagnosis	Systemic Mastocytosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RYDAPT	MIDOSTAURIN CAP 25 MG	21533030000130	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Aggressive systemic mastocytosis (ASM)
- Systemic mastocytosis with associated hematologic neoplasm (SM-AHN)
- Mast cell leukemia (MCL)

Product Name: Rydapt	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RYDAPT	MIDOSTAURIN CAP 25 MG	21533030000130	Brand

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - ONE of the following:

- Patient has a FGFR1 rearrangement
- Patient has a FLT3 rearrangement

Product Name: Rydapt	
Diagnosis	Acute Myeloid Leukemia (AML), Systemic Mastocytosis, Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RYDAPT	MIDOSTAURIN CAP 25 MG	21533030000130	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Rydapt therapy

Product Name: Rydapt	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RYDAPT	MIDOSTAURIN CAP 25 MG	21533030000130	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Rydapt	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RYDAPT	MIDOSTAURIN CAP 25 MG	21533030000130	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rydapt therapy

Samsca

Prior Authorization Guideline

Guideline ID	GL-146638
Guideline Name	Samsca
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Samsca, generic tolvaptan	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOLVAPTAN	TOLVAPTAN TAB 15 MG	30454060000320	Generic
SAMSCA	TOLVAPTAN TAB 15 MG	30454060000320	Brand
TOLVAPTAN	TOLVAPTAN TAB 30 MG	30454060000330	Generic
SAMSCA	TOLVAPTAN TAB 30 MG	30454060000330	Brand

Approval Criteria

1 - ONE of the following:

- Diagnosis of clinically significant euvolemic hyponatremia
- Diagnosis of clinically significant hypervolemic hyponatremia

AND

2 - Patient has not responded to fluid restriction

AND

3 - Treatment has been initiated or re-initiated in a hospital setting prior to discharge

Sandostatin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146639
Guideline Name	Sandostatin
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic

OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - ONE of the following:

2.1 Inadequate response to ONE of the following:

- Surgery
- Radiotherapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

2.2 NOT a candidate for any of the following:

- Surgery
- Radiotherapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Diagnosis of meningioma

AND

2 - Disease is surgically inaccessible

AND

3 - ONE of the following:

- Disease is recurrent
- Disease is progressive

AND

4 - Additional radiation is not possible

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand

OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Patient has neuroendocrine tumors [e.g., carcinoid tumors, Islet cell tumors, gastrinomas, glucagonomas, insulinomas, lung tumors, somatostatinomas, tumors of the pancreas, GI (gastrointestinal) tract, lung and thymus, adrenal glands, and vasoactive intestinal polypeptidomas (VIPomas)]

OR

2 - ALL of the following:

- Diagnosis of Pheochromocytoma or Paraganglioma
- Disease is locally unresectable or distant metastases
- Disease is somatostatin receptor positive
- Presence of symptomatic disease

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic

SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on the requested therapy

OR

2 - Documentation of positive clinical response (e.g., suppression of severe diarrhea, flushing, etc.) to the requested therapy

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand

OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Diagnosis of thymoma or thymic carcinoma

AND

2 - ONE of the following:

2.1 Used as a second-line therapy for ONE of the following:

2.1.1 Unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis

OR

2.1.2 Extrathoracic metastatic disease

OR

2.2 BOTH of the following:

2.2.1 Used as first line therapy for ONE of the following:

- Unresectable locally advanced disease in combination with radiation therapy
- Potentially resectable locally advanced disease
- Potentially resectable solitary metastasis or ipsilateral pleural metastasis
- Consideration following surgery for solitary metastasis or ipsilateral pleural metastasis

- Medically inoperable/unresectable solitary metastasis or ipsilateral pleural metastasis
- Extrathoracic metastatic disease
- Postoperative treatment for thymoma after R2 resection

AND

2.2.2 Patient is unable to tolerate first-line combination regimens

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Meningioma, Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on the requested therapy

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Malignant Bowel Obstruction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Diagnosis of malignant bowel obstruction

AND

2 - Gut function cannot be maintained

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Chemotherapy- and/or Radiation-Induced Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Diagnosis of diarrhea due to concurrent cancer chemotherapy and/or radiation

AND

2 - ONE of the following:

2.1 Presence of Grade 3 or 4 severe diarrhea

OR

2.2 Patient is in palliative or end of life care

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	HIV/AIDS-Related Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Diagnosis of HIV (human immunodeficiency virus)/AIDS (acquired immunodeficiency syndrome)-related diarrhea

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Bleeding Gastroesophageal Varices
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Diagnosis of bleeding gastroesophageal varices associated with liver disease

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Acromegaly, Malignant Bowel Obstruction, Chemotherapy- and/or Radiation-Induced Diarrhea, HIV/AIDS-Related Diarrhea, Bleeding Gastroesophageal Varices, NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 50 MCG/ML	3017007010E505	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 100 MCG/ML	3017007010E510	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE SUBCUTANEOUS SOLN PREF SYR 500 MCG/ML	3017007010E520	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	Generic
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Generic
SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	Brand
OCTREOTIDE ACETATE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

Scemblix

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146640
Guideline Name	Scemblix
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Scemblix	
Diagnosis	Philadelphia Chromosome-Positive Chronic Myeloid Leukemia (Ph+CML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SCEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand

Approval Criteria

1 - Diagnosis of chronic myeloid leukemia (CML)

AND

2 - Disease is Philadelphia chromosome-positive (Ph+)

AND

3 - Disease is in chronic phase

AND

4 - ONE of the following:

4.1 Patient has been previously treated with two or more tyrosine kinase inhibitors [e.g., Bosulif (bosutinib), imatinib (Gleevec), Sprycel (dasatinib), Tasigna (nilotinib)]

OR

4.2 Disease is T315I mutation positive

Product Name: Scemblix	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia and ABL1 Gene Rearrangement
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SCEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand

SCEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and ABL1 rearrangement

AND

1.2 Disease is in chronic phase

OR

2 - BOTH of the following:

2.1 Diagnosis of lymphoid, myeloid, or mixed lineage neoplasm with eosinophilia and ABL1 rearrangement

AND

2.2 Disease is in blast phase

Product Name: Scemblix	
Diagnosis	Philadelphia Chromosome-Positive Chronic Myeloid Leukemia (Ph+CML), Myeloid/Lymphoid Neoplasms with Eosinophilia and ABL1 Gene Rearrangement
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SCEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Scemblix therapy

Product Name: Scemblix	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SCEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Scemblix	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SCEMBLIX	ASCIMINIB HCL TAB 20 MG	21531806100320	Brand
SCEMBLIX	ASCIMINIB HCL TAB 40 MG	21531806100340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Scemblix therapy

Sensipar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146411
Guideline Name	Sensipar
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Generic
SENSIPAR	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Brand
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Generic
SENSIPAR	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Brand

CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Generic
SENSIPAR	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Brand

Approval Criteria

1 - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist

AND

2 - ONE of the following:

2.1 Diagnosis of hypercalcemia with parathyroid carcinoma

OR

2.2 ALL of the following:

2.2.1 Diagnosis of primary hyperparathyroidism (HPT)

AND

2.2.2 Severe hypercalcemia [serum calcium level greater than 12.5 mg/dL (milligrams/deciliter)] due to primary HPT

AND

2.2.3 Patient is unable to undergo parathyroidectomy

OR

2.3 ALL of the following:

2.3.1 Diagnosis of secondary hyperparathyroidism with chronic kidney disease

AND

2.3.2 Patient is on dialysis

AND

2.3.3 BOTH of the following:

2.3.3.1 ONE of the following:

- Patient has therapeutic failure to ONE phosphate binder (e.g., PhosLo, Fosrenol, Renvela, Renagel, etc.) confirmed by claims history or submitted medical records
- Patient has intolerance or contraindication to ONE phosphate binders (e.g., PhosLo, Fosrenol, Renvela, Renagel, etc.) (please specify intolerance or contraindication)

AND

2.3.3.2 ONE of the following:

- Patient has therapeutic failure to ONE vitamin D analog (e.g., calcitriol, Hectorol, Zemplar, etc.) confirmed by claims history or submitted medical records
- Patient has intolerance or contraindication to ONE vitamin D analogs (e.g., calcitriol, Hectorol, Zemplar, etc.) (please specify intolerance or contraindication)

Product Name: Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Generic
SENSIPAR	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	Brand
CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Generic
SENSIPAR	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	Brand

CINACALCET HYDROCHLORIDE	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Generic
SENSIPAR	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	Brand

Approval Criteria

1 - Patient has experienced a reduction in serum calcium from baseline

Sevelamer carbonate

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146412
Guideline Name	Sevelamer carbonate
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Generic sevelamer carbonate tablets	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
SEVELAMER CARBONATE	SEVELAMER CARBONATE TAB 800 MG	52800070050340	Generic

Approval Criteria

1 - The patient did not exhibit an adequate response to treatment with at least an 8-week trial of calcium acetate as supported by claims history or submitted medical records

OR

2 - The patient experienced an intolerance/adverse reaction to previous therapy with calcium acetate (please indicate intolerance/adverse reaction)

OR

3 - The patient has a documented contraindication to treatment with calcium acetate (please indicate contraindication)

SGLT2 Inhibitors

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155750
Guideline Name	SGLT2 Inhibitors
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Steglatro, Segluromet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 5 MG (BASE EQUIV)	27700055200320	Brand
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 15 MG (BASE EQUIV)	27700055200340	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-500 MG	27996002450310	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-1000 MG	27996002450320	Brand

SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-500 MG	27996002450330	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-1000 MG	27996002450340	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

Product Name: Jardiance	
Diagnosis	Type 2 Diabetes Mellitus*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 ONE of the following:

3.1.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

OR

3.1.2 History of intolerance or contraindication to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify intolerance or contraindication)

OR

3.2 BOTH of the following:

3.2.1 ONE of the following:

3.2.1.1 Documented history of heart failure

OR

3.2.1.2 Documented history of chronic kidney disease

OR

3.2.1.3 Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to dapagliflozin (Farxiga authorized generic) for 90 days confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

Notes	*Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use these criteria.

Product Name: Jardiance	
Diagnosis	Heart Failure WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand

JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand

Approval Criteria

1 - The patient has a diagnosis of heart failure WITHOUT diabetes type 2 [NYHA (New York Heart Association) class II-IV*]

AND

2 - ONE of the following:

2.1 Failure to dapagliflozin (Farxiga authorized generic) as confirmed by claims history or submission of medical records.

OR

2.2 History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

Notes	*Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Jardiance	
Diagnosis	Chronic Kidney Disease (CKD), at risk of progression WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand

Approval Criteria

1 - The patient has a diagnosis of chronic kidney disease (CKD) at risk of progression WITHOUT diabetes type 2

AND

2 - ONE of the following:

2.1 Patient is currently taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), as confirmed by claims history or submission of medical records.

OR

2.2 Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to dapagliflozin (Farxiga authorized generic) as confirmed by claims history or submission of medical records.

OR

3.2 History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

Notes	*Patients with heart failure, CKD (chronic kidney disease), or ASCVD (atherosclerotic cardiovascular disease) WITH type 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Invokana	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

INVOKANA	CANAGLIFLOZIN TAB 100 MG	27700020000320	Brand
INVOKANA	CANAGLIFLOZIN TAB 300 MG	27700020000330	Brand

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 ONE of the following:

3.1.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days, confirmed by claims history or submission of medical records

OR

3.1.2 History of contraindication or intolerance to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify contraindication or intolerance)

OR

3.2 Documented history of diabetic nephropathy with albuminuria

OR

3.3 BOTH of the following:

3.3.1 ONE of the following:

3.3.1.1 Documented history of heart failure

OR

3.3.1.2 Documented history of chronic kidney disease

OR

3.3.1.3 Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

AND

3.3.2 ONE of the following:

3.3.2.1 Failure to dapagliflozin (Farxiga authorized generic) for 90 days confirmed by claims history or submission of medical records

OR

3.3.2.2 History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

Product Name: Farxiga, Dapagliflozin	
Diagnosis	Type 2 Diabetes Mellitus*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Documented history of heart failure

OR

3.2 Documented history of chronic kidney disease

OR

3.3 Documented history of atherosclerotic cardiovascular disease defined as having ONE or more of the following:

- History of an acute coronary syndrome or myocardial infarction
- Stable or unstable angina
- Coronary heart disease with or without revascularization
- Other arterial revascularization
- Stroke
- Peripheral artery disease assumed to be atherosclerotic in origin

OR

3.4 TWO of the following risk factors for developing cardiovascular disease:

- Men greater than or equal to 55 years or women greater than or equal to 65 years
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension [pretreatment blood pressure greater than or equal to 140 millimeters of mercury (mmHg) systolic or greater than or equal to 90 mmHg diastolic]
- HDL-C less than or equal to 40 milligrams/deciliter (mg/dL) for men or less than or equal to 50 mg/dL for women
- High-sensitivity C-reactive protein greater than 3.0 milligrams/liter (mg/L)
- Creatinine clearance greater than 30 and less than 60 milliliters/minute (mL/min)
- Retinopathy
- Micro- or macro-albuminuria
- Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication

OR

3.5 ONE of the following:

3.5.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

OR

3.5.2 History of contraindication or intolerance to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify contraindication or intolerance)

AND

4 - If the request is for brand Farxiga, ONE of the following:

4.1 Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

Notes	*Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use these criteria.

Product Name: Farxiga, Dapagliflozin	
Diagnosis	Heart Failure WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic

Approval Criteria

1 - The patient has a diagnosis of heart failure WITHOUT diabetes type 2 [NYHA (New York Heart Association) class II-IV*]

AND

2 - If the request is for brand Farxiga, ONE of the following:

2.1 Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to dapagliflozin (Farxiga authorized generic) (please specify intolerance or contraindication)

Notes	*Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Farxiga, Dapagliflozin	
Diagnosis	Chronic Kidney Disease WITHOUT Diabetes Type 2*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic

Approval Criteria

1 - Patient has a diagnosis of chronic kidney disease WITHOUT diabetes type 2*

AND

2 - ONE of the following:

2.1 Patient currently taking an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) confirmed by claims history or submission of medical records

OR

2.2 Patient has documentation of intolerance or contraindication to ACE inhibitor or ARB (please specify intolerance or contraindication)

AND

3 - If the request is for brand Farxiga, ONE of the following:

3.1 Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

Notes	*Patients with heart failure, CKD (chronic kidney disease), ASCVD (at herosclerotic cardiovascular disease), or ASCVD risk factors WITH ty pe 2 diabetes should use Type 2 Diabetes Mellitus criteria.

Product Name: Brenzavvy, Bexagliflozin, Synjardy, Synjardy XR, Invokamet, Invokamet XR, Xigduo XR, Dapagliflozin/Metformin ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-500 MG	27996002200320	Brand

INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-1000 MG	27996002200330	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-500 MG	27996002200340	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-1000 MG	27996002200350	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-500 MG	27996002400310	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-1000 MG	27996002400315	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-500 MG	27996002400320	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-1000 MG	27996002400325	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27996002207520	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27996002207530	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-500 MG	27996002207540	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-1000 MG	27996002207550	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002407530	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002407540	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 12.5-1000 MG	27996002407550	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 25-1000 MG	27996002407560	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27996002307507	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-500 MG	27996002307510	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-500 MG	27996002307520	Brand

XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
BEXAGLIFLOZIN	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic
BRENZAVVY	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 Suboptimal response to metformin at a minimum dose of 1500 milligrams daily for 90 days confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to metformin (please specify intolerance or contraindication)

AND

3 - ONE of the following:

3.1 Failure to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) for 90 days confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to Steglatro (ertugliflozin) OR Segluromet (ertugliflozin/metformin) (please specify intolerance or contraindication)

Product Name: Inpefa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
INPEFA	SOTAGLIFLOZIN TAB 200 MG	40750010000320	Brand
INPEFA	SOTAGLIFLOZIN TAB 400 MG	40750010000340	Brand

Approval Criteria

1 - ONE of the following:

1.1 The patient has a diagnosis of heart failure

OR

1.2 ALL of the following:

1.2.1 Diagnosis of type 2 diabetes mellitus

AND

1.2.2 Diagnosis of chronic kidney disease

AND

1.2.3 At least ONE additional cardiovascular risk factor such as:

- History of heart failure
- Obesity
- Dyslipidemia
- Hypertension
- Elevated cardiac and inflammatory biomarkers

AND

2 - ONE of the following:

2.1 Failure to dapagliflozin (Farxiga authorized generic) confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to dapagliflozin (Farxiga authorized generic) (please specify contraindication or intolerance)

2 . Revision History

Date	Notes
9/23/2024	Updated step through language for generic Farxiga

Short-Acting Opioid Products

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146846
Guideline Name	Short-Acting Opioid Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond	
Diagnosis	DUR: Non-cough and cold Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit and/or 50-90MME limit*

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand

ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic

HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand

OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155220	Generic

	OPIUM SUPPOS 16.2-60 MG		
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN	65990002202020	Generic

	SOLN 10-300 MG/5ML		
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic

OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - Opioid naïve patients (defined as not having filled an opioid in the past 60 days) may receive greater than the 7 day supply limit and/or greater than 50 morphine milligram equivalents (MME) based on ALL of the following:

1.1 If the request is for greater than the 7 day supply limit, ONE of the following:

1.1.1 Cancer diagnosis

OR

1.1.2 End of life care, including hospice care

OR

1.1.3 Palliative care

OR

1.1.4 Sickle cell anemia

OR

1.1.5 BOTH of the following:

1.1.5.1 ONE of the following:

- Traumatic injury
- Post-surgical procedures, excluding dental procedures
- Prescriber attests that the patient has received an opioid within the past 60 days

AND

1.1.5.2 Prescriber attests if requested for traumatic injury or post-surgical procedure, that based on injury or surgical procedure performed the patient requires greater than a 7 day supply of short-acting opioid to adequately control pain

AND

1.2 If the request is for 50 MME to 90 MME, ONE of the following (NOTE: If the request exceeds 90 MME please skip this section and proceed to the MME Reviews section):

1.2.1 Diagnosis of ONE of the following:

- Cancer
- End of life pain (including hospice care)
- Palliative care
- Sickle cell anemia

OR

1.2.2 Patient is currently exceeding 50 MME and prescriber attests patient has been on opioids in the past 60 days

OR

1.2.3 Document ALL of the following:

- The diagnosis is associated with the need for pain management with opioids
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment
- Prescriber attests the patient requires more than 50 MME per day to adequately control pain

Notes	*This section does NOT apply to cough and cold products. **Approval length for cancer, end of life, palliative care, or sickle cell p ain will be issued for 12 months. All other approvals will be issued for t he requested duration, not to exceed one month.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic

belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond	
Diagnosis	Non-Preferred Reviews*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-	65991004100113	Generic

	CAFF W/ COD CAP 50-300-40-30 MG		
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic

HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic

OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic

PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155210	Generic

	OPIUM SUPPOS 16.2-30 MG		
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic

PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic

OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - ONE of the following:

1.1 If the request is for tramadol 100 mg (milligram) tablets, the physician has provided rationale for needing to use the 100 mg tramadol tablet instead of two 50 mg tramadol tablets

OR

1.2 If the request is for tramadol 25 mg tablets, the physician has provided rationale why the patient is unable to use half of a 50 mg tramadol tablet

OR

1.3 If the request is for Qdolo (tramadol soln), ONE of the following:

1.3.1 Failure of tramadol 50mg tablets as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to tramadol 50mg tablets (please specify intolerance or contraindication)

OR

1.3.3 Patient is unable to swallow a solid dosage form

OR

1.3.4 Patient utilizes a feeding tube for medication administration

OR

1.4 If the request is for another non-preferred medication**, then ONE of the following:

1.4.1 Failure of at least three unique active ingredients from the preferred short-acting opioids list as confirmed by claims history or submission of medical records

OR **1.4.2** History of intolerance or contraindication to three unique active ingredients from the preferred short-acting opioids list (please specify intolerance or contraindication)

Notes	*This section does NOT apply to cough and cold products. **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond

Diagnosis	Cancer/Hospice/End of Life/Sickle Cell Anemia Related Pain Exceeding the 90 MME Cumulative Threshold*
Guideline Type	Morphine Milligram Equivalents (MME) Reviews**

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic

ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic

MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic

HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand

ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand

NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-	65990002020320	Brand

	ACETAMINOPHEN TAB 6.12-325 MG		
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand

HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand

ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	651000951003400	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	651000451003005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	651000951003100	Generic

Approval Criteria

1 - Patient has ONE of the following:

- Cancer pain
- End of life diagnosis (hospice care)
- Sickle cell anemia related pain

Notes	*This section does NOT apply to cough and cold products. **Approval length will be issued for up to the requested amount for 12 months for cancer pain/hospice/end of life/sickle cell anemia related p ain. The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond

Diagnosis	Non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain Exceeding the 90 MME Cumulative Threshold *
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME)**

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic

FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic

HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic

PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS &	49109902155210	Generic

	OPIUM SUPPOS 16.2-30 MG		
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic

PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic

OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - Prescriber attests the patient has been screened for substance abuse/opioid dependence

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - BOTH of the following:

3.1 Patient has been screened for underlying depression and/or anxiety

AND

3.2 If applicable, any underlying conditions have been or will be addressed

AND

4 - BOTH of the following:

- Patient has tried and failed non-opioid pain medication (document drug name and date of trial)
- Opioid medication doses of less than 90 morphine milligram equivalents (MME) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)***

Notes	*This section does NOT apply to cough and cold products. **Approval length will be issued for 6 months for non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain up to the current requested MME plus 90 MME ***If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp,

tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond

Diagnosis	Non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain Exceeding the 90 MME Cumulative Threshold*
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalents (MME)**

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic

CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic

LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand

HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic

PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic
TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic

LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic

PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic

ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	65100095102005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	65995002100320	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	65990002202005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	65100095100340	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	65100095100310	Generic

Approval Criteria

1 - Prescriber attests the patient has been screened for substance abuse/opioid dependence

AND

2 - Documented rationale for not tapering or discontinuing opioid if treatment goals are not met

AND

3 - Documented meaningful improvement in pain and function when assessed against treatment goals (Document improvement in function or pain score improvement)***

Notes	*This section does NOT apply to cough and cold products. **Approval length will be issued for 6 months for non-cancer/non-hospice/non-end of life/non-sickle cell anemia related pain up to the current requested MME plus 90 MME ***If the patient has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested MME dose.

Product Name: butorphanol nasal sol, carisoprodol/aspirin/codeine, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, Brand Lortab, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, Oxaydo, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Brand Ultram, Synapryn, generic tramadol, Qdolo, Tramadol soln, Brand Ultracet, generic tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Apadaz, Benzhydrocodone/acetaminophen, Seglentis, Roxybond

Diagnosis	Criteria for Quantity Limit Reviews*
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
BUTORPHANOL TARTRATE	BUTORPHANOL TARTRATE NASAL SOLN 10 MG/ML	65200020102050	Generic
CARISOPRODOL/ASPIRIN/CODEINE	CARISOPRODOL W/ ASPIRIN & CODEINE TAB 200-325-16 MG	75990003100310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE SOLN 120-12 MG/5ML	65991002052020	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-15 MG	65991002050310	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE #3	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-30 MG	65991002050315	Generic
ACETAMINOPHEN/CODEINE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
ACETAMINOPHEN/CODEINE PHOSPHATE	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
CODEINE/ACETAMINOPHEN	ACETAMINOPHEN W/ CODEINE TAB 300-60 MG	65991002050320	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-325-40-30 MG	65991004100115	Generic
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Generic
FIORICET/CODEINE	BUTALBITAL-ACETAMINOPHEN-CAFF W/ COD CAP 50-300-40-30 MG	65991004100113	Brand
ASCOMP/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/	65991004300115	Generic

	CODEINE CAP 50-325-40-30 MG		
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	BUTALBITAL-ASPIRIN-CAFF W/ CODEINE CAP 50-325-40-30 MG	65991004300115	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 10 MG/5ML	65100055102065	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 100 MG/5ML (20 MG/ML)	65100055102090	Generic
MORPHINE SULFATE	MORPHINE SULFATE ORAL SOLN 20 MG/5ML	65100055102070	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 10 MG	65100055105210	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 20 MG	65100055105215	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 30 MG	65100055105220	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 15 MG	65100055100310	Generic
MORPHINE SULFATE	MORPHINE SULFATE TAB 30 MG	65100055100315	Generic
MORPHINE SULFATE	MORPHINE SULFATE SUPPOS 5 MG	65100055105205	Generic
LORTAB	HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML	65991702102024	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG	65991702100375	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 10-325 MG	65991702100305	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-300 MG	65991702100322	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic

HYDROCODONE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325 MG	65991702100358	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Generic
XODOL	HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG	65991702100309	Brand
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN TAB 5-325 MG	65991702100356	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE BITARTRATE/ACETAMINOPHEN	HYDROCODONE-ACETAMINOPHEN SOLN 7.5-325 MG/15ML	65991702102015	Generic
HYDROMORPHONE HCL	HYDROMORPHONE HCL SUPPOS 3 MG	65100035105205	Generic
DILAUDID	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
DILAUDID	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 8 MG	65100035100330	Generic
DILAUDID	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
OXYCODONE HCL	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CAP 5 MG	65100075100110	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	65100075101320	Generic

OXYCODONE HYDROCHLORIDE	OXYCODONE HCL SOLN 5 MG/5ML	65100075102005	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 10 MG	65100075100320	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 15 MG	65100075100325	Generic
ROXICODONE	OXYCODONE HCL TAB 15 MG	65100075100325	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 10-325 MG	65990002200335	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-325 MG	65990002200327	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	65990002200305	Brand
ENDOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Generic
PERCOCET	OXYCODONE W/ ACETAMINOPHEN TAB 5-325 MG	65990002200310	Brand
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 10 MG	65100080100310	Generic
OXYMORPHONE HYDROCHLORIDE	OXYMORPHONE HCL TAB 5 MG	65100080100305	Generic

TRAMADOL HCL	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 50 MG	65100095100320	Generic
ULTRAM	TRAMADOL HCL TAB 50 MG	65100095100320	Brand
SYNAPRYN FUSEPAQ	*TRAMADOL HCL FOR ORAL SUSP 10 MG/ML (COMPOUND KIT)***	65100095101920	Brand
TRAMADOL HYDROCHLORIDE/ACETAMINOPHEN	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Generic
ULTRACET	TRAMADOL-ACETAMINOPHEN TAB 37.5-325 MG	65995002200320	Brand
NUCYNTA	TAPENTADOL HCL TAB 100 MG	65100091100340	Brand
NUCYNTA	TAPENTADOL HCL TAB 50 MG	65100091100320	Brand
NUCYNTA	TAPENTADOL HCL TAB 75 MG	65100091100330	Brand
MEPERIDINE HCL	MEPERIDINE HCL TAB 50 MG	65100045100305	Generic
MEPERIDINE HCL	MEPERIDINE HCL ORAL SOLN 50 MG/5ML	65100045102060	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 2 MG	65100040100305	Generic
LEVORPHANOL TARTRATE	LEVORPHANOL TARTRATE TAB 3 MG	65100040100310	Generic
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	65991303050115	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-30 MG	49109902155210	Generic
BELLADONNA/OPIUM	BELLADONNA ALKALOIDS & OPIUM SUPPOS 16.2-60 MG	49109902155220	Generic
OPIUM	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic

OPIUM TINCTURE	OPIUM TINCTURE 1% (10 MG/ML) (MORPHINE EQUIV)	47100030201505	Generic
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 8.16-325 MG	65990002020330	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 6.12-325 MG	65990002020320	Brand
APADAZ	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
BENZHYDROCODONE/ACETAMINOPHEN	BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG	65990002020310	Brand
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	65991303050320	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 5-300 MG	65990002200308	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 10-300 MG	65990002200333	Generic
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN SOLN 10-300 MG/5ML	65990002202020	Generic

OXAYDO	OXYCODONE HCL TAB 7.5 MG	65100075100315	Brand
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 4 MG	65100035100320	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL TAB 2 MG	65100035100310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 15 MG	65100020200305	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 30 MG	65100020200310	Generic
CODEINE SULFATE	CODEINE SULFATE TAB 60 MG	65100020200315	Generic
DILAUDID	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Brand
HYDROMORPHONE HCL	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
HYDROMORPHONE HYDROCHLORIDE	HYDROMORPHONE HCL LIQD 1 MG/ML	65100035100920	Generic
OXAYDO	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 5 MG	65100075100310	Generic
ROXICODONE	OXYCODONE HCL TAB 5 MG	65100075100310	Brand
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 20 MG	65100075100330	Generic
OXYCODONE HYDROCHLORIDE	OXYCODONE HCL TAB 30 MG	65100075100340	Generic
ROXICODONE	OXYCODONE HCL TAB 30 MG	65100075100340	Brand
NALOCET	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	65990002200303	Generic
OXYCODONE AND ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic
PROLATE	OXYCODONE W/ ACETAMINOPHEN TAB 7.5-300 MG	65990002200325	Generic

PENTAZOCINE/NALOXONE HCL	PENTAZOCINE W/ NALOXONE HCL TAB 50-0.5 MG	65200040300310	Generic
QDOLO	TRAMADOL HCL ORAL SOLN 5 MG/ML	651000951020005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL ORAL SOLN 5 MG/ML	651000951020005	Generic
SEGLENTIS	CELECOXIB-TRAMADOL HCL TAB 56-44 MG	659950021003210	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 5 MG	6510007510A530	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 15 MG	6510007510A540	Brand
ROXYBOND	OXYCODONE HCL TAB ABUSE DETER 30 MG	6510007510A560	Brand
OXYCODONE HYDROCHLORIDE/ACETAMINOPHEN	OXYCODONE W/ ACETAMINOPHEN SOLN 5-325 MG/5ML	659900022020005	Brand
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 100 MG	651000951003410	Generic
TREZIX	ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	659913030501115	Brand
MEPERIDINE HYDROCHLORIDE	MEPERIDINE HCL TAB 50 MG	651000451003005	Generic
TRAMADOL HYDROCHLORIDE	TRAMADOL HCL TAB 25 MG	651000951003110	Generic

Approval Criteria

1 - The requested dose cannot be achieved by a higher strength formulary product

AND

2 - The requested dose is within FDA (Food and Drug Administration) maximum dose per day, where an FDA maximum dose per day exists**

Notes	*This section does NOT apply to cough and cold products. **Authorization will be issued for: • 12 months for cancer pain/hospice/sickle cell anemia related pain/end of life related pain • 6 months for non-cancer pain/non-hospice/non-sickle cell anemia related pain/non-end of life related pain

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC

Diagnosis	DUR: Cough and Cold Opioid Naïve (Not having filled an opioid in the past 60 days) exceeding the 7 day supply limit*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic

PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-	43101010102010	Brand

	HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML		
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - ONE of the following:

1.1 Cancer diagnosis

OR

1.2 End of life care, including hospice care

OR

1.3 Palliative care

OR

1.4 Sickle cell anemia

OR

1.5 BOTH of the following:

1.5.1 ONE of the following:

- Traumatic injury
- Post-surgical procedures, excluding dental procedures
- Prescriber attests that the patient has received an opioid within the past 60 days

AND

1.5.2 Prescriber attests if requested for traumatic injury or post-surgical procedure, that based on injury or surgical procedure performed the patient requires greater than a 7 day supply of short-acting opioid to adequately control pain

Notes	*Approval length for cancer, end of life, palliative care, or sickle cell pai n will be issued for 12 months. All other approvals will be issued for th e requested duration, not to exceed one month.

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC	
Diagnosis	Cough and Cold Products Exceeding the 90 MME Cumulative Threshold
Guideline Type	Morphine Milligram Equivalents (MME)*

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic

MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic

HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE -BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - The prescriber attests they are aware of patient's current opioid therapy and morphine milligram equivalents (MME) dose and feels the treatment with the requested product is medically necessary	
Notes	*Approval length will be issued for up to 30 days for cough and cold related treatment. The authorization should be entered for the MME requested.

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC

Diagnosis	Under the Age of 18 Years for Cough and Cold Products
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLISTER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLSTER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-	43995303101210	Generic

	CODEINE SYRUP 6.25-5-10 MG/5ML		
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic

HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - Prescriber attests they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

AND

2 - Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30)

AND

3 - Patient has tried and failed at least one non-opioid containing cough and cold remedy

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC

Diagnosis	Cough and Cold Products Exceeding 120mL per fill and/or 360mL per 30 days*
Approval Length	30 days**
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLIST ER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLST ER SUSP 10-8 MG/5ML	4399520236G110	Generic

M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand
CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic

GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic

POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - Prescriber attests that a larger quantity is medically necessary

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists

Notes	*Quantity Limit Rules in place: • 120mL/fill • 360mL/30 days **Authorization will be issued for up to 30 days. The authorization should be entered for the quantity requested.

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuzistra XR, hydrocodone polst-chlorphen polst ER, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss CD, promethazine-codeine syrup, promethazine-phenylephrine-codeine syrup (promethazine VC-codeine syrup), Rydex, Mar-Cof BP, Mar-Cof CG, Ninjacof-XG, Coditussin AC, M-Clear WC, codeine/guaifenesin soln (Virtussin AC/ALC, Virtussin A/C, Maxi-Tuss AC, Guaiatussin AC, G Tussin AC, Guaifenesin AC), Tusnel C, Virtussin DAC, Tuxarin ER, Coditussin DAC	
Diagnosis	Non-Preferred Cough and Cold Products
Approval Length	30 Day(s)

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUZISTRA XR	CODEINE POLIST-CHLORPHEN POLISTER SUSP 14.7-2.8 MG/5ML	4399520231G120	Brand
HYDROCODONE POLISTIREX/CHLORPHENIRAMINE POLISTIREX	HYDROCOD POLST-CHLORPHEN POLSTER SUSP 10-8 MG/5ML	4399520236G110	Generic
M-END PE	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQD 3.33-1.33-6.33 MG/5ML	43995303110916	Brand
PRO-RED AC	PHENYLEPHRINE-DEXCHLORPHENIR-CODEINE SYRUP 5-1-9 MG/5ML	43995303171220	Brand
HISTEX-AC	PHENYLEPHRINE-TRIPROLIDINE-CODEINE SYRUP 10-2.5-10 MG/5ML	43995303361220	Brand
PROMETHAZINE/CODEINE	PROMETHAZINE W/ CODEINE SYRUP 6.25-10 MG/5ML	43995202341210	Generic
PROMETHAZINE VC/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
PROMETHAZINE/PHENYLEPHRINE/CODEINE	PROMETHAZINE-PHENYLEPHRINE-CODEINE SYRUP 6.25-5-10 MG/5ML	43995303101210	Generic
MAR-COF BP	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQD 30-2-7.5 MG/5ML	43995303190940	Brand
NINJACOF-XG	GUAIFENESIN-CODEINE LIQUID 200-8 MG/5ML	43997002280942	Brand
MAR-COF CG EXPECTORANT	GUAIFENESIN-CODEINE LIQUID 225-7.5 MG/5ML	43997002280947	Brand
TUXARIN ER	CODEINE PHOS-CHLORPHENIRAMINE MALEATE TAB ER 12HR 54.3-8 MG	43995202327430	Brand

CODEINE/GUAIFENESIN	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
G TUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIATUSSIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
GUAIFENESIN/CODEINE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
MAXI-TUSS AC	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
VIRTUSSIN A/C	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROMIDE TAB 5-1.5 MG	43101010100310	Brand
HYDROCODONE BITARTRATE/HOMATROPINE METHYLBROMIDE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYDROMET	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic
HYCODAN	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Brand
HYDROCODONE/HOMATROPINE	HYDROCODONE BITART-HOMATROPINE METHYLBROM SOLN 5-1.5 MG/5ML	43101010102010	Generic

M-CLEAR WC	GUAIFENESIN-CODEINE SOLN 100-6.33 MG/5ML	43997002282018	Brand
CAPCOF	PHENYLEPHRINE-CHLORPHEN W/ CODEINE SYRUP 5-2-10 MG/5ML	43995303141220	Brand
CODITUSSIN AC	GUAIFENESIN-CODEINE LIQUID 200-10 MG/5ML	43997002280945	Generic
GUAIFENESIN/CODEINE PHOSPHATE	GUAIFENESIN-CODEINE SOLN 100-10 MG/5ML	43997002282020	Generic
POLY-TUSSIN AC	PHENYLEPHRINE-BROMPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303110935	Generic
MAXI-TUSS CD	PHENYLEPHRINE-CHLORPHEN W/ CODEINE LIQUID 10-4-10 MG/5ML	43995303140913	Generic
RYDEX	PSEUDOEPHEDRINE-BROMPHEN-CODEINE LIQ 10-1.33-6.33 MG/5ML	43995303190922	Brand
CODITUSSIN DAC	PSEUDOEPHEDRINE W/ COD-GG LIQUID 30-10-200 MG/5ML	43997303300938	Generic
TUSNEL C	PSEUDOEPHEDRINE W/ COD-GG SYRUP 30-10-100 MG/5ML	43997303301225	Brand

Approval Criteria

1 - If the request is for a non-preferred* medication, then ONE of the following:

1.1 Failure of at least three unique active ingredients from the preferred cough and cold products list as confirmed by claims history or submission of medical records

OR

1.2 History of intolerance or contraindication to at least three unique active ingredients from the preferred cough and cold products list (please specify intolerance or contraindication)

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
4/30/2024	Updated PDL link

Signifor

Prior Authorization Guideline

Guideline ID	GL-146641
Guideline Name	Signifor
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Signifor	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIGNIFOR	PASIREOTIDE DIASPARTATE INJ 0.3 MG/ML (BASE EQUIV)	30170075202020	Brand
SIGNIFOR	PASIREOTIDE DIASPARTATE INJ 0.6 MG/ML (BASE EQUIV)	30170075202030	Brand
SIGNIFOR	PASIREOTIDE DIASPARTATE INJ 0.9 MG/ML (BASE EQUIV)	30170075202040	Brand

Approval Criteria

1 - Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

2 - One of the following:

- Pituitary surgery has not been curative for the patient
- Patient is not a candidate for pituitary surgery

Product Name: Signifor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIGNIFOR	PASIREOTIDE DIASPARTATE INJ 0.3 MG/ML (BASE EQUIV)	30170075202020	Brand
SIGNIFOR	PASIREOTIDE DIASPARTATE INJ 0.6 MG/ML (BASE EQUIV)	30170075202030	Brand
SIGNIFOR	PASIREOTIDE DIASPARTATE INJ 0.9 MG/ML (BASE EQUIV)	30170075202040	Brand

Approval Criteria

1 - Documentation of positive clinical response to Signifor therapy

Siliq

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146852
Guideline Name	Siliq
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Siliq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SILIQ	BRODALUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 210 MG/1.5ML	9025052000E520	Brand

Approval Criteria

1 - Diagnosis of chronic moderate to severe plaque psoriasis

AND

2 - Patient is not receiving Siliq in combination with ONE of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Siliq therapy as confirmed by claims history or submitted medical records

OR

4.2 All of the following:

4.2.1 One of the following:

4.2.1.1 All of the following:

4.2.1.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

4.2.1.1.2 One of the following:

- Failure of ONE of the following topical therapy classes as confirmed by claims history or submitted medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.1.3 One of the following:

- Failure of a 3 month trial of methotrexate, at maximally indicated dose, confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.1.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

AND

4.2.2 One of the following:

- Failure of TWO of the following as confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab), Ilumya (tildrakizumab)
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab), Ilumya (tildrakizumab)

AND

4.2.3 One of the following:

4.2.3.1 Failure of 6 month trial of Cosentyx (secukinumab), with moderate clinical response yet residual disease activity, confirmed by claims history or submitted medical records

OR

4.2.3.2 Both of the following:

- History of intolerance or contraindication to Cosentyx (please specify intolerance or contraindication)
- Physician attests that in their clinical opinion the same intolerance or adverse event would not be expected to occur with Siliq

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Siliq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SILIQ	BRODALUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 210 MG/1.5ML	9025052000E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Siliq therapy

AND

2 - Patient is NOT receiving Siliq in combination with ONE of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

2 . Background

Benefit/Coverage/Program Information
PDL Link NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
4/30/2024	Updated NM PDL Link

Simponi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155200
Guideline Name	Simponi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Simponi	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML	6627004000D520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	6627004000D540	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML	6627004000E520	Brand

SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML	6627004000E540	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to a 3 month trial of ONE non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses, confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to ONE non-biologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

4.2.2 ONE of the following:

- Failure of THREE of the following as confirmed by claims history or submitted medical records: Cimzia (certolizumab), One of the preferred adalimumab products*, Enbrel (etanercept), Olumiant (baricitinib), Tyenne (tocilizumab-aazg)
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): Cimzia (certolizumab), One of the preferred adalimumab products*, Enbrel (etanercept), Olumiant (baricitinib), Tyenne (tocilizumab-aazg)

Notes	*For a list of preferred adalimumab products please reference drug co verage tools

Product Name: Simponi	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML	6627004000D520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	6627004000D540	Brand

SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML	6627004000E520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML	6627004000E540	Brand

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to a 3 month trial of methotrexate at maximally indicated dose, confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast)]

AND

4.2.2 BOTH of the following:

4.2.2.1 ONE of the following:

- Failure of TWO of the following as confirmed by claims history or submitted medical records: Cimzia (certolizumab), One of the preferred adalimumab products*, Enbrel (etanercept)
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): Cimzia (certolizumab), One of the preferred adalimumab products*, Enbrel (etanercept)

AND

4.2.2.2 ONE of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*For a list of preferred adalimumab products please reference drug coverage tools

Product Name: Simponi	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML	6627004000D520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	6627004000D540	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML	6627004000E520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML	6627004000E540	Brand

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks confirmed by claims history or submitted medical records

OR

4.2.1.2 History of intolerance or contraindication TWO NSAIDs (please specify intolerance or contraindication)

OR

4.2.1.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Xeljanz/Xeljanz XR (tofacitinib)]

AND

4.2.2 BOTH of the following:

4.2.2.1 ONE of the following:

- Failure of TWO of the following as confirmed by claims history or submitted medical records: Cimzia (certolizumab), One of the preferred adalimumab products*, Enbrel (etanercept)
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): Cimzia (certolizumab), One of the preferred adalimumab products*, Enbrel (etanercept)

AND

4.2.2.2 ONE of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*For a list of preferred adalimumab products please reference drug co verage tools

Product Name: Simponi	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML	6627004000D520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	6627004000D540	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML	6627004000E520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML	6627004000E540	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz

(tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - ONE of the following:

4.1 Patient is currently on Simponi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 ONE of the following:

4.2.1.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) as confirmed by claims history or submitted medical records

OR

4.2.1.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Stelara (ustekinumab), Xeljanz (tofacitinib)]

AND

4.2.2 ONE of the following:

- Failure to one of the preferred adalimumab products* as confirmed by claims history or submitted medical records

• History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)	
Notes	*For a list of preferred adalimumab products please reference drug co verage tools

Product Name: Simponi	
Diagnosis	Rheumatoid Arthritis (RA), Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML	6627004000D520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	6627004000D540	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML	6627004000E520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML	6627004000E540	Brand

Approval Criteria

1 - Documentation of positive clinical response to Simponi therapy

AND

2 - Patient is NOT receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]*

Notes	* Examples of drug(s) may not be applicable based on the requested i ndication.

2 . Background

Benefit/Coverage/Program Information
PDL Link NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
9/18/2024	Updated safety language. Updated step through agents due to formu lary change for Tyenne and Kevzara.

Sivextro

Prior Authorization Guideline

Guideline ID	GL-155233
Guideline Name	Sivextro
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Sivextro tablets	
Diagnosis	Skin and Skin Structure Infections
Approval Length	6 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIVEXTRO	TEDIZOLID PHOSPHATE TAB 200 MG	16230070200320	Generic

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - ALL of the following:

3.1 Diagnosis of acute bacterial skin and skin structure infection (including diabetic foot infections)

AND

3.2 ONE of the following:

3.2.1 Infection is caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

3.2.2 Presence of MRSA infection is likely and empiric treatment is warranted

AND

3.3 ONE of the following:

3.3.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

3.3.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

3.4 ONE of the following:

3.4.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

3.4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

4 - ALL of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infection (including diabetic foot infections)

AND

4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Sivextro

AND

4.3 ONE of the following:

4.3.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records

OR

4.3.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

4.4 ONE of the following:

4.4.1 Failure of TWO of the following confirmed by claims history or submitted medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

OR

4.4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- A Penicillin
- A cephalosporin
- A tetracycline
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

Product Name: Sivextro tablets	
Diagnosis	Off-Label Uses
Approval Length	Based on provider and IDSA recommended treatment durations, up to 6 months.
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SIVEXTRO	TEDIZOLID PHOSPHATE TAB 200 MG	16230070200320	Generic

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - BOTH of the following:

3.1 The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

AND

3.2 ONE of the following:

3.2.1 Failure of linezolid (generic Zyvox) confirmed by claims history or submitted medical records, if susceptibility is confirmed by culture

OR

3.2.2 History of intolerance or contraindication to linezolid (generic Zyvox), if susceptibility is confirmed by culture (please specify intolerance or contraindication)

2 . Revision History

Date	Notes
9/18/2024	Added “tablets” to product name to clarify that the policy is specific to oral tablets not IV form

Skyclarys

Prior Authorization Guideline

Guideline ID	GL-146644
Guideline Name	Skyclarys
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYCLARYS	OMAVELOXOLONE CAP 50 MG	74135060000120	Brand

Approval Criteria

1 - Diagnosis of Friedreich's ataxia

AND

2 - Confirmed presence of a mutation in the frataxin (FXN) gene

AND

3 - Prescribed by, or in consultation with, one of the following:

- Neurologist
- Neurogeneticist
- Physical Medicine and Rehabilitation physician (i.e., physiatrist)

Product Name: Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYCLARYS	OMAVELOXOLONE CAP 50 MG	74135060000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Skyclarys therapy

AND

2 - Prescribed by, or in consultation with, one of the following:

- Neurologist
- Neurogeneticist
- Physical Medicine and Rehabilitation physician (i.e., physiatrist)

Skyrizi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155260
Guideline Name	Skyrizi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Skyrizi	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYRIZI PEN	RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML	9025057070D520	Brand
SKYRIZI	RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML	9025057070E540	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML	5250406070E220	Brand

SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML	5250406070E210	Brand

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Skyrizi therapy as confirmed by claims history or submission of medical records

OR

4.2 ALL of the following:

4.2.1 One of the following:

4.2.1.1 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab)]

OR

4.2.1.2 All of the following:

4.2.1.2.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

4.2.1.2.2 One of the following:

- Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapies classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 One of the following:

- Failure to a 3 month trial of methotrexate at maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4.2.2 One of the following:

- Failure to TWO of the following preferred biologic products confirmed by claims history or submission of medical records: One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab), Ilumya (tildrakizumab)
- History of intolerance or contraindication to ALL of the following preferred biologic products (please specify intolerance or contraindication): One of the preferred

adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab), Ilumya (tildrakizumab)

AND

4.2.3 One of the following:

- Failure to Cosentyx (secukinumab) confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Skyrizi	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYRIZI PEN	RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML	9025057070D520	Brand
SKYRIZI	RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML	9025057070E540	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML	5250406070E220	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML	5250406070E210	Brand

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Skyrizi therapy as confirmed by claims history or submission of medical records

OR

4.2 BOTH of the following:

4.2.1 One of the following:

- Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

AND

4.2.2 Both of the following:

4.2.2.1 One of the following:

- Failure to TWO of the following as confirmed by claims history or submission of medical records: One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab)
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab)

AND

4.2.2.2 One of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Skyrizi	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYRIZI PEN	RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML	9025057070D520	Brand
SKYRIZI	RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML	9025057070E540	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML	5250406070E220	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML	5250406070E210	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - One of the following:

2.1 Patient has been established on therapy with Skyrizi under an active UnitedHealthcare prior authorization for the treatment of moderately to severely active Crohn's disease

OR

2.2 Patient is currently on Skyrizi therapy for moderately to severely active Crohn's disease as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name: Skyrizi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYRIZI PEN	RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML	9025057070D520	Brand

SKYRIZI	RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML	9025057070E540	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML	5250406070E220	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML	5250406070E210	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - One of the following:

2.1 Patient has been established on therapy with Skyrizi under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active ulcerative colitis

OR

2.2 Patient is currently on Skyrizi therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submission of medical records

AND

3 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), adalimumab]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name: Skyrizi

Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA), Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SKYRIZI PEN	RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML	9025057070D520	Brand
SKYRIZI	RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML	9025057070E540	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML	5250406070E220	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML	5250406070E210	Brand

Approval Criteria

1 - Documentation of positive clinical response to Skyrizi therapy

AND

2 - Patient is NOT receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]*

Notes	* Examples of drug(s) may not be applicable based on the requested i ndication.

2 . Revision History

Date	Notes
9/18/2024	Added ulcerative colitis. Updated active prior authorization verbiage under Crohn’s disease with no change to clinical intent. Updated safe ty language.

Sohonos

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146646
Guideline Name	Sohonos
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Sohonos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOHONOS	PALOVAROTENE CAP 1 MG	75886060000120	Brand
SOHONOS	PALOVAROTENE CAP 1.5 MG	75886060000125	Brand
SOHONOS	PALOVAROTENE CAP 2.5 MG	75886060000130	Brand
SOHONOS	PALOVAROTENE CAP 5 MG	75886060000135	Brand
SOHONOS	PALOVAROTENE CAP 10 MG	75886060000140	Brand

Approval Criteria

1 - Diagnosis of fibrodysplasia ossificans progressiva (FOP)

AND

2 - Diagnosis has been confirmed by the presence of a mutation in the activin receptor IA (ACVR1) gene

AND

3 - ONE of the following:

3.1 BOTH of the following:

- Patient is female
- Patient is 8 years of age or older

OR

3.2 BOTH of the following:

- Patient is male
- Patient is 10 years of age or older

AND

4 - Sohonos is being used to reduce the volume of new heterotopic ossification (HO)

AND

5 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)

Product Name: Sohonos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOHONOS	PALOVAROTENE CAP 1 MG	75886060000120	Brand
SOHONOS	PALOVAROTENE CAP 1.5 MG	75886060000125	Brand
SOHONOS	PALOVAROTENE CAP 2.5 MG	75886060000130	Brand
SOHONOS	PALOVAROTENE CAP 5 MG	75886060000135	Brand
SOHONOS	PALOVAROTENE CAP 10 MG	75886060000140	Brand

Approval Criteria

1 - Documentation of positive clinical response [e.g., reduction in new HO (heterotopic ossification) volume, improved CAJIS (Cumulative Analogue Joint Involvement Scale) and FOP-PFQ (Fibrodysplasia Ossificans Progressiva-Physical Function Questionnaire) scores, improved quality of life]

AND

2 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)

Somavert

Prior Authorization Guideline

Guideline ID	GL-146647
Guideline Name	Somavert
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Somavert	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOMAVERT	PEGVISOMANT FOR INJ 10 MG (AS PROTEIN)	30180060002120	Brand
SOMAVERT	PEGVISOMANT FOR INJ 15 MG (AS PROTEIN)	30180060002130	Brand
SOMAVERT	PEGVISOMANT FOR INJ 20 MG (AS PROTEIN)	30180060002140	Brand
SOMAVERT	PEGVISOMANT FOR INJ 25 MG (AS PROTEIN)	30180060002150	Brand
SOMAVERT	PEGVISOMANT FOR INJ 30 MG (AS PROTEIN)	30180060002160	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of acromegaly confirmed by ONE of the following:

1.1.1 Serum GH (growth hormone) level greater than 1 ng/mL (nanogram/milliliter) after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis

OR

1.1.2 Elevated serum IGF-1 (insulin-like growth factor-1) levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis

AND

1.2 ONE of the following:

1.2.1 Inadequate response to ONE of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

1.2.2 NOT a candidate for any of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

AND

1.3 Inadequate response, intolerance, or contraindication to a long-acting somatostatin analog [e.g., Sandostatin LAR (octreotide), Somatuline Depot (lanreotide)]

OR

2 - Patient is currently on Somavert therapy for acromegaly

Product Name: Somavert	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOMAVERT	PEGVISOMANT FOR INJ 10 MG (AS PROTEIN)	30180060002120	Brand
SOMAVERT	PEGVISOMANT FOR INJ 15 MG (AS PROTEIN)	30180060002130	Brand
SOMAVERT	PEGVISOMANT FOR INJ 20 MG (AS PROTEIN)	30180060002140	Brand
SOMAVERT	PEGVISOMANT FOR INJ 25 MG (AS PROTEIN)	30180060002150	Brand
SOMAVERT	PEGVISOMANT FOR INJ 30 MG (AS PROTEIN)	30180060002160	Brand

Approval Criteria

1 - Documentation of positive clinical response to Somavert therapy (e.g., age-normalized serum IGF-1 level)

Soriatane

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146417
Guideline Name	Soriatane
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: acitretin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACITRETIN	ACITRETIN CAP 10 MG	90250510000110	Generic
ACITRETIN	ACITRETIN CAP 17.5 MG	90250510000115	Generic
ACITRETIN	ACITRETIN CAP 25 MG	90250510000125	Generic

Approval Criteria

1 - Diagnosis of severe psoriasis

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - ONE of the following:

3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose, as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

AND

4 - ONE of the following:

- Greater than or equal to 10% body surface area involvement
- Palmoplantar, facial, or genital involvement
- Severe scalp psoriasis

Product Name: acitretin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACITRETIN	ACITRETIN CAP 10 MG	90250510000110	Generic

ACITRETIN	ACITRETIN CAP 17.5 MG	90250510000115	Generic
ACITRETIN	ACITRETIN CAP 25 MG	90250510000125	Generic

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Sotyktu

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155262
Guideline Name	Sotyktu
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Sotyktu	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOTYKTU	DEUCRAVACITINIB TAB 6 MG	90250524000320	Brand

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

2.1.3 ONE of the following:

2.1.3.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

AND

3 - ONE of the following:

3.1 Failure to THREE of the following preferred biologic products confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

OR

3.2 History of intolerance or contraindication to ALL of the following preferred biologic products (please specify intolerance or contraindication)

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

AND

4 - ONE of the following:

4.1 Failure to Cosentyx (secukinumab) confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

AND

5 - Patient is NOT receiving Sotyktu in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

6 - Prescribed by or in consultation with a dermatologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Sotyktu	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SOTYKTU	DEUCRAVACITINIB TAB 6 MG	90250524000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Sotyktu therapy

AND

2 - Patient is NOT receiving Sotyktu in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

2 . Background

Benefit/Coverage/Program Information
PDL Link NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
9/18/2024	Updated safety language

Spevigo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151142
Guideline Name	Spevigo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/8/2024

1 . Criteria

Product Name: Spevigo SC	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPEVIGO	SPESOLIMAB-SBZO SUBCUTANEOUS SOLN PREF SYR 150 MG/ML	9025057770E530	Brand

Approval Criteria

1 - Diagnosis of generalized pustular psoriasis (GPP) based on BOTH of the following:

1.1 Presence of primary, sterile, macroscopically visible pustules on non-acral skin

AND

1.2 Pustulation is NOT restricted to psoriatic plaques

AND

2 - BOTH of the following:

- Used to prevent GPP flares
- Patient is NOT currently experiencing a GPP flare

AND

3 - ONE of the following:

3.1 Patient has been established on therapy with Spevigo for GPP under an active UnitedHealthcare medical benefit prior authorization

OR

3.2 Patient is currently on Spevigo therapy for GPP as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

4 - Patient is NOT receiving Spevigo in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by a dermatologist

Product Name: Spevigo SC	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPEVIGO	SPESOLIMAB-SBZO SUBCUTANEOUS SOLN PREF SYR 150 MG/ML	9025057770E530	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in the rate and/or number of GPP flares)

AND

2 - Reduction in the utilization of therapy (e.g., intravenous Spevigo) used for GPP flares

AND

3 - Patient is NOT receiving Spevigo in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

4 - Prescribed by a dermatologist

2 . Revision History

Date	Notes
8/7/2024	New program.

Spravato

Prior Authorization Guideline

Guideline ID	GL-150655
Guideline Name	Spravato
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Spravato	
Diagnosis	Major Depressive Disorder (Treatment-Resistant)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRAVATO 56MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK)	5811002010C520	Brand
SPRAVATO 84MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK)	5811002010C530	Brand

Approval Criteria

1 - Diagnosis of major depressive disorder (treatment-resistant), according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5-TR) criteria, by a mental health professional

AND

2 - Prescribed by or in consultation with a psychiatrist

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline scoring (prior to starting Spravato) on at least ONE of the following clinical assessments has been completed:

- Baseline score on the 17-item Hamilton Rating Scale for Depression (HAMD17)
- Baseline score on the 16-item Quick Inventory of Depressive Symptomatology (QIDS-C16)
- Baseline score on the 10-item Montgomery-Asberg Depression Rating Scale (MADRS)
- Baseline score on the 9-item Patient Health Questionnaire (PHQ-9)

AND

4 - ONE of the following:

4.1 Failure of THREE different antidepressant medications or treatment regimens at the maximally tolerated dose(s) for at least 8 weeks in the current depressive episode, confirmed by claims history or submitted medical records. An antidepressant or treatment regimen would include any of the following classes or combinations:

- Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
- Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine, etc.)
- Bupropion
- Tricyclic antidepressants (e.g., amitriptyline, clomipramine, nortriptyline, etc.)
- Mirtazapine
- Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine, etc.)
- Serotonin modulators (e.g., nefazodone, trazodone, etc.)

- Augmentation with lithium, Cytomel (liothyronine), antipsychotics, or anticonvulsants

OR

4.2 History of intolerance or contraindication to THREE of the following antidepressant medications or treatment regimens (please specify intolerance or contraindication). An antidepressant or treatment regimen would include any of the following classes or combinations:

- Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
- Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine, etc.)
- Bupropion
- Tricyclic antidepressants (e.g., amitriptyline, clomipramine, nortriptyline, etc.)
- Mirtazapine
- Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine, etc.)
- Serotonin modulators (e.g., nefazodone, trazodone, etc.)
- Augmentation with lithium, Cytomel (liothyronine), antipsychotics, or anticonvulsants

AND

5 - Spravato will be used in combination with an oral antidepressant (one that the patient has not previously failed)

AND

6 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

Product Name: Spravato	
Diagnosis	Major Depressive Disorder (Treatment-Resistant)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

SPRAVATO 56MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK)	5811002010C520	Brand
SPRAVATO 84MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK)	5811002010C530	Brand

Approval Criteria

1 - Documentation of remission or a positive clinical response to Spravato therapy

AND

2 - Spravato will be used in combination with an oral antidepressant (confirmed by claims history or submitted medical records)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline and recent (within the last month) scoring on at least ONE of the following assessments demonstrating remission or clinical response (e.g., score reduction from baseline) as defined by:

- Hamilton Rating Scale for Depression (HAMD17; remission defined as a score of less than or equal to 7)
- Quick Inventory of Depressive Symptomatology (QIDS-C16; remission defined as a score of less than or equal to 5)
- Montgomery-Asberg Depression Rating Scale (MADRS; remission defined as a score of less than or equal to 12)
- Baseline score on the 9-item Patient Health Questionnaire (PHQ-9)

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

AND

5 - Prescribed by or in consultation with a psychiatrist

Product Name: Spravato*	
Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRAVATO 56MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK)	5811002010C520	Brand
SPRAVATO 84MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK)	5811002010C530	Brand

Approval Criteria

1 - Diagnosis of major depressive disorder according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5-TR) criteria, by a mental health professional

AND

2 - Patient is experiencing an acute suicidal ideation or behavior

AND

3 - Spravato will be used in combination with a newly initiated or optimized oral antidepressant

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program

Notes	*Spravato is hard-coded with a quantity of 0.29 per day for the 56mg s trength and 0.43 per day for the 84mg strength. If criteria are met, ent er one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days.

Product Name: Spravato*	
Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
SPRAVATO 56MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 2 (56 MG DOSE PACK)	5811002010C520	Brand
SPRAVATO 84MG DOSE	ESKETAMINE HCL NASAL SOLN 28 MG/DEVICE X 3 (84 MG DOSE PACK)	5811002010C530	Brand

Approval Criteria

1 - The requested drug is prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in the compendia of current literature

Notes	*Spravato is hard-coded with a quantity of 0.29 per day for the 56mg s trength and 0.43 per day for the 84mg strength. If criteria are met, ent er one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days.

Sprycel

Prior Authorization Guideline

Guideline ID	GL-146649
Guideline Name	Sprycel
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Sprycel	
Diagnosis	Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand

SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive or BCR-ABL1-positive chronic myeloid leukemia

AND

2 - ONE of the following:

2.1 Patient is not a candidate for imatinib as attested by physician

OR

2.2 Patient is currently on Sprycel therapy

Product Name: Sprycel	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

Product Name: Sprycel	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST) with PDGFRA D842V mutation

Product Name: Sprycel	
Diagnosis	Chondrosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand

SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of metastatic chondrosarcoma

Product Name: Sprycel	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of recurrent chordoma

Product Name: Sprycel	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - Patient has an ABL1 (gene) rearrangement

Product Name: Sprycel	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Diagnosis of cutaneous melanoma

AND

2 - Tumors are metastatic or unresectable

AND

3 - Contains activating mutations of KIT

AND

4 - Used as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy

Product Name: Sprycel	
Diagnosis	Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia, Ph+ALL, GIST, Chondrosarcoma, Chordoma, Myeloid/Lymphoid Neoplasms with Eosinophilia, Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand

SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Sprycel therapy

Product Name: Sprycel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Sprycel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

SPRYCEL	DASATINIB TAB 20 MG	21531820000320	Brand
SPRYCEL	DASATINIB TAB 50 MG	21531820000340	Brand
SPRYCEL	DASATINIB TAB 70 MG	21531820000350	Brand
SPRYCEL	DASATINIB TAB 80 MG	21531820000354	Brand
SPRYCEL	DASATINIB TAB 100 MG	21531820000360	Brand
SPRYCEL	DASATINIB TAB 140 MG	21531820000380	Brand

Approval Criteria

1 - Documentation of positive clinical response to Sprycel therapy

Stelara

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146650
Guideline Name	Stelara
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Stelara	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML	9025058500E520	Brand
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML	9025058500E540	Brand
STELARA	USTEKINUMAB INJ 45 MG/0.5ML	90250585002020	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic moderate to severe plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

1.2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.2.1.2 ONE of the following:

1.2.1.2.1 Failure to ONE of the following topical therapy classes, confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin

- Coal tar

AND

1.2.1.3 ONE of the following:

1.2.1.3.1 Failure to a 3 month trial of methotrexate at maximally indicated dose, confirmed by claims history or submitted medical records

OR

1.2.1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a biologic or targeted synthetic disease modifying anti-rheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Tremfya (guselkumab)]

AND

1.3 ONE of the following:

1.3.1 Failure to TWO of the following preferred biologic products, confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

OR

1.3.2 History of intolerance or contraindication to ALL of the following preferred biologic products (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

AND

1.4 ONE of the following:

1.4.1 Failure to Cosentyx (secukinumab) confirmed by claims history or submitted medical records

OR

1.4.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

AND

1.5 Patient is NOT receiving Stelara in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.6 ONE of the following:

1.6.1 Requested medication is Stelara 45 mg (milligrams)/0.5 mL (milliliters)

OR

1.6.2 BOTH of the following:

- Requested medication is Stelara 90 mg/1 mL

- Patient's weight is greater than 100 kilograms (220 pounds)

AND

1.7 Prescribed by or in consultation with a dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Stelara therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of chronic moderate to severe plaque psoriasis

AND

2.3 Patient is NOT receiving Stelara in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a dermatologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Stelara	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML	9025058500E520	Brand
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML	9025058500E540	Brand
STELARA	USTEKINUMAB INJ 45 MG/0.5ML	90250585002020	Brand

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

1.1.1 BOTH of the following:

1.1.1.1 Requested medication is Stelara 45 mg (milligrams)/0.5 mL (milliliters)

AND

1.1.1.2 Diagnosis of active psoriatic arthritis

OR

1.1.2 ALL of the following:

1.1.2.1 Requested medication is Stelara 90 mg/1 mL

AND

1.1.2.2 Patient’s weight is greater than 100 kilograms (220 pounds)

AND

1.1.2.3 Diagnosis of active psoriatic arthritis

AND

1.1.2.4 Diagnosis of co-existent moderate to severe plaque psoriasis

AND

1.2 Patient is NOT receiving Stelara in combination with any of the following:

- Biologic disease-modifying anti-rheumatic drug (DMARD) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.3 ONE of the following:

1.3.1 Failure to a 3 month trial of methotrexate at maximally indicated dose, confirmed by claims history or submitted medical records

OR

1.3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.3.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Tremfya (guselkumab) Xeljanz (tofacitinib), Otezla (apremilast)]

AND

1.4 BOTH of the following:

1.4.1 ONE of the following:

1.4.1.1 Failure to TWO of the following, confirmed by claims history or submitted medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

OR

1.4.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

AND

1.4.2 ONE of the following:

1.4.2.1 Failure to Cosentyx (secukinumab), confirmed by claims history or submitted medical records

OR

1.4.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

AND

1.5 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Stelara therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Stelara in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Stelara	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML	9025058500E520	Brand
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML	9025058500E540	Brand
STELARA	USTEKINUMAB INJ 45 MG/0.5ML	90250585002020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Stelara therapy

AND

2 - Patient is NOT receiving Stelara in combination with any of the following:

- Biologic disease-modifying anti-rheumatic drug (DMARD) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Product Name: Stelara 90 mg/mL	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML	9025058500E540	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to ONE of the following conventional therapy drugs or classes at maximally indicated dose, confirmed by claims history or submitted medical records:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.1.1.2 History of intolerance or contraindication to ALL of the following conventional therapy drugs or classes (please specify intolerance or contraindication):

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.1.1.3 Patient has been previously treated with a biologic disease-modifying anti-rheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab]

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to BOTH of the following, confirmed by claims history or submitted medical records:

- One of the preferred adalimumab products*
- Cimzia (certolizumab)

OR

2.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- One of the preferred adalimumab products*
- Cimzia (certolizumab)

OR

2.2 Patient is currently on Stelara therapy for moderately to severely active Crohn's disease as confirmed by claims history or submitted medical records

OR

2.3 Patient has been established on therapy with Stelara for moderately to severely active Crohn's disease under an active UnitedHealthcare prior authorization

AND

3 - Patient is NOT receiving Stelara in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus Kinase Inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Stelara 90 mg/mL	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML	9025058500E540	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine), as confirmed by claims history or submitted medical records

OR

2.1.1.2 Patient has been previously treated with a biologic or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Xeljanz (tofacitinib)]

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to one of the preferred adalimumab products*, confirmed by claims history or submitted medical records

OR

2.1.2.2 History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

OR

2.2 Patient is currently on Stelara therapy for moderately to severely active ulcerative colitis as confirmed by claims history or submitted medical records

OR

2.3 Patient has been established on therapy with Stelara for moderately to severely active ulcerative colitis under an active UnitedHealthcare prior authorization

AND

3 - Patient is NOT receiving Stelara in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus Kinase Inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Stelara 90 mg/mL	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML	9025058500E540	Brand

Approval Criteria

1 - Documentation of positive clinical response to Stelara therapy

AND

2 - Patient is NOT receiving Stelara in combination with any of the following:

- Biologic disease-modifying anti-rheumatic drug (DMARD) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus Kinase Inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Stivarga

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152509
Guideline Name	Stivarga
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Stivarga	
Diagnosis	Colorectal Cancer (CRC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Diagnosis of advanced or metastatic colorectal cancer

AND

2 - History of failure, contraindication, or intolerance to treatment with ALL of the following:

- Oxaliplatin-based chemotherapy
- Irinotecan-based chemotherapy
- Fluoropyrimidine-based chemotherapy
- Anti-VEGF therapy-based chemotherapy

AND

3 - ONE of the following:

3.1 Tumor is RAS mutant-type

OR

3.2 BOTH of the following:

3.2.1 Tumor is RAS wild-type

AND

3.2.2 History of failure, contraindication, or intolerance to anti-EGFR therapy [e.g., Erbitux (cetuximab), Vectibix (panitumumab)]

Product Name: Stivarga	
Diagnosis	Soft Tissue Sarcoma (STS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Diagnosis of soft tissue sarcoma (STS)

AND

2 - ONE of the following:

2.1 Extremity/superficial trunk or head/neck that is non-adipocytic with advanced/metastatic disease with disseminated metastases

OR

2.2 Retroperitoneal/intra-abdominal that is non-adipocytic with recurrent unresectable or stage IV disease

OR

2.3 Advanced/metastatic pleomorphic rhabdomyosarcoma

OR

2.4 Angiosarcoma

Product Name: Stivarga	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST)

AND

2 - Disease is one of the following:

- Gross residual (R2 resection)
- Unresectable primary
- Tumor rupture
- Recurrent/metastatic

AND

3 - One of the following:

3.1 SDH-deficient GIST

OR

3.2 One of the following

3.2.1 Failure to both of the following as confirmed by claims history or submission of medical records:

- imatinib mesylate (generic Gleevec)
- sunitinib malate) (generic Sutent)

OR

3.2.2 History of contraindication or intolerance to both of the following (please specify intolerance or contraindication):

- imatinib mesylate (generic Gleevec)

- sunitinib malate) (generic Sutent)

Product Name: Stivarga	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic cholangiocarcinoma
- Intrahepatic cholangiocarcinoma

AND

1.2 Disease is ONE of the following:

- Unresectable
- Resected gross residual (R2)
- Metastatic

OR

2 - BOTH of the following:

2.1 Diagnosis of hepatocellular carcinoma

AND

2.2 Used as subsequent-line therapy for disease progression

Product Name: Stivarga	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Osteosarcoma
- Dedifferentiated chondrosarcoma
- High grade undifferentiated pleomorphic sarcoma (UPS)
- Ewing Sarcoma

AND

2 - Disease is ONE of the following:

- Relapsed/refractory
- Metastatic

AND

3 - Used as second-line therapy

Product Name: Stivarga	
Diagnosis	Glioblastoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Diagnosis of recurrent or progressive glioblastoma

Product Name: Stivarga	
Diagnosis	Colorectal Cancer (CRC), Soft Tissue Sarcoma (STS), Gastrointestinal Stromal Tumor (GIST), Hepatobiliary Cancer, Bone Cancer, Glioblastoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Stivarga therapy

Product Name: Stivarga	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Stivarga	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Stivarga therapy

Strensiq

Prior Authorization Guideline

Guideline ID	GL-146652
Guideline Name	Strensiq
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Strensiq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 18 MG/0.45ML	30905610002020	Brand
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 28 MG/0.7ML	30905610002030	Brand
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 40 MG/ML	30905610002040	Brand
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 80 MG/0.8ML	30905610002050	Brand

Approval Criteria

1 - Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia based on ALL of the following:

1.1 ONE of the following:

1.1.1 Onset of clinical signs and symptoms of hypophosphatasia prior to age 18 years (e.g., respiratory insufficiency, vitamin B6 responsive seizures, hypotonia, failure to thrive, delayed walking, waddling gait, dental abnormalities, low trauma fractures)

OR

1.1.2 Radiographic evidence supporting the diagnosis of hypophosphatasia at the age of onset prior to age 18 years (e.g., craniosynostosis, infantile rickets, non-traumatic fractures)

AND

1.2 ONE of the following:

1.2.1 BOTH of the following:

1.2.1.1 Patient has low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age and gender-adjusted normal range

AND

1.2.1.2 Patient has an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate [e.g., serum pyridoxal 5'-phosphate (PLP) level, serum or urine phosphoethanolamine (PEA) level, urinary inorganic pyrophosphate (PPi level)]

OR

1.2.2 Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA (deoxyribonucleic acid) testing*

AND

2 - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone disorders

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Diagnosis of perinatal/infantile-onset hypophosphatasia

AND

3.1.2 Request does not exceed a maximum supply limit of 9 mg/kg/week (milligrams/kilogram/week)

OR

3.2 BOTH of the following:

3.2.1 Diagnosis of juvenile-onset hypophosphatasia

AND

3.2.2 Request does not exceed a maximum supply limit of 6 mg/kg/week

AND

4 - ONE of the following:

4.1 Patient is prescribed Strensiq 18 mg/0.45 mL (milliliter), Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

4.2 BOTH of the following:

4.2.1 Patient is prescribed Strensiq 80 mg/0.8 mL vial

AND

4.2.2 Patient's weight is greater than or equal to 40 kg

Notes	*Results of prior genetic testing can be submitted as confirmation of di agnosis of HPP, however please note that the provider should confirm coverage status of any new genetic testing under the patient's United Healthcare plan prior to ordering.

Product Name: Strensiq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 18 MG/0.45ML	30905610002020	Brand
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 28 MG/0.7ML	30905610002030	Brand
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 40 MG/ML	30905610002040	Brand
STRENSIQ	ASFOTASE ALFA SUBCUTANEOUS INJ 80 MG/0.8ML	30905610002050	Brand

Approval Criteria

1 - Documentation of positive clinical response to Strensiq therapy (e.g., improvement in clinical symptoms, improvement in Radiographic Global Impression of Change)

AND

2 - Clinically relevant decrease from baseline in tissue non-specific alkaline phosphatase

(TNSALP) substrate [e.g., serum pyridoxal 5'-phosphate (PLP) level, serum or urine phosphoethanolamine (PEA) level, urinary inorganic pyrophosphate (PPi level)]

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone diseases

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Diagnosis of perinatal/infantile-onset hypophosphatasia

AND

4.1.2 Request does not exceed a maximum supply limit of 9 mg/kg/week (milligrams/kilogram/week)

OR

4.2 BOTH of the following:

4.2.1 Diagnosis of juvenile-onset hypophosphatasia

AND

4.2.2 Request does not exceed a maximum supply limit of 6 mg/kg/week

AND

5 - ONE of the following:

5.1 Patient is prescribed Strensiq 18 mg/0.45 mL (milliliter), Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

5.2 BOTH of the following:

5.2.1 Patient is prescribed Strensiq 80 mg/0.8 mL vials

AND

5.2.2 Patient's weight is greater than or equal to 40 kg

Stromectol

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146418
Guideline Name	Stromectol
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Stromectol, generic ivermectin tabs	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STROMECTOL	IVERMECTIN TAB 3 MG	15000007000310	Brand
IVERMECTIN	IVERMECTIN TAB 3 MG	15000007000310	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Onchocerciasis due to nematode parasite
- Pediculosis
- Strongyloidiasis
- Ascariasis
- Scabies (including crusted scabies)
- Cutaneous larva migrans (hook worm disease)
- Enterobiasis
- Filariasis
- Trichuriasis
- Gnathostomiasis

Sublingual Immunotherapy (SLIT)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146419
Guideline Name	Sublingual Immunotherapy (SLIT)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Grastek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GRASTEK	TIMOTHY GRASS POLLEN ALLERGEN EXT SL TAB 2800 BAU	20100048000740	Brand

Approval Criteria

1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

2.1 Positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

OR

2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the grass pollen season

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Oralair)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Grastek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
GRASTEK	TIMOTHY GRASS POLLEN ALLERGEN EXT SL TAB 2800 BAU	20100048000740	Brand

Approval Criteria

1 - Documentation of positive clinical response to Grastek therapy

Product Name: Oralair	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORALAIR CHILDREN/ADOLESCENTS STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 100 IR (INDEX OF REACTIVITY)*	20109905200720	Brand
ORALAIR	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand
ORALAIR ADULT STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand

Approval Criteria

1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

2.1 Positive skin test to any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]

OR

2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]

AND

3 - Treatment is started or will be started at least 4 months before the beginning of the grass pollen season

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Grastek)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Oralair

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ORALAIR CHILDREN/ADOLESCENTS STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 100 IR (INDEX OF REACTIVITY)*	20109905200720	Brand
ORALAIR	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand
ORALAIR ADULT STARTER PACK	*GRASS MIXED POLLEN EXT SL TAB 300 IR (INDEX OF REACTIVITY)*	20109905200730	Brand

Approval Criteria

1 - Documentation of positive clinical response to Oralair therapy

Product Name: Ragwitek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAGWITEK	SHORT RAGWEED POLLEN ALLERGEN EXTRACT SL TAB 12 AMB A 1-U	20100060200720	Brand

Approval Criteria

1 - Diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to short ragweed pollen

- In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for short ragweed pollen

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the short ragweed pollen season

AND

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

5 - Patient does not have unstable and/or uncontrolled asthma

AND

6 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Ragwitek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RAGWITEK	SHORT RAGWEED POLLEN ALLERGEN EXTRACT SL TAB 12 AMB A 1-U	20100060200720	Brand

Approval Criteria

1 - Documentation of positive clinical response to Ragwitek therapy

Product Name: Odactra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ODACTRA	*DUST MITE MIXED EXT SL TAB 12 SQ-HDM***	20109902220740	Brand

Approval Criteria

1 - Diagnosis of house dust mite (HDM)-induced allergic rhinitis

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to licensed house dust mite allergen extracts
- In vitro testing for IgE (immunoglobulin E) antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites

AND

3 - ONE of the following:

3.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

AND

4 - Patient does not have unstable and/or uncontrolled asthma

AND

5 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Odactra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ODACTRA	*DUST MITE MIXED EXT SL TAB 12 SQ-HDM***	20109902220740	Brand

Approval Criteria

1 - Documentation of positive clinical response to Odactra therapy

Sucraid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148728
Guideline Name	Sucraid
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Sucraid	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUCRAID	SACROSIDASE SOLN 8500 UNIT/ML	51200060002030	Brand

Approval Criteria

1 - Diagnosis of congenital sucrase-isomaltase deficiency (CSID)

AND

2 - Diagnosis has been confirmed by ONE of the following:

2.1 Endoscopic biopsy of the small bowel indicating ALL of the following:

2.1.1 Normal small bowel morphology

AND

2.1.2 Absent or markedly reduced sucrase activity

AND

2.1.3 Isomaltase activity varying from 0 to full activity

AND

2.1.4 Reduced maltase activity

AND

2.1.5 ONE of the following:

2.1.5.1 Normal lactase activity

OR

2.1.5.2 BOTH of the following:

- Reduced lactase
- Sucrase:lactase ratio of less than 1.0

OR

2.2 Molecular genetic testing of the sucrase-isomaltase (SI) gene indicating a pathogenic isomaltase gene variant

OR

2.3 Carbon-13 sucrose breath test (13C SBT) indicating a cumulative [13C] CO2 exhalation over 90 minutes below 10th percentile (i.e., less than 3.9% for men and less than 5.2% for women)

AND

3 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist

AND

4 - Will be used with a sucrose-free, low starch diet

Product Name: Sucraid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUCRAID	SACROSIDASE SOLN 8500 UNIT/ML	51200060002030	Brand

Approval Criteria

1 - Documentation of positive clinical response to Sucraid therapy [e.g., reduced symptoms (e.g., abdominal pain, bloating, gas, vomiting), reduced number of stools per day, reduced number of symptomatic days]

AND **2** - Prescribed by or in consultation with a gastroenterologist or rare disease specialist **AND** **3** - Will be used with a sucrose-free, low starch diet

2 . Revision History

Date	Notes
6/20/2024	Added carbon-13 sucrose breath test as an acceptable confirmatory diagnostic test.

Sunosi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146421
Guideline Name	Sunosi
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months.

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a multiple sleep latency test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT.

AND

2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

3.1.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.1.2 ONE of the following:

- Modafinil (generic Provigil)

- Armodafinil (generic Nuvigil)

OR

3.2 History of contraindication or intolerance to ALL of the following drugs or classes (please specify contraindication or intolerance):

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant
- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

Product Name: Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy

Product Name: Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of obstructive sleep apnea with ONE of the following:

1.1 Fifteen or more obstructive respiratory events per hour of sleep confirmed by a sleep study

OR

1.2 BOTH of the following:

1.2.1 Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study

AND

1.2.2 ONE or more of the following signs/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by bed partner or other observer
- Observed apnea

AND

2 - BOTH of the following:

2.1 Standard treatments for the underlying airway obstruction [e.g., continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP)] have been used for one month or longer

AND

2.2 Patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Modafinil (generic Provigil)
- Armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

Product Name: Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUNOSI	SOLRIAMFETOL HCL TAB 75 MG (BASE EQUIV)	61370070200320	Brand
SUNOSI	SOLRIAMFETOL HCL TAB 150 MG (BASE EQUIV)	61370070200340	Brand

Approval Criteria

1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy

AND

2 - Patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP)

Sutent

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147812
Guideline Name	Sutent
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand

SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST)

AND

2 - ONE of the following:

2.1 Disease progression on ONE of the following as confirmed by claims history or submission of medical records:

- imatinib (generic Gleevec)
- Stivarga (regorafenib)
- Standard dose Qinlock (ripretinib)*

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- imatinib (generic Gleevec)
- Stivarga (regorafenib)

OR

2.3 SDH (succinate dehydrogenase)-deficient GIST

Notes	*Qinlock is non-preferred and should not be included in denial to provider.

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Diagnosis of renal cell carcinoma (RCC)

AND

2 - ONE of the following:

2.1 Disease has relapsed

OR

2.2 Disease is advanced

OR

2.3 BOTH of the following:

2.3.1 Used in adjuvant setting

AND

2.3.2 Patient has a high risk of recurrence following nephrectomy

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Progressive pancreatic neuroendocrine tumors (pNET)

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Alveolar soft part sarcoma (ASPS)
- Angiosarcoma
- Solitary fibrous tumor/hemangiopericytoma

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.3 ONE of the following:

- Patient has symptomatic disease

- Patient has progressive disease

AND

1.4 Disease is refractory to radioactive iodine treatment

OR

2 - ALL of the following:

2.1 Diagnosis of medullary thyroid carcinoma

AND

2.2 ONE of the following:

- Patient has progressive disease
- Patient has symptomatic metastatic disease

AND

2.3 ONE of the following:

2.3.1 Clinical trials or preferred systemic therapy options are not available or appropriate [e.g., Caprelsa (vandetanib), Cometriq (cabozantinib)]

OR

2.3.2 There is progression on preferred systemic therapy options [e.g., Caprelsa (vandetanib), Cometriq (cabozantinib)]

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Diagnosis of recurrent chordoma

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Central Nervous System Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand

SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Diagnosis of surgically inaccessible meningiomas

AND

2 - ONE of the following:

- Disease is recurrent
- Disease is progressive

AND

3 - Further radiation is not possible

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic

SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Diagnosis of thymic carcinoma

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic or blast phase

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	GIST, RCC, Neuroendocrine and Adrenal Tumors, Soft Tissue Sarcoma, Thyroid Carcinoma, Chordoma, Central Nervous System Cancer, Thymic Carcinoma, Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic
SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Sutent, generic sunitinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	Generic
SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	Generic

SUTENT	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 37.5 MG (BASE EQUIVALENT)	21533070300135	Generic
SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Brand
SUNITINIB MALATE	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
5/28/2024	Updated criteria for GIST, neuroendocrine/adrenal tumors, and thyroid carcinoma per NCCN recommendations.

Symdeko

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151686
Guideline Name	Symdeko
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Symdeko	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYMDEKO	TEZACAFTOR-IVACAFTOR 100-150 MG & IVACAFTOR 150 MG TAB TBPK	4530990280B720	Brand
SYMDEKO	TEZACAFTOR-IVACAFTOR 50-75 MG & IVACAFTOR 75 MG TAB TBPK	4530990280B710	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory result documenting ONE of the following:

2.1 The patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

OR

2.2 The patient has at least ONE mutation in the CFTR gene that is responsive to Symdeko (See Table in Background Section)

AND

3 - Prescribed by, or in consultation with, a provider who specializes in the treatment of CF

Product Name: Symdeko	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYMDEKO	TEZACAFTOR-IVACAFTOR 100-150 MG & IVACAFTOR 150 MG TAB TBPK	4530990280B720	Brand
SYMDEKO	TEZACAFTOR-IVACAFTOR 50-75 MG & IVACAFTOR 75 MG TAB TBPK	4530990280B710	Brand

Approval Criteria

1 - Documentation of positive clinical response to Symdeko therapy (e.g., improved lung function, stable lung function)

2 . Background

Benefit/Coverage/Program Information

Table 1 CFTR Gene Mutations

546insCTA	E92K	G576A	L346P	R117G	S589N
711+3A→G*	E116K	G576A;R668C †	L967S	R117H	S737F
2789+5G→A*	E193K	G622D	L997F	R117L	S912L
3272-26A→G*	E403D	G970D	L1324P	R117P	S945L *
3849+10kbC→T *	E588V	G1069R	L1335P	R170H	S977F*
A120T	E822K	G1244E	L1480P	R258G	S1159F
A234D	E831X	G1249R	M152V	R334L	S1159P
A349V	F191V	G1349D	M265R	R334Q	S1251N
A455E *	F311del	H939R	M952I	R347H *	S1255P
A554E	F311L	H1054D	M952T	R347L	T338I
A1006E	F508C	H1375P	P5L	R347P	T1036N
A1067T	F508C; S1251N †	I148T	P67L *	R352Q *	T1053I
D110E	F508del ‡	I175V	P205S	R352W	V201M
D110H *	F575Y	I336K	Q98R	R553Q	V232D

D192G	F1016S	I601F	Q237E	R668C	V562I
D443Y	F1052V	I618T	Q237H	R751L	V754M
D443Y; G576A; R668C †	F1074L	I807M	Q359R	R792G	V1153E
D579G *	F1099L	I980K	Q1291R	R933G	V1240G
D614G	G126D	I1027T	R31L	R1066H	V1293G
D836Y	G178E	I1139V	R74Q	R1070Q	W1282R
D924N	G178R	I1269N	R74W	R1070W *	Y109N
D979V	G194R	I1366N	R74W; D1270N †	R1162L	Y161S
D1152H *	G194V	K1060T	R74W; V201M †	R1283M	Y1014C
D1270N	G314E	L15P	R74W; V201M; D1270N †	R1283S	Y1032C
E56K	G551D	L206W *	R75Q	S549N	
E60K	G551S	L320V	R117C *	S549R	

* Clinical data for these mutations in Clinical Studies.

^ A patient must have two copies of the F508del mutation or at least one copy of a responsive mutation presented in the table to be indicated.

† Complex/compound mutations where a single allele of the CFTR gene has multiple mutations; these exist independent of the presence of mutations on the other allele.

3 . Revision History

Date	Notes
8/13/2024	Simplified reauthorization criteria

Synagis

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-157006
Guideline Name	Synagis
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Synagis*			
Diagnosis	Prematurity		
Guideline Type	Prior Authorization		
Product Name	Generic Name	GPI	Brand/Generic
SYNAGIS	PALIVIZUMAB IM SOLN 50 MG/0.5ML	19502060002015	Brand
SYNAGIS	PALIVIZUMAB IM SOLN 100 MG/ML	19502060002020	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Patient is an infant born before 29 weeks, 0 days gestation

AND

1.2 Patient is less than 12 months of age at the start of RSV "season"

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV "season"***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) during or entering the current RSV "season"

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper

airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV “season.” **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Chronic Lung Disease (CLD)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNAGIS	PALIVIZUMAB IM SOLN 50 MG/0.5ML	19502060002015	Brand
SYNAGIS	PALIVIZUMAB IM SOLN 100 MG/ML	19502060002020	Brand

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following for patients age 0 to less than 12 months:

1.1.1 The patient is a preterm infant defined as gestational age less than 32 weeks, 0 days

AND

1.1.2 Patient has developed chronic lung disease (CLD) of prematurity

AND

1.1.3 There was a requirement for greater than 21% oxygen for at least the first 28 days after birth

OR

1.2 ALL of the following for patients age greater than or equal to 12 months to less than 24 months:

1.2.1 The patient was born at less than 32 weeks, 0 days gestation

AND

1.2.2 The patient required at least 28 days of oxygen after birth

AND

1.2.3 The patient continues to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV "season"***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) during or entering the current RSV "season"

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV “season.” **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Congenital Heart Disease (CHD)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNAGIS	PALIVIZUMAB IM SOLN 50 MG/0.5ML	19502060002015	Brand
SYNAGIS	PALIVIZUMAB IM SOLN 100 MG/ML	19502060002020	Brand

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following for patients age 0 to less than 12 months:

1.1.1 Patient has hemodynamically significant congenital heart disease (CHD) including ONE of the following:

- Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures
- Moderate to severe pulmonary hypertension
- Documentation that decisions regarding prophylaxis for infants with cyanotic heart defects were made in consultation with a pediatric cardiologist

OR

1.1.2 The patient is undergoing cardiac transplantation during the RSV "season"

OR

1.2 BOTH of the following:

1.2.1 The patient is greater than or equal to 12 months to less than 24 months of age

AND

1.2.2 ONE of the following:

- After cardiac bypass
- At the conclusion of extracorporeal membrane oxygenation
- The patient is undergoing cardiac transplantation during the RSV "season"

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV "season"***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) during or entering the current RSV "season"

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV “season.” **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Congenital abnormalities of the airway or neuromuscular disease
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNAGIS	PALIVIZUMAB IM SOLN 50 MG/0.5ML	19502060002015	Brand
SYNAGIS	PALIVIZUMAB IM SOLN 100 MG/ML	19502060002020	Brand

Approval Criteria

1 - ALL of the following:

1.1 Patient is age 0 to less than 12 months

AND

1.2 Patient has ONE of the following:

- Neuromuscular disease
- A congenital anomaly that impairs the ability to clear secretions from the lower airway because of ineffective cough

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV “season”***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) during or entering the current RSV “season”

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV “season.” **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose s

	eries for the season. Any subsequent doses received in the hospital s etting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses ma y be needed.

Product Name: Synagis*	
Diagnosis	Immunocompromised children less than 24 months of age
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNAGIS	PALIVIZUMAB IM SOLN 50 MG/0.5ML	19502060002015	Brand
SYNAGIS	PALIVIZUMAB IM SOLN 100 MG/ML	19502060002020	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Patient is less than 24 months of age

AND

1.2 The patient is immunocompromised (e.g. receiving cancer chemotherapy, undergoing hematopoietic stem cell transplantation, or solid organ transplantation)

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV "season"***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) during or entering the current RSV "season"

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

AND

7 - The request is NOT for one of the following:

- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Treatment of symptomatic RSV disease

Notes	*Approval for up to 5 doses per single RSV "season." **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or

	promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

Product Name: Synagis*	
Diagnosis	Cystic fibrosis (CF)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNAGIS	PALIVIZUMAB IM SOLN 50 MG/0.5ML	19502060002015	Brand
SYNAGIS	PALIVIZUMAB IM SOLN 100 MG/ML	19502060002020	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following for patients age 0 to less than 12 months:

1.1.1 Patient has cystic fibrosis

AND

1.1.2 Patient has clinical evidence of at least ONE of the following:

- Chronic lung disease (CLD)
- Nutritional compromise
- Failure to thrive defined as weight for length less than the 10th percentile on a pediatric growth chart

OR

1.2 BOTH of the following:

1.2.1 Patient is greater than or equal to 12 months to less than 24 months of age

AND

1.2.2 Patient has manifestations of severe lung disease including ONE of the following:

- Previous hospitalization for pulmonary exacerbation in the first year of life
- Abnormalities on chest radiography or chest computed tomography that persists when stable
- Weight for length less than the 10th percentile on a pediatric growth chart

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Dosage of Synagis does not exceed 5 monthly doses per single RSV “season”***

AND

5 - Patient has not previously received treatment with Beyfortus (nirsevimab-alip) during or entering the current RSV “season”

AND

6 - Synagis is not being requested for any of the following situations alone:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy

• Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present] • Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present) • Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children • Synagis prophylaxis for prevention of nosocomial disease **AND** **7** - The request is NOT for one of the following: • Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab • Treatment of symptomatic RSV disease	
Notes	*Approval for up to 5 doses per single RSV “season.” **Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports: https://www.cdc.gov/nrevss/php/dashboard/index.html ***Infants in a neonatal intensive care unit who qualify for prophylaxis may receive the first dose 48 to 72 hours before discharge to home or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. Any subsequent doses received in the hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthly doses may be needed.

2 . Background

Benefit/Coverage/Program Information
Additional Information In most of North America, peak RSV activity typically occurs between November and March, usually beginning in November or December, peaking in January or February, and ending by the end of March or sometime in April. Communities in the southern United States, particularly some communities in the state of Florida, tend to experience the earliest onset of

RSV. Data from the Centers for Disease Control and Prevention (CDC) have identified variations in the onset and offset of the RSV "season" in the state of Florida that could affect the timing of Synagis administration.

- Despite varied onsets, the RSV "season" is of the same duration (5 months) in the different regions of Florida.
- On the basis of the epidemiology of RSV in Alaska, particularly in remote regions where the burden of RSV disease is significantly greater than the general US population, the selection of Alaska Native infants eligible for prophylaxis may differ from the remainder of the United States. Clinicians may wish to use RSV surveillance data generated by the state of Alaska to assist in determining onset and end of the RSV season for qualifying infants.
- Limited information is available concerning the burden of RSV disease among Native American populations. However, special consideration may be prudent for Navajo and White Mountain Apache infants in the first year of life.

For analysis of National Respiratory and Enteric Virus Surveillance System (NREVSS) reports in the CDC Morbidity and Mortality Weekly Report, season onset is defined as the first of 2 consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is ≥ 10% or the mean percentage of specimens testing positive for RSV by PCR is ≥ 3%, whichever occurs first. RSV "season" offset is defined as the last week during which the mean percentage of positive specimens is ≥ 10%, or the mean percentage of positive specimens by PCR is ≥ 3%, whichever occurs last. Use of specimens to determine the start of the RSV "season" requires that the number of specimens tested be statistically significant.

3 . Revision History

Date	Notes
10/3/2024	Updated CDC website. Removed old sharepoint link.

Synribo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146657
Guideline Name	Synribo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Synribo	
Diagnosis	Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNRIBO	OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG	21700040102120	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of chronic or accelerated phase chronic myelogenous leukemia

OR

1.2 Diagnosis of advanced phase chronic myelogenous leukemia with progression to accelerated phase

OR

1.3 Patient has relapsed disease after hematopoietic stem cell transplant for chronic myeloid leukemia

AND

2 - Patient has a history of resistance and/or intolerance to TWO or more tyrosine kinase inhibitors [e.g., Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib), Bosulif (bosutinib), Iclusig (ponatinib)]

Product Name: Synribo	
Diagnosis	Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNRIBO	OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG	21700040102120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Synribo therapy

Product Name: Synribo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNRIBO	OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG	21700040102120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Synribo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
SYNRIBO	OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG	21700040102120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Synribo therapy

Tabrecta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146658
Guideline Name	Tabrecta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tabrecta	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TABRECTA	CAPMATINIB HCL TAB 150 MG	21533716200320	Brand
TABRECTA	CAPMATINIB HCL TAB 200 MG	21533716200330	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

2.1 Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors

OR

2.2 High level MET amplification in lung cancer

Product Name: Tabrecta	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TABRECTA	CAPMATINIB HCL TAB 150 MG	21533716200320	Brand
TABRECTA	CAPMATINIB HCL TAB 200 MG	21533716200330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tabrecta therapy

Product Name: Tabrecta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TABRECTA	CAPMATINIB HCL TAB 150 MG	21533716200320	Brand
TABRECTA	CAPMATINIB HCL TAB 200 MG	21533716200330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Tabrecta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TABRECTA	CAPMATINIB HCL TAB 150 MG	21533716200320	Brand
TABRECTA	CAPMATINIB HCL TAB 200 MG	21533716200330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tabrecta therapy

Tafinlar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151115
Guideline Name	Tafinlar
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/7/2024

1 . Criteria

Product Name: Tafinlar	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Unresectable melanoma

OR

1.2 Metastatic melanoma

OR

1.3 BOTH of the following:

1.3.1 Prescribed as adjuvant therapy for melanoma involving the lymph node(s)

AND

1.3.2 Used in combination with Mekinist (trametinib)

AND

2 - Cancer is positive for BRAF V600 mutation

AND

3 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Patient has metastatic brain lesions

AND

1.1.2 Tafinlar is active against primary tumor (melanoma)

OR

1.2 Patient has a glioma

AND

2 - Cancer is positive for BRAF V600E mutation

AND

3 - Used in combination with Mekinist (trametinib)

AND

4 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Advanced
- Recurrent

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - ONE of the following:

- Used in combination with Mekinist (trametinib)
- Used as a single agent if the combination of Mekinist and Tafinlar is not tolerated

AND

5 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of anaplastic thyroid cancer (ATC)

AND

1.2 Cancer is positive for BRAF V600E mutation

AND

1.3 Used in combination with Mekinist (trametinib)

AND

1.4 ONE of the following:

1.4.1 Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

OR

1.4.2 Prescribed as adjuvant therapy following resection

AND

1.5 If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

OR

2 - ALL of the following:

2.1 ONE of the following diagnoses:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

2.4 Disease is refractory to radioactive iodine treatment

AND

2.5 Cancer is positive for BRAF V600 mutation

AND

2.6 If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic Cholangiocarcinoma
- Intrahepatic Cholangiocarcinoma

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E mutation

AND

5 - Used in combination with Mekinist (trametinib)

AND

6 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease

AND

2 - Cancer is positive for BRAF V600E mutation

AND

3 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Presence of solid tumor

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E mutation

AND

5 - Used in combination with Mekinist (trametinib)

AND

6 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial Ovarian Cancer
- Fallopian Tube Cancer
- Primary Peritoneal Cancer

AND

2 - ONE of the following:

- Persistent disease
- Recurrence in BRAF V600E positive tumors
- Recurrence of low-grade serous carcinoma

AND

3 - Used in combination with Mekinist (trametinib)

AND

4 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Pancreatic Cancer / Ampullary Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Pancreatic adenocarcinoma
- Ampullary adenocarcinoma

AND

2 - Disease is ONE of the following:

- Metastatic

- Locally advanced
- Unresectable

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Mekinist (trametinib)

AND

5 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of hairy cell leukemia

AND

2 - Used in combination with Mekinist (trametinib)

AND

3 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Disease is ONE of the following:

- Recurrent and unresectable

- Metastatic

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Mekinist (trametinib)

AND

5 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Diagnosis of BRAF V600E-mutated gastrointestinal stromal tumor (GIST)

AND

2 - Disease is ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Progressive
- Recurrent
- Metastatic

AND

3 - Used in combination with Mekinist (trametinib)

AND

4 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	All Indications except NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tafinlar therapy

Product Name: Tafinlar	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

AND

2 - If the request is for Tafinlar tablets for oral solution, there is a reason or special circumstance why the patient is unable to use Tafinlar capsules (document reason or special circumstance)

Product Name: Tafinlar	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAFINLAR	DABRAFENIB MESYLATE CAP 50 MG (BASE EQUIVALENT)	21532025100120	Brand
TAFINLAR	DABRAFENIB MESYLATE CAP 75 MG (BASE EQUIVALENT)	21532025100130	Brand
TAFINLAR	DABRAFENIB MESYLATE TAB FOR ORAL SUSP 10 MG (BASE EQUIV)	21532025107320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tafinlar therapy

2 . Revision History

Date	Notes
8/6/2024	Added new criteria for hairy cell leukemia, salivary gland tumor, and GIST.

Tagrisso

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146660
Guideline Name	Tagrisso
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tagrisso	
Diagnosis	Central Nervous System (CNS) Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAGRISSO	OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT)	21360068200320	Brand
TAGRISSO	OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT)	21360068200330	Brand

Approval Criteria

1 - Diagnosis of ONE of the following central nervous system (CNS) cancers:

- Limited brain metastases from non-small cell lung cancer (NSCLC)
- Extensive brain metastases from NSCLC
- Leptomeningeal metastases from NSCLC

AND

2 - Primary disease (tumor) is responsive to Tagrisso therapy [e.g., epidermal growth factor receptor (EGFR) T790M mutation, exon 19 deletions, or exon 21 L858R mutation-positive NSCLC]

Product Name: Tagrisso	
Diagnosis	Central Nervous System (CNS) Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAGRISSO	OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT)	21360068200320	Brand
TAGRISSO	OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT)	21360068200330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tagrisso therapy

Product Name: Tagrisso	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAGRISSO	OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT)	21360068200320	Brand
TAGRISSO	OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT)	21360068200330	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Disease is recurrent, advanced, or metastatic

AND

2.1.2 Disease is sensitizing EGFR mutation positive (e.g., EGFR T790M mutation, exon 19 deletions, exon 21 L858R, S768I, L861Q, or G719X mutation-positive)

AND

2.1.3 Used as a first-line therapy

OR

2.2 ALL of the following:

2.2.1 Disease is recurrent, advanced, or metastatic

AND

2.2.2 Disease is sensitizing EGFR mutation positive (e.g., EGFR T790M mutation, positive exon 19 deletions, exon 21 L858R, S768I, L861Q, or G719X mutation-positive)

AND

2.2.3 Subsequent therapy for disease that has progressed while on Tagrisso therapy

OR

2.3 ALL of the following:

2.3.1 Disease is recurrent, advanced, or metastatic

AND

2.3.2 Disease is epidermal growth factor receptor (EGFR) T790M mutation-positive

AND

2.3.3 ONE of the following:

- Failure to prior EGFR tyrosine kinase inhibitor (TKI) therapy [e.g., Tarceva (erlotinib), Gilotrif (afatinib), Iressa (gefitinib)]
- History of contraindication or intolerance to prior EGFR TKI therapy [e.g., Tarceva (erlotinib), Gilotrif (afatinib), Iressa (gefitinib)]

OR

2.4 BOTH of the following:

2.4.1 Disease is EGFR exon 19 deletion or exon 21 L858R mutation positive

AND

2.4.2 Used as adjuvant therapy after tumor resection

Product Name: Tagrisso	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAGRISSO	OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT)	21360068200320	Brand
TAGRISSO	OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT)	21360068200330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tagrisso therapy

Product Name: Tagrisso	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAGRISSO	OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT)	21360068200320	Brand
TAGRISSO	OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT)	21360068200330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Tagrisso	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAGRISSO	OSIMERTINIB MESYLATE TAB 40 MG (BASE EQUIVALENT)	21360068200320	Brand
TAGRISSO	OSIMERTINIB MESYLATE TAB 80 MG (BASE EQUIVALENT)	21360068200330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tagrisso therapy

Takhzyro

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147196
Guideline Name	Takhzyro
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Takhzyro	
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAKHZYRO	LANADELUMAB-FLYO SOLN PREF SYRINGE 150 MG/ML	8584204020E510	Brand
TAKHZYRO	LANADELUMAB-FLYO SOLN PREF SYRINGE 300 MG/2ML (150 MG/ML)	8584204020E520	Brand
TAKHZYRO	LANADELUMAB-FLYO INJ 300 MG/2ML (150 MG/ML)	85842040202020	Brand

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

1.2.1 Confirmed presence variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6

OR

1.2.2 Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

OR

1.2.3 Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - BOTH of the following:

2.1 For prophylaxis against HAE attacks

AND

2.2 Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

AND

3 - BOTH of the following:

3.1 Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Takhzyro

AND

3.2 Documentation of baseline HAE attack rate is greater than or equal to one attack per 4 weeks

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

5 - ONE of the following:

5.1 Failure to Haegarda confirmed by claims history or submitted medical records

OR

5.2 History of contraindication or intolerance to Haegarda (please specify intolerance or contraindication)

OR

5.3 Patient is currently on Takhzyro therapy confirmed by claims history or submitted medical records

AND

6 - ONE of the following:

6.1 For adult and pediatric patients 12 years and older, Takhzyro 300 mg (milligrams) is given every 2 weeks*

OR

6.2 For pediatric patients 6 to less than 12 years of age, Takhzyro 150 mg is given every 2 weeks*

OR

6.3 For pediatric patients less than 6 years of age, Takhzyro 150 mg is given every 4 weeks**

Notes	*Adult and pediatric patients 6 years of age and older approval length: 8 months. **Pediatric patients less than 6 years of age approval length: 12 months.

Product Name: Takhzyro	
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAKHZYRO	LANADELUMAB-FLYO SOLN PREF SYRINGE 150 MG/ML	8584204020E510	Brand
TAKHZYRO	LANADELUMAB-FLYO SOLN PREF SYRINGE 300 MG/2ML (150 MG/ML)	8584204020E520	Brand
TAKHZYRO	LANADELUMAB-FLYO INJ 300 MG/2ML (150 MG/ML)	85842040202020	Brand

Approval Criteria

1 - Documentation of positive clinical response while on Takhzyro therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ruconest, Firazyr, Kalbitor) as determined by claims information, while on Takhzyro therapy

AND

3 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

4 - BOTH of the following:

4.1 For prophylaxis against hereditary angioedema (HAE) attacks

AND

4.2 Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

AND

5 - ONE of the following:

5.1 Patient is less than 6 years of age and Takhzyro 150 mg (milligrams) is given every 4 weeks*

OR

5.2 Patient is at least 6 years of age, and BOTH of the following:

5.2.1 Documentation of the number of acute HAE attacks in the previous 6 months, while on Takhzyro therapy

AND

5.2.2 ONE of the following:

5.2.2.1 If the patient experienced no (zero) acute HAE attacks in the previous 6 months, ONE of the following*:

- For adult and pediatric patients 12 years of age and older, Takhzyro 300 mg is given every 4 weeks**
- For pediatric patients 6 to less than 12 years of age, Takhzyro 150 mg is given every 4 weeks**

OR

5.2.2.2 If the patient experienced one or more HAE attacks in the previous 6 months, ONE of the following***:

- For adult and pediatric patients 12 years of age and older, Takhzyro 300 mg is given every 2 weeks
- For pediatric patients 6 to less than 12 years of age, Takhzyro 150 mg is given every 2 weeks

Notes	*Patient experienced no acute HAE attacks in the previous 6 months, or is less than 6 years of age approval length: 12 months. **Patients experiencing unexpected breakthrough HAE attacks once s witched to every 4 week dosing will require additional review to allow f or 2 weeks dosing. ***Patient experienced 1 or more HAE attacks in the previous 6 month s approval length: 6 months.

2 . Revision History

Date	Notes
5/9/2024	Update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated and simplified reauthorization criteria.

Taltz

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146919
Guideline Name	Taltz
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Taltz	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic moderate to severe plaque psoriasis

AND

1.2 ONE of the following:

1.2.1 ALL of the following:

1.2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.2.1.2 One of the following:

1.2.1.2.1 Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

1.2.1.2.2 History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication)

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin

- Coal tar

AND

1.2.1.3 ONE of the following:

- Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

AND

1.3 One of the following:

1.3.1 Failure to TWO of the following preferred biologic products confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products^
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

OR

1.3.2 History of intolerance or contraindication to ALL of the following preferred biologic products (please specify intolerance or contraindication)

- One of the preferred adalimumab products^
- Enbrel (etanercept)
- Cimzia (certolizumab)
- Ilumya (tildrakizumab)

AND

1.4 ONE of the following:

1.4.1 Failure to a 6 month trial of Cosentyx (secukinumab) with moderate clinical response yet residual disease activity confirmed by claims history or submission of medical records

OR

1.4.2 BOTH of the following:

1.4.2.1 History of intolerance or adverse event to Cosentyx (please specify intolerance or contraindication)

AND

1.4.2.2 Physician attests that in their clinical opinion the same intolerance or adverse event would not be expected to occur with Taltz

AND

1.5 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.6 Prescribed by or in consultation with a dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of chronic moderate to severe plaque psoriasis

AND

2.3 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a dermatologist

Notes	^PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Taltz	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Skyrizi (risankizumab)]

AND

1.3 One of the following:

1.3.1 Failure to TWO of the following preferred biologic products confirmed by claims history or submission of medical records

- Cimzia (certolizumab)
- One of the preferred adalimumab products^
- Enbrel (etanercept)

OR

1.3.2 History of intolerance or contraindication to ALL of the following preferred biologic products (please specify intolerance or contraindication)

- Cimzia (certolizumab)
- One of the preferred adalimumab products^
- Enbrel (etanercept)

AND

1.4 ONE of the following:

1.4.1 Failure to a 6 month trial of Cosentyx (secukinumab) with moderate clinical response yet residual disease activity confirmed by claims history or submission of medical records

OR

1.4.2 BOTH of the following:

1.4.2.1 History of intolerance or adverse event to Cosentyx (please specify intolerance or contraindication)

AND

1.4.2.2 Physician attests that in their clinical opinion the same intolerance or adverse event would not be expected to occur with Taltz

AND

1.5 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.6 Prescribed by or in consultation with one of the following:

- Rheumatologist
- Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with one of the following:

- Rheumatologist
- Dermatologist

Notes	^PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Taltz	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active ankylosing spondylitis

AND

1.2 ONE of the following:

1.2.1 Failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab)].

AND

1.3 One of the following:

1.3.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products^
- Enbrel (etanercept)

OR

1.3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication)

- Cimzia (certolizumab)
- One of the preferred adalimumab products^
- Enbrel (etanercept)

AND

1.4 ONE of the following:

1.4.1 Failure to a 6 months trial of Cosentyx (secukinumab) with moderate clinical response yet residual disease activity as confirmed by claims history or submission of medical records

OR

1.4.2 BOTH of the following:

- History of intolerance or adverse event to Cosentyx (please specify intolerance or contraindication)
- Physician attests that in their clinical opinion the same intolerance or adverse event would not be expected to occur with Taltz

AND

1.5 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]

- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.6 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	^PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Taltz	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA), Ankylosing Spondylitis
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Taltz therapy

AND

2 - Patient is NOT receiving Taltz in combination with any of the following:

- Biologic disease modifying anti-rheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Product Name: Taltz	
Diagnosis	Non-Radiographic Axial Spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active non-radiographic axial spondyloarthritis

AND

1.2 ONE of the following:

1.2.1 Failure to two NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic DMARD (disease modifying anti-rheumatic drug) FDA (Food and Drug Administration)-approved for the treatment of non-radiographic axial spondyloarthritis as confirmed by claims history or submission of medical records [e.g. Cimzia (certolizumab), Cosentyx (secukinumab)]

AND

1.3 ONE of the following:

- Failure to Cimzia (certolizumab) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Cimzia (certolizumab) (please specify intolerance or contraindication)

AND

1.4 ONE of the following:

1.4.1 Failure to a 6 months trial of Cosentyx (secukinumab) with moderate clinical response yet residual disease activity confirmed by claims history or submission of medical records

OR

1.4.2 BOTH of the following:

- History of intolerance or adverse event to Cosentyx (please specify intolerance or contraindication)
- Physician attests that in their clinical opinion the same intolerance or adverse event would not be expected to occur with Taltz

AND

1.5 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.6 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Taltz therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active non-radiographic axial spondyloarthritis

AND

2.3 Patient is NOT receiving Taltz in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a rheumatologist

Product Name: Taltz	
Diagnosis	Non-Radiographic Axial Spondyloarthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Taltz therapy

AND

2 - Patient is NOT receiving Taltz in combination with any of the following:

- Biologic disease modifying anti-rheumatic drug (DMARD) [e.g., adalimumab, Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept), Skyrizi (risankizumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

2 . Revision History

Date	Notes
5/1/2024	Updated NM PDL Link

Talzenna

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146663
Guideline Name	Talzenna
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Talzenna	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT)	21535580400110	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT)	21535580400114	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT)	21535580400118	Brand

TALZENNA	TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT)	21535580400120	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT)	21535580400105	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT)	21535580400112	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Disease is ONE of the following:

- Locally advanced
- Metastatic

AND

3 - Presence of a germline BRCA (breast cancer)-mutation

AND

4 - ONE of the following:

4.1 Patient is currently on Talzenna therapy as confirmed by claims history or submitted medical records

OR

4.2 History of intolerance or contraindication to Lynparza (please specify intolerance or contraindication)

OR

4.3 Provider attests that the patient is not an appropriate candidate for Lynparza

Product Name: Talzenna	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT)	21535580400110	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT)	21535580400114	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT)	21535580400118	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT)	21535580400120	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT)	21535580400105	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT)	21535580400112	Brand

Approval Criteria

1 - Diagnosis of metastatic castration-resistant prostate cancer

AND

2 - Presence of homologous recombination repair (HRR) gene mutations

AND

3 - Used in combination with Xtandi (enzalutamide)

AND

4 - ONE of the following:

4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

4.2 Patient has had bilateral orchiectomy

Product Name: Talzenna	
Diagnosis	Breast Cancer, Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT)	21535580400110	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT)	21535580400114	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT)	21535580400118	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT)	21535580400120	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT)	21535580400105	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT)	21535580400112	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Talzenna therapy

Product Name: Talzenna	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT)	21535580400110	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT)	21535580400114	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT)	21535580400118	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT)	21535580400120	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT)	21535580400105	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT)	21535580400112	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Talzenna	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.25 MG (BASE EQUIVALENT)	21535580400110	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.5 MG (BASE EQUIVALENT)	21535580400114	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.75 MG (BASE EQUIVALENT)	21535580400118	Brand

TALZENNA	TALAZOPARIB TOSYLATE CAP 1 MG (BASE EQUIVALENT)	21535580400120	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.1 MG (BASE EQUIVALENT)	21535580400105	Brand
TALZENNA	TALAZOPARIB TOSYLATE CAP 0.35 MG (BASE EQUIVALENT)	21535580400112	Brand

Approval Criteria

1 - Documentation of positive clinical response to Talzenna therapy

Tarceva

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146664
Guideline Name	Tarceva
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	Pancreatic Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand

ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Diagnosis of pancreatic cancer

AND

2 - Disease is ONE of the following:

- Locally advanced
- Unresectable
- Metastatic

AND

3 - Used in combination with gemcitabine

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic

TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Recurrent
- Advanced

AND

3 - ONE of the following:

- Tumors are positive for epidermal growth factor receptor (EGFR)exon 19 deletions
- Tumors are positive for exon 21 (L858R) substitution mutations
- Tumors are positive for a known sensitizing EGFR mutation (e.g., S768I, L861Q, G719X)

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic

TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Diagnosis of chordoma

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Diagnosis of kidney cancer

AND

2 - Disease is stage IV or relapsed

AND

3 - Disease is of non-clear cell histology

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Diagnosis of brain, leptomeningeal, or spine metastases from non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

- Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions
- Tumors are positive for exon 21 (L858R) substitution mutations
- Tumors are positive for a known sensitizing EGFR mutation (e.g., S768I, L861Q, G719X)

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	Vulvar cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Diagnosis of vulvar cancer

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	Pancreatic Cancer, Non-Small Cell Lung Cancer (NSCLC), Chordoma, Kidney Cancer, Central Nervous System (CNS) Cancers, Vulvar Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tarceva therapy

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Tarceva, generic erlotinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARCEVA	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 25 MG (BASE EQUIVALENT)	21360025100320	Generic
TARCEVA	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 100 MG (BASE EQUIVALENT)	21360025100330	Generic
TARCEVA	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Brand
ERLOTINIB HYDROCHLORIDE	ERLOTINIB HCL TAB 150 MG (BASE EQUIVALENT)	21360025100360	Generic

Approval Criteria

1 - Documentation of positive clinical response to Tarceva therapy

Targretin (bexarotene)

Prior Authorization Guideline

Guideline ID	GL-146665
Guideline Name	Targretin (bexarotene)
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Targretin, generic bexarotene	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BEXAROTENE	BEXAROTENE CAP 75 MG	21708220000120	Generic
TARGRETIN	BEXAROTENE CAP 75 MG	21708220000120	Brand
TARGRETIN	BEXAROTENE GEL 1%	90376220004020	Brand
BEXAROTENE	BEXAROTENE GEL 1%	90376220004020	Generic

Approval Criteria

1 - Diagnosis of cutaneous T-cell lymphoma (CTCL)

AND

2 - ONE of the following:

2.1 Failure to at least one prior therapy (including skin-directed therapies [e.g., corticosteroids (clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate), phototherapy, or systemic therapies [e.g., interferons]) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to at least one prior therapy (including skin-directed therapies [e.g., corticosteroids (clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate), phototherapy, or systemic therapies [e.g., interferons]) (please specify contraindication or intolerance)

Product Name: Brand Targretin, generic bexarotene	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BEXAROTENE	BEXAROTENE CAP 75 MG	21708220000120	Generic
TARGRETIN	BEXAROTENE CAP 75 MG	21708220000120	Brand
TARGRETIN	BEXAROTENE GEL 1%	90376220004020	Brand
BEXAROTENE	BEXAROTENE GEL 1%	90376220004020	Generic

Approval Criteria

1 - Patient has not had disease progression while on therapy

Product Name: Brand Targretin, generic bexarotene	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BEXAROTENE	BEXAROTENE CAP 75 MG	21708220000120	Generic
TARGRETIN	BEXAROTENE CAP 75 MG	21708220000120	Brand
TARGRETIN	BEXAROTENE GEL 1%	90376220004020	Brand
BEXAROTENE	BEXAROTENE GEL 1%	90376220004020	Generic

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Targretin, generic bexarotene	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
BEXAROTENE	BEXAROTENE CAP 75 MG	21708220000120	Generic
TARGRETIN	BEXAROTENE CAP 75 MG	21708220000120	Brand
TARGRETIN	BEXAROTENE GEL 1%	90376220004020	Brand
BEXAROTENE	BEXAROTENE GEL 1%	90376220004020	Generic

Approval Criteria

1 - Documentation of positive clinical response to therapy

Tarpeyo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146666
Guideline Name	Tarpeyo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tarpeyo	
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TARPEYO	BUDESONIDE DELAYED RELEASE CAP 4 MG	22100012006520	Brand

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

AND

2 - Patient is at risk for disease progression

AND

3 - Used to reduce the loss of kidney function

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m^2 (milliliters/minute/1.73 square meters)

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, as confirmed by claims history or submitted medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

6.1 Failure of ONE 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records

OR

6.2 History of intolerance or contraindication to ONE glucocorticoid (please specify intolerance or contraindication)

AND

7 - Prescribed by or in consultation with a nephrologist

Tasigna

Prior Authorization Guideline

Guideline ID	GL-146667
Guideline Name	Tasigna
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tasigna	
Diagnosis	Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Diagnosis of chronic myeloid leukemia

AND

2 - ONE of the following:

2.1 Patient is not a candidate for imatinib (Gleevec) as attested by physician

OR

2.2 Patient is currently on Tasigna therapy

Product Name: Tasigna	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Diagnosis of progressive gastrointestinal stromal tumor (GIST)

AND

2 - ONE of the following:

2.1 Failure to ALL of the following, as confirmed by claims history or submission of medical records:

- Imatinib (generic Gleevec)
- Sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- Imatinib (generic Gleevec)
- Sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

Product Name: Tasigna	
Diagnosis	Acute Lymphoblastic Leukemia (Ph+B-ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive B-cell acute lymphoblastic leukemia (Ph+B-ALL)

Product Name: Tasigna	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Diagnosis of myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and ABL1 (gene) rearrangement

AND

2 - Neoplasm is in blast or chronic phase

Product Name: Tasigna	
Diagnosis	Melanoma: Cutaneous
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Diagnosis of metastatic or unresectable melanoma cutaneous tumors with activating mutations of KIT

AND

2 - Used as second-line or subsequent therapy for disease progression, intolerance, and or projected risk of progression with BRAF-targeted therapy

Product Name: Tasigna	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Diagnosis of pigmented villonodular synovitis/tenosynovial giant cell tumor

Product Name: Tasigna	
Diagnosis	Chronic Myeloid Leukemia, Gastrointestinal Stromal Tumor (GIST), Acute Lymphoblastic Leukemia (Ph+B-ALL), Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes, Melanoma: Cutaneous, Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tasigna therapy

Product Name: Tasigna	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Tasigna will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Tasigna	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TASIGNA	NILOTINIB HCL CAP 50 MG (BASE EQUIVALENT)	21531860200110	Brand
TASIGNA	NILOTINIB HCL CAP 150 MG (BASE EQUIVALENT)	21531860200115	Brand
TASIGNA	NILOTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21531860200125	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tasigna therapy

Tasmar

Prior Authorization Guideline

Guideline ID	GL-146422
Guideline Name	Tasmar
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic tolcapone, Brand Tasmar	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOLCAPONE	TOLCAPONE TAB 100 MG	73152070000320	Generic
TASMAR	TOLCAPONE TAB 100 MG	73152070000320	Brand

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

3 - ONE of the following:

3.1 Failure to TWO of the following anti-Parkinson's disease adjunctive pharmacotherapy classes (trial must be from TWO different classes) as confirmed by claims history or submission of medical records:

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

OR

3.2 History of intolerance or contraindication to ALL of the following anti-Parkinson's disease adjunctive pharmacotherapy classes (please specify intolerance or contraindication):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

AND

4 - Patient has received baseline liver function tests to rule out the presence of underlying liver disease

AND

5 - Prescribed by or in consultation with a neurologist or specialist in the treatment of Parkinson's disease

AND

6 - Prescriber attests they have had complete discussion with the patient about the risks and benefits of Tasmar (tolcapone) use, including the risk of liver failure

Product Name: generic tolcapone, Brand Tasmar	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOLCAPONE	TOLCAPONE TAB 100 MG	73152070000320	Generic
TASMAR	TOLCAPONE TAB 100 MG	73152070000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tasmar (tolcapone) therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

AND

3 - Patient has received periodic evaluation of liver function tests to rule out liver failure associated with Tasmar (tolcapone) use

Tavalisse

Prior Authorization Guideline

Guideline ID	GL-146668
Guideline Name	Tavalisse
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tavalisse	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAVALISSE	FOSTAMATINIB DISODIUM TAB 100 MG (BASE EQUIVALENT)	85756040100310	Brand
TAVALISSE	FOSTAMATINIB DISODIUM TAB 150 MG (BASE EQUIVALENT)	85756040100320	Brand

Approval Criteria

1 - Diagnosis of chronic immune thrombocytopenia (ITP)

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to at least ONE of the following classes confirmed by claims history or submitted medical records:

- Corticosteroids
- Immunoglobulins

OR

2.1.1.2 History of contraindication or intolerance to BOTH of the following classes (please specify intolerance or contraindication):

- Corticosteroids
- Immunoglobulins

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to Promacta (eltrombopag) confirmed by claims history or submitted medical records

OR

2.1.2.2 History of contraindication or intolerance to Promacta (eltrombopag) (please specify intolerance or contraindication)

OR

2.2 Patient is currently on Tavalisse therapy

Product Name: Tavalisse	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAVALISSE	FOSTAMATINIB DISODIUM TAB 100 MG (BASE EQUIVALENT)	85756040100310	Brand
TAVALISSE	FOSTAMATINIB DISODIUM TAB 150 MG (BASE EQUIVALENT)	85756040100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tavalisse therapy

Tavneos

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146669
Guideline Name	Tavneos
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tavneos	
Diagnosis	ANCA (Anti-Neutrophil Cytoplasmic Autoantibody)-Associated Vasculitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAVNEOS	AVACOPAN CAP 10 MG	85805510000120	Brand

Approval Criteria

1 - Diagnosis of severe active ANCA (anti-neutrophil cytoplasmic autoantibody)-associated vasculitis

AND

2 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the disease is ONE of the following types:

2.1 Granulomatosis with polyangiitis (GPA)

OR

2.2 Microscopic polyangiitis (MPA)

AND

3 - Patient is being treated with an initial immunosuppressive regimen to induce remission (i.e., rituximab, cyclophosphamide)

AND

4 - Tavneos is being prescribed as adjunctive treatment in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide)

AND

5 - Prescribed by ONE of the following:

- Rheumatologist
- Nephrologist
- Pulmonologist
- Vascular Medicine Specialist

Product Name: Tavneos

Diagnosis	ANCA (Anti-Neutrophil Cytoplasmic Autoantibody)-Associated Vasculitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAVNEOS	AVACOPAN CAP 10 MG	85805510000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tavneos therapy

AND

2 - Tavneos is being prescribed as adjunctive treatment in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide)

AND

3 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Nephrologist
- Pulmonologist
- Vascular Medicine Specialist

Tazverik

Prior Authorization Guideline

Guideline ID	GL-147187
Guideline Name	Tazverik
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tazverik	
Diagnosis	Epithelioid Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAZVERIK	TAZEMETOSTAT HBR TAB 200 MG	21533675200320	Brand

Approval Criteria

1 - Diagnosis of epithelioid sarcoma

AND

2 - Disease is ONE of the following:

- Metastatic
- Locally advanced

AND

3 - Disease is not eligible for complete resection

Product Name: Tazverik	
Diagnosis	Follicular Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAZVERIK	TAZEMETOSTAT HBR TAB 200 MG	21533675200320	Brand

Approval Criteria

1 - Diagnosis of relapsed or refractory follicular lymphoma

AND

2 - ONE of the following:

2.1 Subsequent therapy in EZH2 (gene) mutation positive disease after 2 prior therapies

OR

2.2 Second-line therapy irrespective of EZH2 mutation status for older or infirm patients with indications for treatment (i.e., other therapy options are not expected to be tolerable)

OR

2.3 Third-line and/or subsequent therapy (if not previously given) irrespective of EZH2 mutation status in patients with indications for treatment

Product Name: Tazverik	
Diagnosis	Epithelioid Sarcoma, Follicular Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAZVERIK	TAZEMETOSTAT HBR TAB 200 MG	21533675200320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tazverik therapy

Product Name: Tazverik	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAZVERIK	TAZEMETOSTAT HBR TAB 200 MG	21533675200320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Tazverik	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TAZVERIK	TAZEMETOSTAT HBR TAB 200 MG	21533675200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tazverik therapy

2 . Revision History

Date	Notes
5/8/2024	New guideline

Tegsedi

Prior Authorization Guideline

Guideline ID	GL-146671
Guideline Name	Tegsedi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tegsedi	
Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEGSEDI	INOTERSEN SOD SUBCUTANEOUS PREF SYR 284 MG/1.5ML (BASE EQ)	6270104010E520	Brand

Approval Criteria

1 - BOTH of the following:

- Diagnosis of Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
- Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Documentation of ONE of the following:

- Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb
- Patient has a baseline familial amyloidotic polyneuropathy (FAP) Stage 1 or 2
- Patient has a baseline neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130

AND

4 - Patient has not had a liver transplant

AND

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

AND

6 - Patient is not receiving Tegsedi in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Product Name: Tegsedi	
Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEGSEDI	INOTERSEN SOD SUBCUTANEOUS PREF SYR 284 MG/1.5ML (BASE EQ)	6270104010E520	Brand

Approval Criteria

1 - Documentation that the patient has experienced a positive clinical response to Tegsedi therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.)

AND

2 - Patient is not receiving Tegsedi in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Temodar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146672
Guideline Name	Temodar
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Central Nervous Systems (CNS) Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic

TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Diagnosis of ONE of the following types of central nervous system tumors:

- Intracranial and Spinal Ependymoma (excluding Subependymoma)
- World Health Organization (WHO) Grade 2, 3, or 4 isocitrate dehydrogenase (IDH)-mutation Astrocytoma
- WHO Grade 2 or 3 IDH-mutant, 1p19q Codeleted Oligodendroglioma
- Medulloblastoma
- Circumscribed Gliomas
- Glioblastoma
- Limited or extensive brain metastases
- Primary CNS (central nervous system) lymphoma

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Diagnosis of ONE of the following types of melanoma:

- Metastatic or unresectable cutaneous melanoma
- Metastatic or unresectable uveal melanoma
- Mucosal melanoma

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Diagnosis of ONE of the following types of neuroendocrine tumors:

- Bronchopulmonary/thymic disease
- Poorly controlled carcinoid syndrome in gastrointestinal tract, lung or thymus
- Pancreas
- Pheochromocytoma/paraganglioma
- Poorly differentiated (High Grade)/ large or small cell
- Well differentiated grade 3 neuroendocrine tumors

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Diagnosis of ONE of the following types of primary cutaneous lymphomas:

- Mycosis fungoides (MF)
- Sézary syndrome (SS)

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - ONE of the following:

- Diagnosis of recurrent unresectable or stage IV retroperitoneal/intra-abdominal soft tissue sarcoma
- Diagnosis of rhabdomyosarcoma
- Undifferentiated pleomorphic sarcoma
- Diagnosis of solitary fibrous tumor/hemangiopericytoma

OR

2 - BOTH of the following:

2.1 Diagnosis of soft tissue sarcoma of the extremity/body wall, head/neck

AND

2.2 ONE of the following:

- Disease is stage IV
- Disease has disseminated metastases

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand

TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Ewing's sarcoma family of tumors
- Mesenchymal chondrosarcoma

AND

2 - ONE of the following:

- Disease has relapsed
- Disease is progressive following primary treatment
- Used as second-line therapy for metastatic disease

AND

3 - Used in combination with Campostar (irinotecan)

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic

TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Diagnosis of recurrent or metastatic uterine sarcoma

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Small Cell Lung Cancer (SCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Diagnosis of small cell lung cancer (SCLC)

AND

2 - ONE of the following:

2.1 Relapse following complete or partial response or stable disease with primary treatment

OR

2.2 Primary progressive disease

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	Central Nervous Systems (CNS) Tumor, Melanoma, Neuroendocrine and Adrenal Tumors, Primary Cutaneous Lymphomas, Soft Tissue Sarcoma, Bone Cancer, Uterine Sarcoma, Small Cell Lung Cancer (SCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Temodar therapy

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Temodar will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Temodar, generic temozolomide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 100 MG	21104070000140	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 140 MG	21104070000143	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 180 MG	21104070000147	Generic
TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	Brand
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 250 MG	21104070000150	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 5 MG	21104070000110	Generic
TEMOZOLOMIDE	TEMOZOLOMIDE CAP 20 MG	21104070000120	Generic

Approval Criteria

1 - Documentation of positive clinical response to Temodar therapy

Tepmetko

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146673
Guideline Name	Tepmetko
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tepmetko	
Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEPMETKO	TEPOTINIB HCL TAB 225 MG	21533773100320	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer

AND

2 - Disease is recurrent, advanced, or metastatic

AND

3 - Tumor is MET exon 14 skipping mutation positive

Product Name: Tepmetko	
Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEPMETKO	TEPOTINIB HCL TAB 225 MG	21533773100320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tepmetko therapy

Product Name: Tepmetko	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEPMETKO	TEPOTINIB HCL TAB 225 MG	21533773100320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Tepmetko	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEPMETKO	TEPOTINIB HCL TAB 225 MG	21533773100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tepmetko therapy

Test Strips

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146425
Guideline Name	Test Strips
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Non-preferred Test Strips			
Approval Length	12 month(s)		
Guideline Type	Prior Authorization		
Product Name	**Generic Name**	**GPI**	**Brand/Generic**
ACCU-CHEK AVIVA PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK GUIDE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK SMARTVIEW STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCUTREND GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

ADVANCE INTUITION TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVANCE MICRO-DRAW TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE+ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX AMP NO CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX JAZZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX KEYNOTE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX PRESTO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II CHECK STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PLATINUM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRISM MULTI TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 4 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BIOSCANNER GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/VALUE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARESENS N BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARETOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE VOICE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE AUTO-CODE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE TALK NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR NEXT BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
COOL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS ADVANCED GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
D-CARE BLOOD GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

DIATHRIVE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATRUE PLUS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DUO-CARE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY PLUS II BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY STEP TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TRAK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYGLUCO	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX 15 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT COMPACT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE EVO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

EMBRACE PRO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EQ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EVOLUTION AUTOCODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FIFTY50 GLUCOSE TEST STRIP 2.0	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D15G BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D40/G31 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD20 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD50 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GTEL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G30/PREMIUM V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G/TN'G VOICE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

FORA V12 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V30A BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE GD40	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE PREMIUM V10 TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE TEST N GO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORTISCARE BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE LITE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE PRECISION NEO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GENULTIMATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GE100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GHT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCO PERFECT 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD EXPRESSION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD SHINE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOCARD VITAL TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD X-SENSOR	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCOM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCONAVII BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOSE METER TEST STRIPS ADVANCED	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOODSENSE PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
HW EMBRACE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
HW EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IGLUCOSE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IN TOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY VOICE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

LIBERTY NEXT GENERATION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
LIBERTY TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER ESSENTIAL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETRACK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MM EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MYGLUCOHEALTH BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NEUTEK 2TEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NOVA MAX GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONE DROP BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
OPTIUMEZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE AUTOCODE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE NO CODING BLOOD	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOSE TEST STRIPS			
POCKETCHEM EZ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRECISION XTRA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRO VOICE V8/V9 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRODIGY NO CODING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PTS PANELS GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUICKTEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET AC BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REFUAH PLUS BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION CONFIRM/MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PREMIER BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PRIME BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION ULTIMA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REXALL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

RIGHTEST GS300 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS550 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE PREMIUM BLOODGLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE VALUE BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMARTEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SOLUS V2 AUDIBLE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SUPREME TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE FOCUS SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX SELF MONITORING BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
UNISTRIP1 GENERIC	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLULINK GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATHRIVE+ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TRAK II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G ADVANCE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA 6 CONNECT	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOJJI BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOJJI BLOOD GLUCOSE TEST STRIPS/GOJJI STERILE LANCETS 30G	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT XTRA TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION TRUE METRIX BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX PRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VERASENS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VIVAGUARD INO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK PLUS II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

FORTISCARE G1 BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUE METRIX SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK SMART SYSTEM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS333 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS333	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ON CALL EXPRESS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH VERIO IN VITRO MEDI-CAL	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PIP BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure of both of the following confirmed by claims history or submitted medical records:

- OneTouch Ultra Test Strips
- OneTouch Verio Test Strips

OR

1.2 History of intolerance or contraindication to both of the following (please specify intolerance or contraindication):

- OneTouch Ultra Test Strips

- OneTouch Verio Test Strips

OR

2 - Patient is on an insulin pump

Product Name: All Test Strips	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
ACCU-CHEK AVIVA PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK GUIDE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCU-CHEK SMARTVIEW STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ACCUTREND GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVANCE INTUITION TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVANCE MICRO-DRAW TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE REDI-CODE+ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ADVOCATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX AMP NO CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX JAZZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX KEYNOTE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
AGAMATRIX PRESTO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

ASSURE II	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II CHECK STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE II TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PLATINUM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRISM MULTI TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ASSURE 4 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BIOSCANNER GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CAREONE BLOOD GLUCOSE TEST STRIPS/VALUE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARESENS N BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CARETOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK AUTO-CODE VOICE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

CLEVER CHOICE AUTO-CODE PRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CLEVER CHOICE TALK NO CODING TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CONTOUR NEXT BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
COOL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS ADVANCED GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
D-CARE BLOOD GLUCOSE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATHRIVE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATRUE PLUS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DUO-CARE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY PLUS II BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY STEP TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TOUCH HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

EASY TRAK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYGLUCO	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYMAX 15 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASYPRO PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT COMPACT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ELEMENT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE EVO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE PRO BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EQ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EVOLUTION AUTOCODE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FIFTY50 GLUCOSE TEST STRIP 2.0	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D15G BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA D20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

FORA D40/G31 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD20 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GD50 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA GTEL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA G30/PREMIUM V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G/TN'G VOICE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V10 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V12 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V20 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA V30A BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE GD40	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE PREMIUM V10 TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORACARE TEST N GO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORTISCARE BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE INSULINX BLOOD	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOSE TEST STRIPS			
FREESTYLE LITE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE PRECISION NEO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FREESTYLE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GENULTIMATE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GE100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GHT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCO PERFECT 3 TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD EXPRESSION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD SHINE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD VITAL TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD X-SENSOR	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCARD 01 SENSOR PLUS TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOCOM TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCONAVII BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GLUCOSE METER TEST STRIPS ADVANCED	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOODSENSE PREMIUM BLOOD	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GLUCOSE TEST STRIPS			
HW EMBRACE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
HW EMBRACE TALK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IGLUCOSE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
IN TOUCH BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
INFINITY VOICE	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
LIBERTY NEXT GENERATION BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
LIBERTY TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER BLOOD GLUCOSE TESTSTRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER ESSENTIAL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MEIJER TRUETRACK	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLOOD GLUCOSE TEST STRIPS			
MICRODOT TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MM EASY TOUCH GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MYGLUCOHEALTH BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NEUTEK 2TEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
NOVA MAX GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONE DROP BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH VERIO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
OPTIUMEZ TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE AUTOCODE BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PHARMACIST CHOICE NO CODING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
POCKETCHEM EZ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRECISION XTRA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PREMIUM BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRO VOICE V8/V9 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PRODIGY NO CODING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

PTS PANELS GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUICKTEK TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET AC BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
QUINTET BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REFUAH PLUS BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION CONFIRM/MICRO TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PREMIER BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION PRIME BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION ULTIMA BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
REXALL BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS100 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS300 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS550 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE PREMIUM BLOODGLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMART SENSE VALUE BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SMARTEST BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
SOLUS V2 AUDIBLE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

SUPREME TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TGT BLOOD GLUCOSE TEST STRIPS PREMIUM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE FOCUS SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX BLOOD GLUCOSETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX SELF MONITORING BLOOD GLUCOSE STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK BLOOD GLUCOSE TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUETRACK TEST	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
UNISTRIP1 GENERIC	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
BLULINK GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
CVS GLUCOSE METER TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
DIATHRIVE+ BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TRAK II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA TN'G ADVANCE PRO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORA 6 CONNECT	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

GOJJI BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GOJJI BLOOD GLUCOSE TEST STRIPS/GOJJI STERILE LANCETS 30G	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
KROGER HEALTHPRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
MICRODOT XTRA TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH ULTRA	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RELION TRUE METRIX BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
TRUE METRIX PRO GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VERASENS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
VIVAGUARD INO BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
EASY TALK PLUS II BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
FORTISCARE G1 BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUE METRIX SELF MONITORING BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
GNP TRUETRACK SMART SYSTEM	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
RIGHTEST GS333 BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

BLOOD GLUCOSE TEST STRIPS333	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ON CALL EXPRESS BLOOD GLUCOSE TEST STRIPS	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
ONETOUCH VERIO IN VITRO MEDI-CAL	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand
PIP BLOOD GLUCOSE TEST STRIP	GLUCOSE BLOOD TEST STRIP	94100030006100	Brand

Approval Criteria

1 - If the patient is insulin dependent or pregnant, the physician must confirm the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions)

OR

2 - If the patient is not insulin dependent nor pregnant, ONE the following:

2.1 The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control

OR

2.2 The patient's physician is adjusting medications and the patient requires additional blood glucose testing during this time

OR

2.3 The patient's physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time

OR

2.4 The patient requires additional testing due to fluctuations in blood glucose due to physical activity/exercise **OR** **2.5** Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by UnitedHealthcare reviewing pharmacist and/or medical director)	
Notes	The quantity limit for insulin-dependent and pregnant patients is 6 test strips/day. The quantity limit for non-insulin dependent and non-pregnant patients is 2 test strips/day.

Testosterone

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148271
Guideline Name	Testosterone
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Androderm, generic testosterone gel, Brand Androgel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ANDRODERM	TESTOSTERONE TD PATCH 24HR 2 MG/24HR	23100030008503	Brand
ANDRODERM	TESTOSTERONE TD PATCH 24HR 4 MG/24HR	23100030008510	Brand

TESTOSTERONE	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Generic
ANDROGEL	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML	2310003020D520	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML	2310003020D530	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML	2310003020D540	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 100 MG	23100030800124	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 150 MG	23100030800128	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Brand

TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Generic
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - ONE of the following:

1.1 TWO pre-treatment serum total testosterone levels less than 300 ng/dL (nanograms/deciliter) [less than 10.4 nmol/L (nanomoles/liter)] or less than the reference range for the lab, taken at separate times (This may require treatment to be temporarily held. Document lab value and date for both levels)

OR

1.2 BOTH of the following:

1.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2 ONE pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (picograms/milliliter) (< 5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)

OR

1.3 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

AND

2 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking any aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

AND

4 - Patient was male at birth

AND

5 - Diagnosis of hypogonadism

AND

6 - ONE of the following:

- Significant reduction in weight (less than 90% ideal body weight) [e.g., AIDS (acquired immunodeficiency syndrome) wasting syndrome]

- Osteopenia
- Osteoporosis
- Decreased bone density
- Decreased libido
- Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

AND

7 - ONE of the following:

7.1 If the request is for a non-preferred** topical testosterone (gel, solution) or testosterone transdermal systems (patches), ONE of the following:

7.1.1 Failure to ONE of the following, confirmed by claims history or submitted medical records

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.2 If the request is for Xyosted, BOTH of the following:

7.2.1 ONE of the following:

7.2.1.1 Failure to testosterone cypionate injection (generic Depo-Testosterone), confirmed by claims history or submitted medical records

OR

7.2.1.2 History of intolerance or contraindication to testosterone cypionate injection (generic Depo-Testosterone) (please specify intolerance or contraindication)

AND

7.2.2 ONE of the following:

7.2.2.1 Failure to intramuscular testosterone enanthate injection, confirmed by claims history or submitted medical records

OR

7.2.2.2 History of intolerance or contraindication to intramuscular testosterone enanthate injection (please specify intolerance or contraindication)

OR

7.3 If the request is for Jatenzo, Kyzatrex, or Tlando, ONE of the following:

7.3.1 Failure to ALL of the following:

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle, or testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

7.3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic Androgel 1.62% pump)

Notes	*Patients that have previously received injectable testosterone open a ccess should be reviewed using reauthorization criteria **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Androderm, generic testosterone gel, Brand Androgel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ANDRODERM	TESTOSTERONE TD PATCH 24HR 2 MG/24HR	23100030008503	Brand
ANDRODERM	TESTOSTERONE TD PATCH 24HR 4 MG/24HR	23100030008510	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Generic
ANDROGEL	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic

XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML	2310003020D520	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML	2310003020D530	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML	2310003020D540	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 100 MG	23100030800124	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 150 MG	23100030800128	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Brand
TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Generic
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - Patient is using hormones to change physical characteristics

AND

2 - Patient must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

3 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

4 - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

AND

5 - ONE of the following:

5.1 If the request is for a non-preferred** topical testosterone (gel, solution) or testosterone transdermal systems (patches), ONE of the following:

5.1.1 Failure to ONE of the following, confirmed by claims history or submitted medical records:

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

5.1.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- generic testosterone 1% topical gel
- testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

5.2 If the request is for Xyosted, BOTH of the following:

5.2.1 ONE of the following:

5.2.1.1 Failure to testosterone cypionate injection (generic Depo-Testosterone), confirmed by claims history or submitted medical records

OR

5.2.1.2 History of intolerance or contraindication to testosterone cypionate injection (generic Depo-Testosterone) (please specify intolerance or contraindication)

AND

5.2.2 ONE of the following:

5.2.2.1 Failure to intramuscular testosterone enanthate injection, confirmed by claims history or submitted medical records

OR

5.2.2.2 History of intolerance or contraindication to intramuscular testosterone enanthate injection (please specify intolerance or contraindication)

OR

5.3 If the request is for Jatenzo, Kyzatrex, or Tlando, ONE of the following:

5.3.1 Failure to ALL of the following:

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic Androgel 1.62% pump)

OR

5.3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- testosterone cypionate vials
- testosterone enanthate vials
- testosterone gel - tube, pack, or pump bottle or testosterone 1.62% pump (generic Androgel 1.62% pump)

Notes	*Patients that have previously received injectable testosterone open access should be reviewed using reauthorization criteria **PDL link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Androderm, generic testosterone gel, Brand Androgel, generic testosterone gel pump, Brand Androgel Pump, testosterone soln, Brand Fortesta, generic testosterone TD gel, Natesto, Brand Testim, Brand Vogelxo, Brand Vogelxo Pump, Xyosted, Jatenzo, Kyzatrex, Tlando, Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate

Diagnosis	Hypogonadism, Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ANDRODERM	TESTOSTERONE TD PATCH 24HR 2 MG/24HR	23100030008503	Brand
ANDRODERM	TESTOSTERONE TD PATCH 24HR 4 MG/24HR	23100030008510	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Generic
ANDROGEL	TESTOSTERONE TD GEL 25 MG/2.5GM (1%)	23100030004025	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Generic
ANDROGEL	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Generic
ANDROGEL	TESTOSTERONE TD GEL 40.5 MG/2.5GM (1.62%)	23100030004047	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Generic
ANDROGEL PUMP	TESTOSTERONE TD GEL 20.25 MG/ACT (1.62%)	23100030004050	Brand
TESTOSTERONE	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic

TESTOSTERONE TOPICAL SOLUTION	TESTOSTERONE TD SOLN 30 MG/ACT	23100030002020	Generic
FORTESTA	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 10MG/ACT (2%)	23100030004070	Generic
TESTIM	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
VOGELXO	TESTOSTERONE TD GEL 50 MG/5GM (1%)	23100030004030	Brand
TESTOSTERONE PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Generic
VOGELXO PUMP	TESTOSTERONE TD GEL 12.5 MG/ACT (1%)	23100030004040	Brand
TESTOSTERONE	TESTOSTERONE TD GEL 20.25 MG/1.25GM (1.62%)	23100030004044	Generic
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 50 MG/0.5ML	2310003020D520	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 75 MG/0.5ML	2310003020D530	Brand
XYOSTED	TESTOSTERONE ENANTHATE SOLUTION AUTO-INJECTOR 100 MG/0.5ML	2310003020D540	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 158 MG	23100030800130	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 198 MG	23100030800135	Brand
JATENZO	TESTOSTERONE UNDECANOATE CAP 237 MG	23100030800140	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 100 MG	23100030800124	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 150 MG	23100030800128	Brand
KYZATREX	TESTOSTERONE UNDECANOATE CAP 200 MG	23100030800136	Brand
TLANDO	TESTOSTERONE UNDECANOATE CAP 112.5 MG	23100030800125	Brand
NATESTO	TESTOSTERONE NASAL GEL 5.5 MG/ACT	23100030004080	Brand
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 100 MG/ML	23100030102010	Generic
DEPO-TESTOSTERONE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Brand
TESTOSTERONE CYPIONATE	TESTOSTERONE CYPIONATE IM INJ IN OIL 200 MG/ML	23100030102015	Generic
TESTOSTERONE ENANTHATE	TESTOSTERONE ENANTHATE IM INJ IN OIL 200 MG/ML	23100030202010	Generic

Approval Criteria

1 - ONE of the following:

1.1 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

OR

1.2 BOTH of the following:

1.2.1 Patient has a diagnosis of ONE of the following:

- Hypogonadism
- Gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

1.2.2 ONE of the following:

1.2.2.1 Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document value and date)

OR

1.2.2.2 Follow-up total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

OR

1.2.2.3 BOTH of the following:

1.2.2.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2.3.2 ONE of the following:

- Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document lab value and date)
- Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

AND

2 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

2 . Revision History

Date	Notes
6/7/2024	Updated Natesto GPI. Added injectable testosterone agents that were previously open access to clinical review. Updated Initial auth notes and T/F options. Updated reauth criteria.

Tezspire

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155266
Guideline Name	Tezspire
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Tezspire auto-injector pen	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEZSPIRE	TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML	4460807525D520	Brand

Approval Criteria

1 - Patient has been established on therapy with Tezspire under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma

AND

2 - Documentation of positive clinical response to Tezspire therapy as demonstrated by at least ONE of the following:

2.1 Reduction in the frequency of exacerbations

OR

2.2 Decreased utilization of rescue medications

OR

2.3 Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline

OR

2.4 Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

AND

3 - Tezspire is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

AND

4 - Patient is NOT receiving Tezspire in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

- Anti-IgE-therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]

AND

5 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Tezspire auto-injector pen	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEZSPIRE	TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML	4460807525D520	Brand

Approval Criteria

1 - Diagnosis of severe asthma

AND

2 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

2.1 Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control test [ACT] score consistently less than 20)

OR

2.2 Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months

OR

2.3 Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)

OR

2.4 Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])

OR

2.5 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Tezspire will be used in combination with ONE of the following:

3.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) product [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

3.2 Combination therapy including BOTH of the following:

3.2.1 ONE maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

3.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Tezspire will be used to treat eosinophilic asthma

AND

4.1.2 BOTH of the following:

4.1.2.1 ONE of the following

- Failure to a 4-month trial of an anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Fasenra (benralizumab)] as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to an anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Fasenra (benralizumab)] (please specify contraindication or intolerance)

AND

4.1.2.2 ONE of the following:

- Failure to a 4-month trial of Dupixent (dupilumab) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Dupixent (dupilumab) (please specify contraindication or intolerance)

OR

4.2 BOTH of the following:

4.2.1 Tezspire will be used to treat persistent allergic asthma

AND

4.2.2 ONE of the following:

- Failure to a 4-month trial of Xolair (omalizumab) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Xolair (omalizumab) (please specify contraindication or intolerance)

OR

4.3 BOTH of the following:

4.3.1 Tezspire will be used to treat oral corticosteroid dependent asthma

AND

4.3.2 ONE of the following:

- Failure to a 4-month trial of Dupixent (dupilumab) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Dupixent (dupilumab) (please specify contraindication or intolerance)

OR

4.4 Patient's asthma is not of the eosinophilic, allergic, or oral corticosteroid dependent phenotype

AND

5 - Patient is NOT receiving Tezspire in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

AND

6 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Tezspire auto-injector pen	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TEZSPIRE	TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML	4460807525D520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tezspire therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

AND

2 - Tezspire is being used in combination with an ICS-containing maintenance medication [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

AND

3 - Patient is NOT receiving Tezspire in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]

2 . Revision History

Date	Notes
9/19/2024	Modified wording for existing prior authorization for under the medical benefit.

Thalomid

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150980
Guideline Name	Thalomid
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/5/2024

1 . Criteria

Product Name: Thalomid	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - Diagnosis of multiple myeloma

Product Name: Thalomid	
Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - Diagnosis of moderate to severe erythema nodosum leprosum (ENL)

AND

2 - ONE of the following:

2.1 Used for acute treatment

OR

2.2 Used as maintenance therapy for prevention and suppression of cutaneous manifestations of ENL recurrence

Product Name: Thalomid	
Diagnosis	Castleman Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - Diagnosis of Castleman Disease (CD)

AND

2 - ONE of the following:

2.1 NOT used as first line therapy

OR

2.2 ALL of the following:

2.2.1 Therapy is for active idiopathic multicentric CD with no evidence of organ failure

AND

2.2.2 Used in combination with cyclophosphamide and prednisone

AND

2.2.3 Patient is human immunodeficiency virus (HIV)-negative

AND

2.2.4 Patient is human herpesvirus-8 (HHV8)-negative

Product Name: Thalomid	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of HIV (human immunodeficiency virus)-negative Kaposi Sarcoma

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of AIDS-related Kaposi Sarcoma

AND

1.2.2 Patient is currently being treated with antiretroviral therapy (ART) as confirmed by claims history or submission of medical records

AND

2 - NOT used as first line therapy

AND

3 - Patient has immune reconstitution inflammatory syndrome (IRIS)

Product Name: Thalomid	
Diagnosis	Langerhans Cell Histiocytosis, Rosai-Dorfman Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - Diagnosis of Langerhans cell histiocytosis

OR

2 - Diagnosis of Rosai-Dorfman Disease

Product Name: Thalomid	
Diagnosis	Multiple Myeloma, Castleman Disease (CD), Kaposi Sarcoma, Langerhans Cell Histiocytosis, Rosai-Dorfman Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Thalomid therapy

Product Name: Thalomid	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Thalomid	
Diagnosis	Erythema Nodosum Leprosum (ENL), NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	Brand
THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	Brand
THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	Brand
THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

2 . Revision History

Date	Notes
8/5/2024	Removed criteria for myelofibrosis-associated anemia. Renamed dia gnosis header from B-Cell Lymphomas to Castleman Disease (CD). Updated criteria for Kaposi sarcoma per NCCN guidance.

Therapeutic Duplication (Subtype A)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155101
Guideline Name	Therapeutic Duplication (Subtype A)
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Generic arformoterol nebulizer solution, Brand Brovana nebulizer, generic formoterol nebulizer solution, Brand Perforomist nebulizer, Striverdi Respimat, Serevent Diskus, Incruse Ellipta, Brand Spiriva Handihaler, generic tiotropium, Spiriva Respimat, Tudorza Pressair, generic ipratropium inhalation solution, Atrovent HFA, Anoro Ellipta, Stiolto Respimat, Bevespi Aerosphere, Duaklir Pressair, Breztri Aerosphere, Glyxambi, Steglujan, Qtern, Trijardy XR, Brand Pulmicort suspension, generic budesonide suspension, Victoza, Adlyxin, Trulicity, Bydureon BCise, Byetta, Ozempic, Rybelsus, Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Nesina, alogliptin, Kazano, alogliptin/metformin, Oseni, alogliptin/pioglitazone, Mounjaro, Xultophy, Soliqua, Invokana, brand Farxiga, generic dapagliflozin, Jardiance, Invokamet, Invokamet XR, brand Xigduo XR, generic dapagliflozin/metformin ER, Synjardy, Synjardy XR, Steglatro, Segluromet, Zituvio, Brand Flovent HFA, Fluticasone propionate HFA, Flovent Diskus, Brand Fluticasone propionate Diskus, Brand Pulmicort Flexhaler, Airsupra, Alvesco, ArmonAir Digihaler, Asmanex Twisthaler, Asmanex HFA, Arnuity Ellipta, Qvar RediHaler, Lonhala Magnair, Trelegy Ellipta, Brand Advair Diskus, generic fluticasone propionate/salmeterol diskus (generic Advair Diskus), generic Wixela Inhub (generic Advair Diskus), AirDuo Respiclick,

fluticasone/salmeterol (authorized generic of AirDuo), Brand Advair HFA, Brand Fluticasone/salmeterol HFA, Brand Symbicort, generic budesonide/formoterol, Breyna, AirDuo Digihaler, Dulera, Breo Ellipta, Brand fluticasone/vilanterol Ellipta, Basaglar Tempo pen, Basaglar Kwikpen, Insulin Glargine Solostar, Lantus Solostar, Toujeo Solostar, Toujeo Max Solostar, Semglee Pen Injector, Insulin Glargine-YFGN pen, Lantus vial, Insulin Glargine vial, Semglee vial, Insulin Glargine-YFGN vial, Levemir vial, Levemir Flextouch, Levemir Flexpen, Tresiba vial, Insulin Degludec vial, Tresiba Flextouch, Insulin Degludec Flextouch, Rezvoglar, Baclofen tabs, generic baclofen suspension, Brand Fleqsuvy, Brand Ozobax DS, brand Ozobax, Brand Baclofen solution, brand Lioresal intrathecal, generic baclofen intrathecal, brand Gablofen intrathecal, baclofen intrathecal solution, Lyvispah, generic carisoprodol tab, brand Soma, brand Vanadom tab, generic chlorzoxazone, brand Lorzone, generic cyclobenzaprine, brand Fexmid, generic cyclobenzaprine ER, brand Amrix, metaxalone, methocarbamol, orphenadrine CR/ER, generic tizanidine caps/tabs, brand Zanaflex caps/tabs, brand Dantrium, generic dantrolene, brand Norgesic, generic orphenadrine/aspirin/caffeine, norgesic forte, orphengesic forte, Brand Neurontin caps/tabs/soln, generic gabapentin caps/tabs/soln, gabapentin tinytabs, brand Lyrica caps/soln, generic pregabalin caps/soln, brand Gralise, brand Lyrica CR, generic pregabalin ER, Horizant, Zorvolex, brand Zipsor, generic diclofenac caps, brand Lofena, generic diclofenac tabs, diclofenac DR/ER, brand Cambia, generic diclofenac packet (migraine), etodolac cap, brand Lodine, generic etodolac tab, etodolac ER, brand Nalfon caps/tabs, generic fenoprofen caps/tabs, flurbiprofen, ibuprofen caps/tabs/chewable (includes All Manufactures), Brand Advil, ibuprofen suspension (40 mg/ml & 100 mg/5ml), indomethacin caps, indomethacin ER/SR caps, indocin susp, indocin suppository, indomethacin suppository, ketoprofen cap, ketoprofen ER cap, ketorolac tabs, meclofenamate cap, mefenamic acid, meloxicam cap/tab, brand Relafen DS, generic nabumetone, generic naproxen tab/susp/caps (includes All Manufactures), brand naprosyn tab/susp, brand Aleve, brand Anaprox DS, brand EC-Naprosyn, generic naproxen DR, generic EC-naproxen, brand Naprelan, generic naproxen CR/ER, Brand Daypro, generic oxaprozin, brand Feldene, generic piroxicam, sulindac, tolmetin, brand Celebrex, generic celecoxib, Elyxyb, brand Arthrotec, generic diclofenac sodium/misoprostol, brand Duexis, generic ibuprofen/famotidine, brand Vimovo, generic naproxen/esomeprazole, brand Advil PM, generic ibuprofen/diphenhydramine, brand Aleve PM, generic naproxen/diphenhydramine, hydrocodone/ibuprofen, brand Treximet, generic sumatriptan/naproxen, Motrin Dual Action/Tylenol, Advil Dual Action/acetaminophen, acetaminophen/ibuprofen, Naproxen/capsaicin cream (Naprotin), Inpefa, Saxenda, Wegovy, Brand Brenzavvy, Brand Bexagliflozin, Zepbound, Coxanto, Jantoven, warfarin tabs, Pradaxa, generic dabigatran, Eliquis, Savaysa, Xarelto, Brand Lunesta, generic eszopiclone, zaleplon, Zolpidem, Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem CR. Edluar, Zolpimist, Brand Rozerem, generic ramelteon, Brand Silenor, generic doxepin (sleep) 3mg and 6 mg tabs, Belsomra, Dayvigo, Quviviq, Brand Precedex, generic dexmedetomidine, Dexmedetomidine, Igalmi, Brand Hetlioz, generic tasimelteon, Hetlioz LQ, Brand Restoril, generic temazepam, Brand Halcion, generic triazolam, Brand Doral, generic quazepam, flurazepam, estazolam, Sitagliptin/metformin, Brand Tanlor

Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ARFORMOTEROL TARTRATE	ARFORMOTEROL TARTRATE SOLN NEBU 15 MCG/2ML (BASE EQUIV)	44201012102520	Generic
BROVANA	ARFORMOTEROL TARTRATE SOLN NEBU 15 MCG/2ML (BASE EQUIV)	44201012102520	Brand
FORMOTEROL FUMARATE	FORMOTEROL FUMARATE SOLN NEBU 20 MCG/2ML	44201027102520	Generic
PERFOROMIST	FORMOTEROL FUMARATE SOLN NEBU 20 MCG/2ML	44201027102520	Brand
STRIVERDI RESPIMAT	OLODATEROL HCL INHAL AEROSOL SOLN 2.5 MCG/ACT (BASE EQUIV)	44201052203410	Brand
SPIRIVA HANDIHALER	TIOTROPIUM BROMIDE MONOHYDRATE INHAL CAP 18 MCG (BASE EQUIV)	44100080100120	Brand
SPIRIVA RESPIMAT	TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 1.25 MCG/ACT	44100080103410	Brand
SPIRIVA RESPIMAT	TIOTROPIUM BROMIDE MONOHYDRATE INHAL AEROSOL 2.5 MCG/ACT	44100080103420	Brand
TUDORZA PRESSAIR	ACLIDINIUM BROMIDE AEROSOL POWD BREATH ACTIVATED 400 MCG/ACT	44100007108020	Brand
IPRATROPIUM BROMIDE	IPRATROPIUM BROMIDE INHAL SOLN 0.02%	44100030102020	Generic
ATROVENT HFA	IPRATROPIUM BROMIDE HFA INHAL AEROSOL 17 MCG/ACT	44100030123420	Brand
STIOLTO RESPIMAT	TIOTROPIUM BR-OLODATEROL INHAL AERO SOLN 2.5-2.5 MCG/ACT	44209902923420	Brand
BEVESPI AEROSPHERE	GLYCOPYRROLATE-FORMOTEROL FUMARATE AEROSOL 9-4.8 MCG/ACT	44209902543220	Brand
DUAKLIR PRESSAIR	ACLIDINIUM BR-FORMOTEROL FUM AERO POW BR ACT 400-12 MCG/ACT	44209902268030	Brand
GLYXAMBI	EMPAGLIFLOZIN-LINAGLIPTIN TAB 10-5 MG	27996502300320	Brand
GLYXAMBI	EMPAGLIFLOZIN-LINAGLIPTIN TAB 25-5 MG	27996502300330	Brand
STEGLUJAN	ERTUGLIFLOZIN-SITAGLIPTIN TAB 5-100 MG	27996502350320	Brand
STEGLUJAN	ERTUGLIFLOZIN-SITAGLIPTIN TAB 15-100 MG	27996502350330	Brand

QTERN	DAPAGLIFLOZIN-SAXAGLIPTIN TAB 5-5 MG	27996502200320	Brand
QTERN	DAPAGLIFLOZIN-SAXAGLIPTIN TAB 10-5 MG	27996502200330	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 5-2.5-1000MG	27996703407510	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 10-5-1000 MG	27996703407520	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIP-METFORMIN TAB ER 24HR 12.5-2.5-1000MG	27996703407530	Brand
TRIJARDY XR	EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN TAB ER 24HR 25-5-1000 MG	27996703407540	Brand
BREZTRI AEROSPHERE	BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT	44209903303220	Brand
PULMICORT	BUDESONIDE INHALATION SUSP 0.25 MG/2ML	44400015001830	Brand
BUDESONIDE	BUDESONIDE INHALATION SUSP 0.25 MG/2ML	44400015001830	Generic
PULMICORT	BUDESONIDE INHALATION SUSP 0.5 MG/2ML	44400015001840	Brand
BUDESONIDE	BUDESONIDE INHALATION SUSP 0.5 MG/2ML	44400015001840	Generic
PULMICORT	BUDESONIDE INHALATION SUSP 1 MG/2ML	44400015001850	Brand
BUDESONIDE	BUDESONIDE INHALATION SUSP 1 MG/2ML	44400015001850	Generic
ADLYXIN	LIXISENATIDE SOLN PEN-INJECTOR 20 MCG/0.2ML (100 MCG/ML)	2717005600D230	Brand
VICTOZA	LIRAGLUTIDE SOLN PEN-INJECTOR 18 MG/3ML (6 MG/ML)	2717005000D220	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 0.75 MG/0.5ML	2717001500D520	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 1.5 MG/0.5ML	2717001500D530	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 3 MG/0.5ML	2717001500D540	Brand
TRULICITY	DULAGLUTIDE SOLN PEN-INJECTOR 4.5 MG/0.5ML	2717001500D550	Brand

BYDUREON BCISE	EXENATIDE EXTENDED RELEASE SUSP AUTO-INJECTOR 2 MG/0.85ML	2717002000D420	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 5 MCG/0.02ML	2717002000D220	Brand
BYETTA	EXENATIDE SOLN PEN-INJECTOR 10 MCG/0.04ML	2717002000D240	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/1.5ML)	2717007000D210	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 0.25 OR 0.5 MG/DOSE (2 MG/3ML)	2717007000D221	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 1 MG/DOSE (4 MG/3ML)	2717007000D222	Brand
OZEMPIC	SEMAGLUTIDE SOLN PEN-INJ 2 MG/DOSE (8 MG/3ML)	2717007000D225	Brand
RYBELSUS	SEMAGLUTIDE TAB 3 MG	27170070000310	Brand
RYBELSUS	SEMAGLUTIDE TAB 7 MG	27170070000320	Brand
RYBELSUS	SEMAGLUTIDE TAB 14 MG	27170070000330	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 25 MG (BASE EQUIV)	27550070100320	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 50 MG (BASE EQUIV)	27550070100330	Brand
JANUVIA	SITAGLIPTIN PHOSPHATE TAB 100 MG (BASE EQUIV)	27550070100340	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-500 MG	27992502700320	Brand
JANUMET	SITAGLIPTIN-METFORMIN HCL TAB 50-1000 MG	27992502700340	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27992502707520	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27992502707530	Brand
JANUMET XR	SITAGLIPTIN-METFORMIN HCL TAB ER 24HR 100-1000 MG	27992502707540	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Brand
ONGLYZA	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Brand

KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Brand
KOMBIGLYZE XR	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Brand
TRADJENTA	LINAGLIPTIN TAB 5 MG	27550050000320	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-500 MG	27992502400320	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-850 MG	27992502400330	Brand
JENTADUETO	LINAGLIPTIN-METFORMIN HCL TAB 2.5-1000 MG	27992502400340	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502407520	Brand
JENTADUETO XR	LINAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502407530	Brand
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 6.25 MG (BASE EQUIV)	27550010100310	Generic
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 12.5 MG (BASE EQUIV)	27550010100320	Generic
ALOGLIPTIN	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Generic
NESINA	ALOGLIPTIN BENZOATE TAB 25 MG (BASE EQUIV)	27550010100330	Generic
ALOGLIPTIN/METFORMIN HCL	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-500 MG	27992502100320	Generic
ALOGLIPTIN/METFORMIN HYDROCHLORIDE	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Generic
KAZANO	ALOGLIPTIN-METFORMIN HCL TAB 12.5-1000 MG	27992502100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-15 MG	27994002100320	Brand
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Generic

OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-30 MG	27994002100325	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 12.5-45 MG	27994002100330	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-15 MG	27994002100340	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-30 MG	27994002100345	Generic
ALOGLIPTIN/PIOGLITAZONE	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Generic
OSENI	ALOGLIPTIN-PIOGLITAZONE TAB 25-45 MG	27994002100350	Generic
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 2.5 MG/0.5ML	2717308000D510	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 5 MG/0.5ML	2717308000D515	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 7.5 MG/0.5ML	2717308000D520	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 10 MG/0.5ML	2717308000D525	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 12.5 MG/0.5ML	2717308000D530	Brand
MOUNJARO	TIRZEPATIDE SOLN PEN-INJECTOR 15 MG/0.5ML	2717308000D535	Brand
XULTOPHY 100/3.6	INSULIN DEGLUDEC-LIRAGLUTIDE SOL PEN-INJ 100-3.6 UNIT-MG/ML	2799100225D220	Brand
SOLIQUA 100/33	INSULIN GLARGINE-LIXISENATIDE SOL PEN-INJ 100-33 UNIT-MCG/ML	2799100235D220	Brand
INVOKANA	CANAGLIFLOZIN TAB 100 MG	27700020000320	Brand

INVOKANA	CANAGLIFLOZIN TAB 300 MG	27700020000330	Brand
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Brand
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 10 MG	27700050000310	Brand
JARDIANCE	EMPAGLIFLOZIN TAB 25 MG	27700050000320	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-500 MG	27996002200320	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 50-1000 MG	27996002200330	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-500 MG	27996002200340	Brand
INVOKAMET	CANAGLIFLOZIN-METFORMIN HCL TAB 150-1000 MG	27996002200350	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-500 MG	27996002207520	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 50-1000 MG	27996002207530	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-500 MG	27996002207540	Brand
INVOKAMET XR	CANAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 150-1000 MG	27996002207550	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-500 MG	27996002400310	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 5-1000 MG	27996002400315	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-500 MG	27996002400320	Brand
SYNJARDY	EMPAGLIFLOZIN-METFORMIN HCL TAB 12.5-1000 MG	27996002400325	Brand

SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002407530	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002407540	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 12.5-1000 MG	27996002407550	Brand
SYNJARDY XR	EMPAGLIFLOZIN-METFORMIN HCL TAB ER 24HR 25-1000 MG	27996002407560	Brand
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 5 MG (BASE EQUIV)	27700055200320	Brand
STEGLATRO	ERTUGLIFLOZIN L-PYROGLUTAMIC ACID TAB 15 MG (BASE EQUIV)	27700055200340	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-500 MG	27996002450310	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 2.5-1000 MG	27996002450320	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-500 MG	27996002450330	Brand
SEGLUROMET	ERTUGLIFLOZIN-METFORMIN HCL TAB 7.5-1000 MG	27996002450340	Brand
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE)	44400033223220	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE)	44400033223230	Generic
FLOVENT HFA	FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE)	44400033223240	Generic
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 50 MCG/ACT	44400033208010	Brand
FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 100 MCG/ACT	44400033208020	Brand

FLOVENT DISKUS	FLUTICASONE PROPIONATE AER POW BA 250 MCG/ACT	44400033208030	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 80 MCG/ACT	44400017003420	Brand
ALVESCO	CICLESONIDE INHAL AEROSOL 160 MCG/ACT	44400017003440	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 55 MCG/ACT WITH SENSOR	44400033218020	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 113 MCG/ACT WITH SENSOR	44400033218030	Brand
ARMONAIR DIGIHALER	FLUTICASONE PROPIONATE AER POW BA 232 MCG/ACT WITH SENSOR	44400033218040	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 50 MCG/ACT	44400036203210	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 100 MCG/ACT	44400036203220	Brand
ASMANEX HFA	MOMETASONE FUROATE INHAL AEROSOL SUSPENSION 200 MCG/ACT	44400036203230	Brand
ASMANEX TWISTHALER 30 METERED DOSES	MOMETASONE FUROATE INHAL POWD 110 MCG/ACT (BREATH ACTIVATED)	44400036208010	Brand
ASMANEX TWISTHALER 120 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 14 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 30 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ASMANEX TWISTHALER 60 METERED DOSES	MOMETASONE FUROATE INHAL POWD 220 MCG/ACT (BREATH ACTIVATED)	44400036208020	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50 MCG/ACT	44400033108010	Brand

ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100 MCG/ACT	44400033108020	Brand
ARNUITY ELLIPTA	FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200 MCG/ACT	44400033108030	Brand
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 40 MCG/ACT	44400010128120	Brand
QVAR REDIHALER	BECLOMETHASONE DIPROP HFA BREATH ACT INH AER 80 MCG/ACT	44400010128140	Brand
LONHALA MAGNAIR REFILL KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
LONHALA MAGNAIR STARTER KIT	GLYCOPYRROLATE INHAL SOLUTION 25 MCG/ML	44100020102030	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT	44209903408020	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT	44209903408040	Brand
AIRDUO RESPICLICK 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT	44209902708010	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT	44209902708010	Generic
AIRDUO RESPICLICK 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT	44209902708015	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT	44209902708015	Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Brand
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Generic

FLUTICASONE PROPIONATE/SALMETEROL DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Generic
WIXELA INHUB	FLUTICASONE-SALMETEROL AER POWDER BA 100-50 MCG/ACT	44209902708020	Generic
AIRDUO RESPICLICK 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT	44209902708025	Generic
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT	44209902708025	Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Brand
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Generic
FLUTICASONE PROPIONATE/SALMETEROL DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Generic
WIXELA INHUB	FLUTICASONE-SALMETEROL AER POWDER BA 250-50 MCG/ACT	44209902708030	Generic
ADVAIR DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Brand
FLUTICASONE PROPIONATE/SALMETEROL	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Generic
FLUTICASONE PROPIONATE/SALMETEROL DISKUS	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Generic
WIXELA INHUB	FLUTICASONE-SALMETEROL AER POWDER BA 500-50 MCG/ACT	44209902708040	Generic
BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic

BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic
AIRDUO DIGIHALER 55/14	FLUTICASONE-SALMETEROL AER POWDER BA 55-14 MCG/ACT W/ SENSOR	44209902718020	Brand
AIRDUO DIGIHALER 113/14	FLUTICASONE-SALMETEROL AER POWDER BA 113-14 MCG/ACT W/SENSOR	44209902718030	Brand
AIRDUO DIGIHALER 232/14	FLUTICASONE-SALMETEROL AER POWDER BA 232-14 MCG/ACT W/SENSOR	44209902718040	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 50-5 MCG/ACT	44209902903210	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 100-5 MCG/ACT	44209902903220	Brand
DULERA	MOMETASONE FUROATE-FORMOTEROL FUMARATE AEROSOL 200-5 MCG/ACT	44209902903240	Brand
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 100-25 MCG/ACT	44209902758020	Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic
FLUTICASONE FUROATE/VILANTEROL ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 200-25 MCG/ACT	44209902758030	Generic
BASAGLAR TEMPO PEN	INSULIN GLARGINE PEN-INJ WITH TRANSMITTER PORT 100 UNIT/ML	2710400300D222	Brand
BASAGLAR KWIKPEN	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
INSULIN GLARGINE SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand
LANTUS SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 100 UNIT/ML	2710400300D220	Brand

TOUJEO SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (1 UNIT DIAL)	2710400300D233	Brand
TOUJEO MAX SOLOSTAR	INSULIN GLARGINE SOLN PEN-INJECTOR 300 UNIT/ML (2 UNIT DIAL)	2710400300D236	Brand
INSULIN GLARGINE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
SEMGLEE	INSULIN GLARGINE-YFGN SOLN PEN-INJECTOR 100 UNIT/ML	2710400390D220	Brand
INSULIN GLARGINE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
LANTUS	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE INJ 100 UNIT/ML	27104003002020	Brand
SEMGLEE	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
LEVEMIR	INSULIN DETEMIR INJ 100 UNIT/ML	27104006002020	Brand
LEVEMIR FLEXPEN	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand
LEVEMIR FLEXTOUCH	INSULIN DETEMIR SOLN PEN-INJECTOR 100 UNIT/ML	2710400600D220	Brand
INSULIN DEGLUDEC	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
TRESIBA	INSULIN DEGLUDEC INJ 100 UNIT/ML	27104007002020	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 100 UNIT/ML	2710400700D210	Brand
INSULIN DEGLUDEC FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
TRESIBA FLEXTOUCH	INSULIN DEGLUDEC SOLN PEN-INJECTOR 200 UNIT/ML	2710400700D220	Brand
REZVOGLAR KWIKPEN	INSULIN GLARGINE-AGLR SOLN PEN-INJECTOR 100 UNIT/ML	2710400305D220	Brand
BACLOFEN	BACLOFEN TAB 5 MG	75100010000303	Generic

BACLOFEN	BACLOFEN TAB 10 MG	75100010000305	Generic
BACLOFEN	BACLOFEN TAB 20 MG	75100010000310	Generic
BACLOFEN	BACLOFEN SUSP 25 MG/5ML	75100010001825	Generic
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 0.05 MG/ML (50 MCG/ML)	75100010002020	Brand
BACLOFEN	BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML)	75100010002034	Generic
GABLOFEN	BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML)	75100010002034	Brand
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML)	75100010002034	Brand
BACLOFEN	BACLOFEN INTRATHECAL INJ 20 MG/20ML (1000 MCG/ML)	75100010002039	Generic
GABLOFEN	BACLOFEN INTRATHECAL INJ 20 MG/20ML (1000 MCG/ML)	75100010002039	Brand
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 10 MG/5ML (2000 MCG/ML)	75100010002046	Brand
BACLOFEN	BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML)	75100010002050	Generic
GABLOFEN	BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML)	75100010002050	Brand
LIORESAL INTRATHECAL	BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML)	75100010002050	Brand
BACLOFEN	BACLOFEN ORAL SOLN 5 MG/5ML	75100010002070	Generic
OZOBAX	BACLOFEN ORAL SOLN 5 MG/5ML	75100010002070	Generic
LYVISPAH	BACLOFEN GRANULES PACKET 5 MG	75100010003010	Brand
LYVISPAH	BACLOFEN GRANULES PACKET 10 MG	75100010003020	Brand
LYVISPAH	BACLOFEN GRANULES PACKET 20 MG	75100010003030	Brand
CARISOPRODOL	CARISOPRODOL TAB 250 MG	75100020000304	Generic

SOMA	CARISOPRODOL TAB 250 MG	75100020000304	Brand
CARISOPRODOL	CARISOPRODOL TAB 350 MG	75100020000305	Generic
SOMA	CARISOPRODOL TAB 350 MG	75100020000305	Brand
VANADOM	CARISOPRODOL TAB 350 MG	75100020000305	Brand
CHLORZOXAZONE	CHLORZOXAZONE TAB 250 MG	75100040000305	Generic
CHLORZOXAZONE	CHLORZOXAZONE TAB 375 MG	75100040000307	Generic
LORZONE	CHLORZOXAZONE TAB 375 MG	75100040000307	Brand
CHLORZOXAZONE	CHLORZOXAZONE TAB 500 MG	75100040000310	Generic
CHLORZOXAZONE	CHLORZOXAZONE TAB 750 MG	75100040000320	Generic
LORZONE	CHLORZOXAZONE TAB 750 MG	75100040000320	Brand
CYCLOBENZAPRINE HYDROCHLORIDE	CYCLOBENZAPRINE HCL TAB 5 MG	75100050100303	Generic
CYCLOBENZAPRINE HYDROCHLORIDE	CYCLOBENZAPRINE HCL TAB 7.5 MG	75100050100304	Generic
FEXMID	CYCLOBENZAPRINE HCL TAB 7.5 MG	75100050100304	Brand
CYCLOBENZAPRINE HYDROCHLORIDE	CYCLOBENZAPRINE HCL TAB 10 MG	75100050100305	Generic
AMRIX	CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG	75100050107015	Brand
CYCLOBENZAPRINE HYDROCHLORIDE ER	CYCLOBENZAPRINE HCL CAP ER 24HR 15 MG	75100050107015	Generic
AMRIX	CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG	75100050107030	Brand
CYCLOBENZAPRINE HYDROCHLORIDE ER	CYCLOBENZAPRINE HCL CAP ER 24HR 30 MG	75100050107030	Generic
METAXALONE	METAXALONE TAB 400 MG	75100060000310	Generic
METAXALONE	METAXALONE TAB 800 MG	75100060000320	Generic
METHOCARBAMOL	METHOCARBAMOL TAB 500 MG	75100070000305	Generic
METHOCARBAMOL	METHOCARBAMOL TAB 750 MG	75100070000310	Generic
METHOCARBAMOL	METHOCARBAMOL TAB 1000 MG	75100070000320	Generic

ORPHENADRINE CITRATE CR	ORPHENADRINE CITRATE TAB ER 12HR 100 MG	75100080107410	Generic
ORPHENADRINE CITRATE ER	ORPHENADRINE CITRATE TAB ER 12HR 100 MG	75100080107410	Generic
TIZANIDINE HCL	TIZANIDINE HCL CAP 2 MG (BASE EQUIVALENT)	75100090100110	Generic
ZANAFLEX	TIZANIDINE HCL CAP 2 MG (BASE EQUIVALENT)	75100090100110	Brand
TIZANIDINE HCL	TIZANIDINE HCL CAP 4 MG (BASE EQUIVALENT)	75100090100120	Generic
ZANAFLEX	TIZANIDINE HCL CAP 4 MG (BASE EQUIVALENT)	75100090100120	Brand
TIZANIDINE HCL	TIZANIDINE HCL CAP 6 MG (BASE EQUIVALENT)	75100090100130	Generic
ZANAFLEX	TIZANIDINE HCL CAP 6 MG (BASE EQUIVALENT)	75100090100130	Brand
TIZANIDINE HCL	TIZANIDINE HCL TAB 2 MG (BASE EQUIVALENT)	75100090100310	Generic
TIZANIDINE HYDROCHLORIDE	TIZANIDINE HCL TAB 4 MG (BASE EQUIVALENT)	75100090100320	Generic
ZANAFLEX	TIZANIDINE HCL TAB 4 MG (BASE EQUIVALENT)	75100090100320	Brand
DANTRIUM	DANTROLENE SODIUM CAP 25 MG	75200010100105	Brand
DANTROLENE SODIUM	DANTROLENE SODIUM CAP 25 MG	75200010100105	Generic
DANTROLENE SODIUM	DANTROLENE SODIUM CAP 50 MG	75200010100110	Generic
DANTROLENE SODIUM	DANTROLENE SODIUM CAP 100 MG	75200010100115	Generic
NORGESIC	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 25-385-30 MG	75990003200310	Brand
ORPHENADRINE/ASPIRIN/CAFFEINE	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 25-385-30 MG	75990003200310	Generic
NORGESIC FORTE	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 50-770-60 MG	75990003200320	Generic
ORPHENGESIC FORTE	ORPHENADRINE W/ ASPIRIN & CAFFEINE TAB 50-770-60 MG	75990003200320	Generic
GABAPENTIN	GABAPENTIN CAP 100 MG	72600030000110	Generic
NEURONTIN	GABAPENTIN CAP 100 MG	72600030000110	Brand
GABAPENTIN	GABAPENTIN CAP 300 MG	72600030000130	Generic

NEURONTIN	GABAPENTIN CAP 300 MG	72600030000130	Brand
GABAPENTIN	GABAPENTIN CAP 400 MG	72600030000140	Generic
NEURONTIN	GABAPENTIN CAP 400 MG	72600030000140	Brand
GABAPENTIN TINYTABS	GABAPENTIN TAB 25 MG	72600030000303	Brand
GABAPENTIN TINYTABS	GABAPENTIN TAB 50 MG	72600030000305	Brand
GABAPENTIN	GABAPENTIN TAB 600 MG	72600030000330	Generic
NEURONTIN	GABAPENTIN TAB 600 MG	72600030000330	Brand
GABAPENTIN	GABAPENTIN TAB 800 MG	72600030000340	Generic
NEURONTIN	GABAPENTIN TAB 800 MG	72600030000340	Brand
GABAPENTIN	GABAPENTIN ORAL SOLN 250 MG/5ML	72600030002020	Generic
NEURONTIN	GABAPENTIN ORAL SOLN 250 MG/5ML	72600030002020	Brand
LYRICA	PREGABALIN CAP 25 MG	72600057000110	Brand
PREGABALIN	PREGABALIN CAP 25 MG	72600057000110	Generic
LYRICA	PREGABALIN CAP 50 MG	72600057000115	Brand
PREGABALIN	PREGABALIN CAP 50 MG	72600057000115	Generic
LYRICA	PREGABALIN CAP 75 MG	72600057000120	Brand
PREGABALIN	PREGABALIN CAP 75 MG	72600057000120	Generic
LYRICA	PREGABALIN CAP 100 MG	72600057000125	Brand
PREGABALIN	PREGABALIN CAP 100 MG	72600057000125	Generic
LYRICA	PREGABALIN CAP 150 MG	72600057000135	Brand
PREGABALIN	PREGABALIN CAP 150 MG	72600057000135	Generic
LYRICA	PREGABALIN CAP 200 MG	72600057000145	Brand
PREGABALIN	PREGABALIN CAP 200 MG	72600057000145	Generic
LYRICA	PREGABALIN CAP 225 MG	72600057000150	Brand
PREGABALIN	PREGABALIN CAP 225 MG	72600057000150	Generic
LYRICA	PREGABALIN CAP 300 MG	72600057000160	Brand
PREGABALIN	PREGABALIN CAP 300 MG	72600057000160	Generic
LYRICA	PREGABALIN SOLN 20 MG/ML	72600057002020	Brand
PREGABALIN	PREGABALIN SOLN 20 MG/ML	72600057002020	Generic
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 300 MG	62540030000320	Brand

GRALISE	GABAPENTIN (ONCE-DAILY) TAB 450 MG	62540030000325	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 600 MG	62540030000330	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 750 MG	62540030000345	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB 900 MG	62540030000360	Brand
GRALISE	GABAPENTIN (ONCE-DAILY) TAB PACK 300 MG (9) & 600 MG (24)	62540030006330	Brand
LYRICA CR	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 82.5 MG	62540060007520	Generic
LYRICA CR	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 165 MG	62540060007530	Generic
LYRICA CR	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Brand
PREGABALIN ER	PREGABALIN TAB ER 24HR 330 MG	62540060007540	Generic
HORIZANT	GABAPENTIN ENACARBIL TAB ER 300 MG	62560030200420	Brand
HORIZANT	GABAPENTIN ENACARBIL TAB ER 600 MG	62560030200430	Brand
ZORVOLEX	DICLOFENAC CAP 18 MG	66100007000120	Brand
ZORVOLEX	DICLOFENAC CAP 35 MG	66100007000130	Brand
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM TAB 25 MG	66100007100320	Generic
LOFENA	DICLOFENAC POTASSIUM TAB 25 MG	66100007100320	Brand
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM TAB 50 MG	66100007100330	Generic
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM CAP 25 MG	66100007100120	Generic
ZIPSOR	DICLOFENAC POTASSIUM CAP 25 MG	66100007100120	Brand
DICLOFENAC SODIUM DR	DICLOFENAC SODIUM TAB DELAYED RELEASE 25 MG	66100007200610	Generic
DICLOFENAC SODIUM DR	DICLOFENAC SODIUM TAB DELAYED RELEASE 50 MG	66100007200620	Generic
DICLOFENAC SODIUM DR	DICLOFENAC SODIUM TAB DELAYED RELEASE 75 MG	66100007200630	Generic

DICLOFENAC SODIUM ER	DICLOFENAC SODIUM TAB ER 24HR 100 MG	66100007207530	Generic
CAMBIA	DICLOFENAC POTASSIUM (MIGRAINE) PACKET 50 MG	67600040103020	Brand
DICLOFENAC POTASSIUM	DICLOFENAC POTASSIUM (MIGRAINE) PACKET 50 MG	67600040103020	Generic
ETODOLAC	ETODOLAC CAP 200 MG	66100008000120	Generic
ETODOLAC	ETODOLAC CAP 300 MG	66100008000130	Generic
ETODOLAC	ETODOLAC TAB 400 MG	66100008000310	Generic
LODINE	ETODOLAC TAB 400 MG	66100008000310	Brand
ETODOLAC	ETODOLAC TAB 500 MG	66100008000320	Generic
ETODOLAC ER	ETODOLAC TAB ER 24HR 400 MG	66100008007520	Generic
ETODOLAC ER	ETODOLAC TAB ER 24HR 500 MG	66100008007530	Generic
ETODOLAC ER	ETODOLAC TAB ER 24HR 600 MG	66100008007540	Generic
FENOPROFEN CALCIUM	FENOPROFEN CALCIUM CAP 200 MG	66100010100105	Generic
FENOPROFEN CALCIUM	FENOPROFEN CALCIUM CAP 400 MG	66100010100120	Generic
NALFON	FENOPROFEN CALCIUM CAP 400 MG	66100010100120	Brand
FENOPROFEN CALCIUM	FENOPROFEN CALCIUM TAB 600 MG	66100010100305	Generic
NALFON	FENOPROFEN CALCIUM TAB 600 MG	66100010100305	Brand
FLURBIPROFEN	FLURBIPROFEN TAB 50 MG	66100012000310	Generic
FLURBIPROFEN	FLURBIPROFEN TAB 100 MG	66100012000315	Generic
IBUPROFEN	IBUPROFEN CAP 200 MG	66100020000105	Generic
IBUPROFEN	IBUPROFEN TAB 200 MG	66100020000305	Generic
IBUPROFEN	IBUPROFEN TAB 400 MG	66100020000320	Generic
IBUPROFEN	IBUPROFEN TAB 600 MG	66100020000330	Generic
IBUPROFEN	IBUPROFEN TAB 800 MG	66100020000340	Generic
IBUPROFEN	IBUPROFEN CHEW TAB 100 MG	66100020000520	Generic
IBUPROFEN INFANTS	IBUPROFEN SUSP 40 MG/ML	66100020001810	Generic

CHILDRENS IBUPROFEN	IBUPROFEN SUSP 100 MG/5ML	66100020001820	Generic
INDOMETHACIN	INDOMETHACIN CAP 25 MG	66100030000105	Generic
INDOMETHACIN	INDOMETHACIN CAP 50 MG	66100030000110	Generic
INDOMETHACIN ER	INDOMETHACIN CAP ER 75 MG	66100030000205	Generic
INDOMETHACIN SR	INDOMETHACIN CAP ER 75 MG	66100030000205	Generic
INDOCIN	INDOMETHACIN SUSP 25 MG/5ML	66100030001805	Brand
INDOCIN	INDOMETHACIN SUPPOS 50 MG	66100030005205	Brand
INDOMETHACIN	INDOMETHACIN SUPPOS 100 MG	66100030005210	Brand
KETOPROFEN	KETOPROFEN CAP 25 MG	66100035000103	Generic
KETOPROFEN	KETOPROFEN CAP 50 MG	66100035000105	Generic
KETOPROFEN ER	KETOPROFEN CAP ER 24HR 200 MG	66100035007030	Generic
KETOROLAC TROMETHAMINE	KETOROLAC TROMETHAMINE TAB 10 MG	66100037100320	Generic
MECLOFENAMATE SODIUM	MECLOFENAMATE SODIUM CAP 50 MG	66100040100105	Generic
MECLOFENAMATE SODIUM	MECLOFENAMATE SODIUM CAP 100 MG	66100040100110	Generic
MEFENAMIC ACID	MEFENAMIC ACID CAP 250 MG	66100050000105	Generic
MELOXICAM	MELOXICAM CAP 5 MG	66100052000115	Generic
MELOXICAM	MELOXICAM CAP 10 MG	66100052000125	Generic
MELOXICAM	MELOXICAM TAB 7.5 MG	66100052000320	Generic
MELOXICAM	MELOXICAM TAB 15 MG	66100052000330	Generic
NABUMETONE	NABUMETONE TAB 500 MG	66100055000320	Generic
NABUMETONE	NABUMETONE TAB 750 MG	66100055000330	Generic
RELAFEN DS	NABUMETONE TAB 1000 MG	66100055000340	Brand
NAPROXEN	NAPROXEN TAB 250 MG	66100060000305	Generic
NAPROXEN	NAPROXEN TAB 375 MG	66100060000310	Generic
NAPROSYN	NAPROXEN TAB 500 MG	66100060000315	Brand
NAPROXEN	NAPROXEN TAB 500 MG	66100060000315	Generic

EC-NAPROSYN	NAPROXEN TAB EC 375 MG	66100060000610	Brand
EC-NAPROXEN	NAPROXEN TAB EC 375 MG	66100060000610	Generic
NAPROXEN	NAPROXEN TAB EC 375 MG	66100060000610	Generic
EC-NAPROSYN	NAPROXEN TAB EC 500 MG	66100060000615	Brand
EC-NAPROXEN	NAPROXEN TAB EC 500 MG	66100060000615	Generic
NAPROXEN	NAPROXEN TAB EC 500 MG	66100060000615	Generic
NAPROSYN	NAPROXEN SUSP 125 MG/5ML	66100060001805	Brand
NAPROXEN	NAPROXEN SUSP 125 MG/5ML	66100060001805	Generic
NAPROXEN SODIUM	NAPROXEN SODIUM CAP 220 MG	66100060100127	Generic
NAPROXEN	NAPROXEN SODIUM TAB 220 MG	66100060100303	Generic
NAPROXEN SODIUM	NAPROXEN SODIUM TAB 275 MG	66100060100305	Generic
NAPROXEN SODIUM	NAPROXEN SODIUM TAB 550 MG	66100060100310	Generic
NAPRELAN	NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV)	66100060107520	Brand
NAPROXEN SODIUM CR	NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV)	66100060107520	Generic
NAPROXEN SODIUM ER	NAPROXEN SODIUM TAB ER 24HR 375 MG (BASE EQUIV)	66100060107520	Generic
NAPRELAN	NAPROXEN SODIUM TAB ER 24HR 500 MG (BASE EQUIV)	66100060107540	Brand
NAPROXEN SODIUM ER	NAPROXEN SODIUM TAB ER 24HR 500 MG (BASE EQUIV)	66100060107540	Generic
NAPRELAN	NAPROXEN SODIUM TAB ER 24HR 750 MG (BASE EQUIV)	66100060107550	Brand
NAPROXEN SODIUM	NAPROXEN SODIUM TAB ER 24HR 750 MG (BASE EQUIV)	66100060107550	Generic
DAYPRO	OXAPROZIN TAB 600 MG	66100065000320	Brand
OXAPROZIN	OXAPROZIN TAB 600 MG	66100065000320	Generic

FELDENE	PIROXICAM CAP 10 MG	66100070000105	Brand
PIROXICAM	PIROXICAM CAP 10 MG	66100070000105	Generic
FELDENE	PIROXICAM CAP 20 MG	66100070000110	Brand
PIROXICAM	PIROXICAM CAP 20 MG	66100070000110	Generic
SULINDAC	SULINDAC TAB 150 MG	66100080000305	Generic
SULINDAC	SULINDAC TAB 200 MG	66100080000310	Generic
TOLMETIN SODIUM	TOLMETIN SODIUM TAB 600 MG	66100090100320	Generic
CELEBREX	CELECOXIB CAP 50 MG	66100525000110	Brand
CELECOXIB	CELECOXIB CAP 50 MG	66100525000110	Generic
CELEBREX	CELECOXIB CAP 100 MG	66100525000120	Brand
CELECOXIB	CELECOXIB CAP 100 MG	66100525000120	Generic
CELEBREX	CELECOXIB CAP 200 MG	66100525000130	Brand
CELECOXIB	CELECOXIB CAP 200 MG	66100525000130	Generic
CELEBREX	CELECOXIB CAP 400 MG	66100525000140	Brand
CELECOXIB	CELECOXIB CAP 400 MG	66100525000140	Generic
ELYXYB	CELECOXIB ORAL SOLN 120 MG/4.8ML (25 MG/ML)	67604030002020	Brand
ARTHROTEC 50	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 50-0.2 MG	66109902200620	Brand
DICLOFENAC SODIUM/MISOPROSTOL	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 50-0.2 MG	66109902200620	Generic
ARTHROTEC 75	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 75-0.2 MG	66109902200630	Brand
DICLOFENAC SODIUM/MISOPROSTOL	DICLOFENAC W/ MISOPROSTOL TAB DELAYED RELEASE 75-0.2 MG	66109902200630	Generic
DUEXIS	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Brand
IBUPROFEN/FAMOTIDINE	IBUPROFEN-FAMOTIDINE TAB 800-26.6 MG	66109902320340	Generic
NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Generic

VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 375-20 MG	66109902440620	Brand
NAPROXEN/ESOMEPRAZOLE MAGNESIUM	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Generic
VIMOVO	NAPROXEN-ESOMEPRAZOLE MAGNESIUM TAB DR 500-20 MG	66109902440640	Brand
QC IBUPROFEN/DIPHENHYDRAMINE	IBUPROFEN-DIPHENHYDRAMINE HCL CAP 200-25 MG	60309902420120	Generic
ALEVE PM	NAPROXEN SODIUM-DIPHENHYDRAMINE HCL TAB 220-25 MG	60309902600320	Brand
RA NAPROXEN SODIUM PM	NAPROXEN SODIUM-DIPHENHYDRAMINE HCL TAB 220-25 MG	60309902600320	Generic
ADVIL PM	IBUPROFEN-DIPHENHYDRAMINE HCL CAP 200-25 MG	60309902420120	Brand
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 5-200 MG	65991702500315	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	65991702500320	Generic
HYDROCODONE/IBUPROFEN	HYDROCODONE-IBUPROFEN TAB 10-200 MG	65991702500330	Generic
SUMATRIPTAN/NAPROXEN SODIUM	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Generic
TREXIMET	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Brand
ADVIL DUAL ACTION /ACETAMINOPHEN	IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG	66109902300305	Brand
MOTRIN DUAL ACTION/TYLENOL	IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG	66109902300305	Brand
NAPROTIN	NAPROXEN TAB 500 MG & CAPSAICIN CREAM 0.025% KIT	66109902476420	Brand
SM IBUPROFEN JR	IBUPROFEN TAB 100 MG	66100020000303	Generic
ALEVE	NAPROXEN SODIUM CAP 220 MG	66100060100127	Brand

ALEVE	NAPROXEN SODIUM TAB 220 MG	66100060100303	Brand
ANAPROX DS	NAPROXEN SODIUM TAB 550 MG	66100060100310	Brand
INPEFA	SOTAGLIFLOZIN TAB 200 MG	40750010000320	Brand
SAXENDA	LIRAGLUTIDE (WEIGHT MNGMT) SOLN PEN-INJ 18 MG/3ML (6 MG/ML)	6125205000D220	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML	6125207000D520	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML	6125207000D525	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML	6125207000D530	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML	6125207000D535	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML	6125207000D540	Brand
TOLMETIN SODIUM	TOLMETIN SODIUM CAP 400 MG	66100090100105	Generic
BREO ELLIPTA	FLUTICASONE FUROATE-VILANTEROL AERO POWD BA 50-25 MCG/ACT	44209902758010	Brand
AIRSUPRA	ALBUTEROL-BUDESONIDE INHALATION AEROSOL 90-80 MCG/ACT	44209902783220	Brand
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 45-21 MCG/ACT	44209902703250	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 115-21 MCG/ACT	44209902703260	Generic
FLUTICASONE PROPIONATE/SALMETEROL HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic

ADVAIR HFA	FLUTICASONE-SALMETEROL INHAL AEROSOL 230-21 MCG/ACT	44209902703270	Generic
FLEQSUVY	BACLOFEN SUSP 25 MG/5ML	75100010001825	Brand
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 90 MCG/ACT (BREATH ACTIVATED)	44400015008009	Generic
PULMICORT FLEXHALER	BUDESONIDE INHAL AERO POWD 180 MCG/ACT (BREATH ACTIVATED)	44400015008018	Generic
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Generic
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 80-4.5 MCG/ACT	44209902413220	Brand
BREYNA	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Generic
SYMBICORT	BUDESONIDE-FORMOTEROL FUMARATE DIHYD AEROSOL 160-4.5 MCG/ACT	44209902413240	Brand
ANORO ELLIPTA	UMECLIDINIUM-VILANTEROL AERO POWD BA 62.5-25 MCG/ACT	44209902958020	Brand
INCRUSE ELLIPTA	UMECLIDINIUM BR AERO POWD BREATH ACT 62.5 MCG/ACT (BASE EQ)	44100090208030	Brand
SEREVENT DISKUS	SALMETEROL XINAFOATE AER POW BA 50 MCG/ACT (BASE EQUIV)	44201058108020	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27996002307507	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-500 MG	27996002307510	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Brand
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-500 MG	27996002307520	Brand

XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Brand
INSULIN GLARGINE-YFGN	INSULIN GLARGINE-YFGN INJ 100 UNIT/ML	27104003902020	Brand
INDOMETHACIN	INDOMETHACIN SUPPOS 50 MG	66100030005205	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 2.5-1000 MG	27992502607520	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-500 MG	27992502607530	Generic
SAXAGLIPTIN HYDROCHLORIDE/METFORMIN HYDROCHLORIDE ER	SAXAGLIPTIN-METFORMIN HCL TAB ER 24HR 5-1000 MG	27992502607540	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 2.5 MG (BASE EQUIV)	27550065100320	Generic
SAXAGLIPTIN HYDROCHLORIDE	SAXAGLIPTIN HCL TAB 5 MG (BASE EQUIV)	27550065100330	Generic
TIOTROPIUM BROMIDE	TIOTROPIUM BROMIDE MONOHYDRATE INHAL CAP 18 MCG (BASE EQUIV)	44100080100120	Generic
INPEFA	SOTAGLIFLOZIN TAB 400 MG	40750010000340	Brand
BACLOFEN	BACLOFEN ORAL SOLN 10 MG/5ML	75100010002075	Generic
OZOBAX DS	BACLOFEN ORAL SOLN 10 MG/5ML	75100010002075	Generic
BEXAGLIFLOZIN	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic
FLUTICASONE PROPIONATE DISKUS	FLUTICASONE PROPIONATE AER POW BA 50 MCG/ACT	44400033208010	Brand
FLUTICASONE PROPIONATE DISKUS	FLUTICASONE PROPIONATE AER POW BA 100 MCG/ACT	44400033208020	Brand
FLUTICASONE PROPIONATE DISKUS	FLUTICASONE PROPIONATE AER POW BA 250 MCG/ACT	44400033208030	Brand
FLUTICASONE PROPIONATE HFA	FLUTICASONE PROPIONATE HFA INHAL AERO 44 MCG/ACT (50/VALVE)	44400033223220	Brand
FLUTICASONE PROPIONATE HFA	FLUTICASONE PROPIONATE HFA INHAL AER 110 MCG/ACT (125/VALVE)	44400033223230	Brand

FLUTICASONE PROPIONATE HFA	FLUTICASONE PROPIONATE HFA INHAL AER 220 MCG/ACT (250/VALVE)	44400033223240	Brand
NAPROXEN DR	NAPROXEN TAB EC 500 MG	66100060000615	Generic
ACETAMINOPHEN/IBUPROFEN	IBUPROFEN-ACETAMINOPHEN TAB 125-250 MG	66109902300305	Generic
BRENZAVVY	BEXAGLIFLOZIN TAB 20 MG	27700010000320	Generic
ADVIL JUNIOR STRENGTH	IBUPROFEN TAB 100 MG	66100020000303	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.5 MG/0.5ML	6125258000D520	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 5 MG/0.5ML	6125258000D525	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 7.5 MG/0.5ML	6125258000D530	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 10 MG/0.5ML	6125258000D535	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 12.5 MG/0.5ML	6125258000D540	Brand
ZEPBOUND	TIRZEPATIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 15 MG/0.5ML	6125258000D545	Brand
COXANTO	OXAPROZIN CAP 300 MG	66100065000120	Brand
JANTOVEN	WARFARIN SODIUM TAB 1 MG	83200030200303	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 1 MG	83200030200303	Generic
JANTOVEN	WARFARIN SODIUM TAB 2 MG	83200030200305	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 2 MG	83200030200305	Generic
JANTOVEN	WARFARIN SODIUM TAB 2.5 MG	83200030200310	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 2.5 MG	83200030200310	Generic
JANTOVEN	WARFARIN SODIUM TAB 3 MG	83200030200311	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 3 MG	83200030200311	Generic

JANTOVEN	WARFARIN SODIUM TAB 4 MG	83200030200313	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 4 MG	83200030200313	Generic
JANTOVEN	WARFARIN SODIUM TAB 5 MG	83200030200315	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 5 MG	83200030200315	Generic
JANTOVEN	WARFARIN SODIUM TAB 6 MG	83200030200317	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 6 MG	83200030200317	Generic
JANTOVEN	WARFARIN SODIUM TAB 7.5 MG	83200030200320	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 7.5 MG	83200030200320	Generic
JANTOVEN	WARFARIN SODIUM TAB 10 MG	83200030200325	Generic
WARFARIN SODIUM	WARFARIN SODIUM TAB 10 MG	83200030200325	Generic
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 75 MG (ETEXILATE BASE EQ)	83337030200120	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 110 MG (ETEXILATE BASE EQ)	83337030200130	Brand
DABIGATRAN ETEXILATE	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Generic
PRADAXA	DABIGATRAN ETEXILATE MESYLATE CAP 150 MG (ETEXILATE BASE EQ)	83337030200140	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 20 MG	83337030203020	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 30 MG	83337030203025	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 40 MG	83337030203030	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 50 MG	83337030203035	Brand

PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 110 MG	83337030203040	Brand
PRADAXA	DABIGATRAN ETEXILATE MESYLATE PELLET PACK 150 MG	83337030203045	Brand
ELIQUIS	APIXABAN TAB 2.5 MG	83370010000320	Brand
ELIQUIS	APIXABAN TAB 5 MG	83370010000330	Brand
SAVAYSA	EDOXABAN TOSYLATE TAB 15 MG (BASE EQUIVALENT)	83370030200315	Brand
SAVAYSA	EDOXABAN TOSYLATE TAB 30 MG (BASE EQUIVALENT)	83370030200330	Brand
SAVAYSA	EDOXABAN TOSYLATE TAB 60 MG (BASE EQUIVALENT)	83370030200350	Brand
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand
ESZOPICLONE	ESZOPICLONE TAB 1 MG	60204035000320	Generic
LUNESTA	ESZOPICLONE TAB 1 MG	60204035000320	Brand
ESZOPICLONE	ESZOPICLONE TAB 2 MG	60204035000330	Generic
LUNESTA	ESZOPICLONE TAB 2 MG	60204035000330	Brand
ESZOPICLONE	ESZOPICLONE TAB 3 MG	60204035000340	Generic
LUNESTA	ESZOPICLONE TAB 3 MG	60204035000340	Brand
ZALEPLON	ZALEPLON CAP 5 MG	60204070000120	Generic
ZALEPLON	ZALEPLON CAP 10 MG	60204070000130	Generic
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE CAP 7.5 MG	60204080100120	Brand
AMBIEN	ZOLPIDEM TARTRATE TAB 5 MG	60204080100310	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE TAB 5 MG	60204080100310	Generic

AMBIEN	ZOLPIDEM TARTRATE TAB 10 MG	60204080100315	Brand
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE TAB 10 MG	60204080100315	Generic
AMBIEN CR	ZOLPIDEM TARTRATE TAB ER 6.25 MG	60204080100410	Brand
ZOLPIDEM TARTRATE ER	ZOLPIDEM TARTRATE TAB ER 6.25 MG	60204080100410	Generic
AMBIEN CR	ZOLPIDEM TARTRATE TAB ER 12.5 MG	60204080100420	Brand
ZOLPIDEM TARTRATE ER	ZOLPIDEM TARTRATE TAB ER 12.5 MG	60204080100420	Generic
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE SL TAB 1.75 MG	60204080100708	Generic
ZOLPIDEM TARTRATE	ZOLPIDEM TARTRATE SL TAB 3.5 MG	60204080100715	Generic
EDLUAR	ZOLPIDEM TARTRATE SL TAB 5 MG	60204080100720	Brand
EDLUAR	ZOLPIDEM TARTRATE SL TAB 10 MG	60204080100730	Brand
RAMELTEON	RAMELTEON TAB 8 MG	60250060000320	Generic
ROZEREM	RAMELTEON TAB 8 MG	60250060000320	Brand
DOXEPIN HYDROCHLORIDE	DOXEPIN HCL (SLEEP) TAB 3 MG (BASE EQUIV)	60400030100320	Generic
SILENOR	DOXEPIN HCL (SLEEP) TAB 3 MG (BASE EQUIV)	60400030100320	Brand
DOXEPIN HYDROCHLORIDE	DOXEPIN HCL (SLEEP) TAB 6 MG (BASE EQUIV)	60400030100330	Generic
SILENOR	DOXEPIN HCL (SLEEP) TAB 6 MG (BASE EQUIV)	60400030100330	Brand
BELSOMRA	SUVOREXANT TAB 5 MG	60500070000305	Brand
BELSOMRA	SUVOREXANT TAB 10 MG	60500070000310	Brand
BELSOMRA	SUVOREXANT TAB 15 MG	60500070000315	Brand
BELSOMRA	SUVOREXANT TAB 20 MG	60500070000320	Brand
DAYVIGO	LEMBOREXANT TAB 5 MG	60500040000320	Brand
DAYVIGO	LEMBOREXANT TAB 10 MG	60500040000340	Brand
QUVIVIQ	DARIDOREXANT HCL TAB 25 MG	60500020100320	Brand
QUVIVIQ	DARIDOREXANT HCL TAB 50 MG	60500020100340	Brand
DEXMEDETOMIDINE HCL	DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML	60206030102020	Generic

DEXMEDETOMIDINE HYDROCHLORIDE	DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML	60206030102020	Generic
PRECEDEX	DEXMEDETOMIDINE HCL IV SOLN 200 MCG/2ML	60206030102020	Brand
DEXMEDETOMIDINE HCL	DEXMEDETOMIDINE HCL IV SOLN 400 MCG/4ML	60206030102030	Brand
DEXMEDETOMIDINE HCL	DEXMEDETOMIDINE HCL IV SOLN 1000 MCG/10ML	60206030102040	Brand
IGALMI	DEXMEDETOMIDINE HCL FILM 120 MCG	60206030108220	Brand
IGALMI	DEXMEDETOMIDINE HCL FILM 180 MCG	60206030108230	Brand
HETLIOZ	TASIMELTEON CAPSULE 20 MG	60250070000130	Brand
TASIMELTEON	TASIMELTEON CAPSULE 20 MG	60250070000130	Generic
HETLIOZ LQ	TASIMELTEON ORAL SUSP 4 MG/ML	60250070001820	Brand
RESTORIL	TEMAZEPAM CAP 7.5 MG	60201030000103	Brand
TEMAZEPAM	TEMAZEPAM CAP 7.5 MG	60201030000103	Generic
RESTORIL	TEMAZEPAM CAP 15 MG	60201030000105	Brand
TEMAZEPAM	TEMAZEPAM CAP 15 MG	60201030000105	Generic
RESTORIL	TEMAZEPAM CAP 22.5 MG	60201030000108	Brand
TEMAZEPAM	TEMAZEPAM CAP 22.5 MG	60201030000108	Generic
RESTORIL	TEMAZEPAM CAP 30 MG	60201030000110	Brand
TEMAZEPAM	TEMAZEPAM CAP 30 MG	60201030000110	Generic
TRIAZOLAM	TRIAZOLAM TAB 0.125 MG	60201040000305	Generic
HALCION	TRIAZOLAM TAB 0.25 MG	60201040000310	Brand
TRIAZOLAM	TRIAZOLAM TAB 0.25 MG	60201040000310	Generic
DORAL	QUAZEPAM TAB 15 MG	60201028000310	Brand
QUAZEPAM	QUAZEPAM TAB 15 MG	60201028000310	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 15 MG	60201010100105	Generic
FLURAZEPAM HYDROCHLORIDE	FLURAZEPAM HCL CAP 30 MG	60201010100110	Generic
ESTAZOLAM	ESTAZOLAM TAB 1 MG	60201005000310	Generic
ESTAZOLAM	ESTAZOLAM TAB 2 MG	60201005000320	Generic
ZITUVIO	SITAGLIPTIN TAB 25 MG	27550070000320	Brand
ZITUVIO	SITAGLIPTIN TAB 50 MG	27550070000330	Brand

ZITUVIO	SITAGLIPTIN TAB 100 MG	27550070000340	Brand
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 5 MG (BASE EQUIVALENT)	27700040200310	Generic
DAPAGLIFLOZIN PROPANEDIOL	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
FARXIGA	DAPAGLIFLOZIN PROPANEDIOL TAB 10 MG (BASE EQUIVALENT)	27700040200320	Generic
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 5-1000 MG	27996002307515	Generic
XIGDUO XR	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
DAPAGLIFLOZIN PROPANEDIOL/METFORMIN HYDROCHLORIDE	DAPAGLIFLOZIN PROP-METFORMIN HCL TAB ER 24HR 10-1000 MG	27996002307525	Generic
COXANTO	OXAPROZIN CAP 300 MG	66100065000120	Generic
OXAPROZIN	OXAPROZIN CAP 300 MG	66100065000120	Generic
BACLOFEN	BACLOFEN TAB 15 MG	75100010000308	Generic
SITAGLIPTIN/METFORMIN HYDROCHLORIDE	SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-500 MG	27992502690320	Brand
SITAGLIPTIN/METFORMIN HYDROCHLORIDE	SITAGLIPTIN FREE BASE-METFORMIN HCL TAB 50-1000 MG	27992502690330	Brand
TANLOR	METHOCARBAMOL TAB 1000 MG	75100070000320	Brand

Approval Criteria

1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

OR

2 - All of the following:

2.1 The requested medication combination is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2.2 The drug combination is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

AND

2.3 The provider attests that they are aware that the patient is using duplicate therapy

AND

2.4 Special clinical circumstances exist that necessitate the need for duplicate therapy (document special circumstances)

AND

2.5 Provider attests that the necessity for continued concomitant therapy and safety will be periodically assessed

2 . Revision History

Date	Notes
9/18/2024	Added Tanlor

Therapeutic Duplication (Subtype B)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155254
Guideline Name	Therapeutic Duplication (Subtype B)
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: (All formulations/packaging, except for Entyvio) Entyvio Pen, Stelara, Cimzia, Abrilada, Humira, Amjevita, Idacio, Hulio, Cyltezo, Yusimry, Yuflyma, Hadlima, Hyrimoz, adalimumab (adalimumab-AATY, adalimumab-RYVK, adalimumab-ADBM, adalimumab-AACF, adalimumab-ADAZ, adalimumab-FKJP), Simponi, Enbrel, Actemra, Cosentyx, Ilaris, Kineret, Kevzara, Taltz, Tremfya, Orencia, Xeljanz, Xeljanz XR, Xeljanz Solution, Siliq, Otezla, Olumiant, Ilumya, Skyrizi, Rinvoq, Sotyktu, Cibinqo, Adbry, Dupixent, brand Copaxone, generic glatiramer acetate, generic glatopa, Mavenclad, Rebif, Avonex, Betaseron, Extavia, brand Aubagio, generic teriflunomide, Plegridy, Lemtrada, Tysabri, Ocrevus, brand Tecfidera, generic dimethyl fumarate, Vumerity, brand Gilenya, generic fingolimod, Tascenso ODT, Zeposia, Mayzent, Bafiertam, Kesimpta, Ponvory, Xolair, Fasenra, Nucala, Cinqair, Tezspire, Velsipity, Bimzelx, Omvoh, Zymfentra, Simlandi, Spevigo, Tyenne, Rinvoq LQ, Nemluvio	
Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 45 MG/0.5ML	9025058500E520	Brand
STELARA	USTEKINUMAB SOLN PREFILLED SYRINGE 90 MG/ML	9025058500E540	Brand
STELARA	USTEKINUMAB INJ 45 MG/0.5ML	90250585002020	Brand
CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.8ML	6627001500F520	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 40 MG/0.4ML	6627001500F530	Brand
HUMIRA PEN	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-CD/UC/HS STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PEDIATRIC UC STARTER PACK	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML	6627001500F540	Brand
HUMIRA PEN-PS/UV STARTER	ADALIMUMAB PEN-INJECTOR KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F550	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 10 MG/0.1ML	6627001500F804	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001500F809	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001500F820	Brand
HUMIRA	ADALIMUMAB PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001500F830	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML	6627001500F840	Brand
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB PREFILLED SYRINGE KIT 80 MG/0.8ML & 40 MG/0.4ML	6627001500F880	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001510D520	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 10 MG/0.2ML	6627001510E505	Brand

AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.4ML	6627001510E510	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001510E520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 50 MG/0.5ML	6627004000D520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	6627004000D540	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.5ML	6627004000E520	Brand
SIMPONI	GOLIMUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/ML	6627004000E540	Brand
ENBREL SURECLICK	ETANERCEPT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	6629003000D530	Brand
ENBREL MINI	ETANERCEPT SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	6629003000E230	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 25 MG/0.5ML	6629003000E525	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/ML	6629003000E530	Brand
ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002015	Brand
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
ACTEMRA	TOCILIZUMAB IV INJ 80 MG/4ML	66500070002030	Brand
ACTEMRA	TOCILIZUMAB IV INJ 200 MG/10ML	66500070002035	Brand
ACTEMRA	TOCILIZUMAB IV INJ 400 MG/20ML	66500070002040	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	9025057500D520	Brand
COSENTYX SENSOREADY PEN	SECUKINUMAB SUBCUTANEOUS AUTO-INJ 150 MG/ML (300 MG DOSE)	9025057500D530	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	9025057500E510	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	9025057500E520	Brand
COSENTYX	SECUKINUMAB SUBCUTANEOUS PREF SYR 150 MG/ML (300 MG DOSE)	9025057500E530	Brand
ILARIS	CANAKINUMAB SUBCUTANEOUS INJ 150 MG/ML	66460020002015	Brand
KINERET	ANAKINRA SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	6626001000E520	Brand

KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML	6650006000D520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	6650006000D530	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/1.14ML	6650006000E520	Brand
KEVZARA	SARILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	6650006000E530	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 80 MG/ML	9025055400D520	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 80 MG/ML	9025055400E520	Brand
TREMFYA	GUSELKUMAB SOLN PEN-INJECTOR 100 MG/ML	9025054200D520	Brand
TREMFYA	GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML	9025054200E520	Brand
ORENCIA CLICKJECT	ABATACEPT SUBCUTANEOUS SOLN AUTO-INJECTOR 125 MG/ML	6640001000D520	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 50 MG/0.4ML	6640001000E510	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 87.5 MG/0.7ML	6640001000E515	Brand
ORENCIA	ABATACEPT SUBCUTANEOUS SOLN PREFILLED SYRINGE 125 MG/ML	6640001000E520	Brand
ORENCIA	ABATACEPT FOR IV SOLN 250 MG	66400010002120	Brand
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ	TOFACITINIB CITRATE ORAL SOLN 1 MG/ML (BASE EQUIVALENT)	66603065102020	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT)	66603065107530	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT)	66603065107550	Brand
SILIQ	BRODALUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 210 MG/1.5ML	9025052000E520	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 10 MG & 20 MG & 30 MG	6670001500B720	Brand
OTEZLA	APREMILAST TAB 30 MG	66700015000330	Brand
OLUMIANT	BARICITINIB TAB 1 MG	66603010000310	Brand
OLUMIANT	BARICITINIB TAB 2 MG	66603010000320	Brand
OLUMIANT	BARICITINIB TAB 4 MG	66603010000340	Brand

ILUMYA	TILDRAKIZUMAB-ASMN SUBCUTANEOUS SOLN PREF SYRINGE 100 MG/ML	9025058010E520	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 180 MG/1.2ML	5250406070E210	Brand
SKYRIZI	RISANKIZUMAB-RZAA SUBCUTANEOUS SOLN CARTRIDGE 360 MG/2.4ML	5250406070E220	Brand
SKYRIZI	RISANKIZUMAB-RZAA IV SOLN 600 MG/10ML (60 MG/ML)	52504060702020	Brand
SKYRIZI PEN	RISANKIZUMAB-RZAA SOLN AUTO-INJECTOR 150 MG/ML	9025057070D520	Brand
SKYRIZI	RISANKIZUMAB-RZAA SOLN PREFILLED SYRINGE 150 MG/ML	9025057070E540	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 15 MG	66603072007520	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 30 MG	66603072007530	Brand
RINVOQ	UPADACITINIB TAB ER 24HR 45 MG	66603072007540	Brand
SOTYKTU	DEUCRAVACITINIB TAB 6 MG	90250524000320	Brand
CIBINQO	ABROCITINIB TAB 50 MG	90272005000320	Brand
CIBINQO	ABROCITINIB TAB 100 MG	90272005000325	Brand
CIBINQO	ABROCITINIB TAB 200 MG	90272005000330	Brand
ADBRY	TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN PREFILLED SYR 150 MG/ML	9027308045E520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 200 MG/1.14ML	9027302000D515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PEN-INJECTOR 300 MG/2ML	9027302000D520	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 100 MG/0.67ML	9027302000E510	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 200 MG/1.14ML	9027302000E515	Brand
DUPIXENT	DUPILUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	9027302000E520	Brand
STELARA	USTEKINUMAB IV SOLN 130 MG/26ML (5 MG/ML) (FOR IV INFUSION)	52504070002020	Brand
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Brand
GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic
GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 20 MG/ML	6240003010E520	Generic
COPAXONE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Brand
GLATIRAMER ACETATE	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic

GLATOPA	GLATIRAMER ACETATE SOLN PREFILLED SYRINGE 40 MG/ML	6240003010E540	Generic
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (4 TABS)	6240101500B718	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (5 TABS)	6240101500B722	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (6 TABS)	6240101500B726	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (7 TABS)	6240101500B732	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (8 TABS)	6240101500B736	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (9 TABS)	6240101500B740	Brand
MAVENCLAD	CLADRIBINE TAB THERAPY PACK 10 MG (10 TABS)	6240101500B744	Brand
REBIF REBIDOSE	INTERFERON BETA-1A SOLN AUTO-INJ 22 MCG/0.5ML	6240306045D520	Brand
REBIF REBIDOSE	INTERFERON BETA-1A SOLN AUTO-INJ 44 MCG/0.5ML	6240306045D540	Brand
REBIF REBIDOSE TITRATION PACK	INTERFERON BETA-1A AUTO-INJ 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML	6240306045D560	Brand
REBIF	INTERFERON BETA-1A SOLN PREF SYR 22 MCG/0.5ML	6240306045E520	Brand
REBIF	INTERFERON BETA-1A SOLN PREF SYR 44 MCG/0.5ML	6240306045E540	Brand
REBIF TITRATION PACK	INTERFERON BETA-1A PREF SYR 6X8.8 MCG/0.2ML & 6X22 MCG/0.5ML	6240306045E560	Brand
AVONEX PEN	INTERFERON BETA-1A IM AUTO-INJECTOR KIT 30 MCG/0.5ML	6240306045F530	Brand
AVONEX	INTERFERON BETA-1A IM PREFILLED SYRINGE KIT 30 MCG/0.5ML	6240306045F830	Brand
BETASERON	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
EXTAVIA	INTERFERON BETA-1B FOR INJ KIT 0.3 MG	62403060506420	Brand
PLEGRIDY	PEGINTERFERON BETA-1A SOLN PEN-INJECTOR 125 MCG/0.5ML	6240307530D520	Brand
PLEGRIDY STARTER PACK	PEGINTERFERON BETA-1A SOLN PEN-INJ 63 & 94 MCG/0.5ML PACK	6240307530D550	Brand
PLEGRIDY	PEGINTERFERON BETA-1A SOLN PREFILLED SYRINGE 125 MCG/0.5ML	6240307530E520	Brand
PLEGRIDY	PEGINTERFERON BETA-1A IM SOLN PREFILLED SYR 125 MCG/0.5ML	6240307530E521	Brand
PLEGRIDY STARTER PACK	PEGINTERFERON BETA-1A SOLN PREF SYR 63 & 94 MCG/0.5ML PACK	6240307530E550	Brand

AUBAGIO	TERIFLUNOMIDE TAB 7 MG	62404070000320	Brand
TERIFLUNOMIDE	TERIFLUNOMIDE TAB 7 MG	62404070000320	Generic
AUBAGIO	TERIFLUNOMIDE TAB 14 MG	62404070000330	Brand
TERIFLUNOMIDE	TERIFLUNOMIDE TAB 14 MG	62404070000330	Generic
LEMTRADA	ALEMTUZUMAB IV INJ 12 MG/1.2ML (10 MG/ML)	62405010002020	Brand
TYSABRI	NATALIZUMAB FOR IV INJ CONC 300 MG/15ML	62405050001320	Brand
OCREVUS	OCRELIZUMAB SOLN FOR IV INFUSION 300 MG/10ML	62405060002020	Brand
VUMERITY	DIROXIMEL FUMARATE CAPSULE DELAYED RELEASE 231 MG	62405530006540	Brand
GILENYA	FINGOLIMOD HCL CAP 0.25 MG (BASE EQUIV)	62407025100110	Brand
FINGOLIMOD	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Generic
GILENYA	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	Brand
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.25 MG	62407025207220	Brand
TASCENSO ODT	FINGOLIMOD LAURYL SULFATE TABLET DISINTEGRATING 0.5 MG	62407025207230	Brand
ZEPOSIA	OZANIMOD HCL CAP 0.92 MG	62407050200120	Brand
MAYZENT	SIPONIMOD FUMARATE TAB 0.25 MG (BASE EQUIV)	62407070200320	Brand
MAYZENT	SIPONIMOD FUMARATE TAB 1 MG (BASE EQUIV)	62407070200330	Brand
MAYZENT	SIPONIMOD FUMARATE TAB 2 MG (BASE EQUIV)	62407070200340	Brand
MAYZENT STARTER PACK	SIPONIMOD FUMARATE TAB 0.25 MG (7) STARTER PACK	6240707020B710	Brand
MAYZENT STARTER PACK	SIPONIMOD FUMARATE TAB 0.25 MG (12) STARTER PACK	6240707020B720	Brand
BAFIERTAM	MONOMETHYL FUMARATE CAPSULE DELAYED RELEASE 95 MG	62405550006520	Brand
KESIMPTA	OFATUMUMAB SOLN AUTO-INJECTOR 20 MG/0.4ML	6240506500D520	Brand
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Generic
TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 120 MG	62405525006520	Brand
DIMETHYL FUMARATE	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Generic

TECFIDERA	DIMETHYL FUMARATE CAPSULE DELAYED RELEASE 240 MG	62405525006540	Brand
PONVORY	PONESIMOD TAB 20 MG	62407060000320	Brand
PONVORY 14-DAY STARTER PACK	PONESIMOD TAB STARTER PACK 2,3,4,5,6,7,8,9 &10 MG	6240706000B720	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
FASENRA PEN	BENRALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 30 MG/ML	4460402000D520	Brand
FASENRA	BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 30 MG/ML	4460402000E520	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4460405500D530	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 40 MG/0.4ML	4460405500E520	Brand
NUCALA	MEPOLIZUMAB SUBCUTANEOUS SOLUTION PREF SYRINGE 100 MG/ML	4460405500E530	Brand
NUCALA	MEPOLIZUMAB FOR INJ 100 MG	44604055002120	Brand
CINQAIR	RESLIZUMAB IV INFUSION SOLN 100 MG/10ML (10 MG/ML)	44604460002020	Brand
TEZSPIRE	TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN PREF SYR 210 MG/1.91ML	4460807525E520	Brand
TEZSPIRE	TEZEPELUMAB-EKKO SUBCUTANEOUS SOLN AUTO-INJ 210 MG/1.91ML	4460807525D520	Brand
ZEPOSIA 7-DAY STARTER PACK	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG	6240705020B210	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG	6240705020B215	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG	6240705020B220	Brand
IDACIO	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR CROHNS DISEASE	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO STARTER PACKAGE FOR PLAQUE PSORIASIS	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand

HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001535F810	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
HULIO	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML	6627001535F520	Brand
ADALIMUMAB-FKJP	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
HULIO	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001535F820	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
CYLTEZO STARTER PACKAGE FOR PSORIASIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
YUSIMRY	ADALIMUMAB-AQVH SOLN PEN-INJECTOR 40 MG/0.8ML	6627001509D520	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001520D510	Brand
HADLIMA PUSHTOUCH	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001520D520	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001520E510	Brand
HADLIMA	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001520E520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001504D515	Brand
HYRIMOZ CROHN'S DISEASE AND ULCERATIVE COLITIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand

HYRIMOZ PLAQUE PSORIASIS STARTER PACK	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML & 40 MG/0.4ML	6627001504D560	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 10 MG/0.1ML	6627001504E508	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001504E513	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
ADALIMUMAB-ADAZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001504E515	Brand
HYRIMOZ PEDIATRIC CROHNS DISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 80 MG/0.8ML	6627001504E540	Brand
HYRIMOZ PEDIATRIC CROHN'SDISEASE STARTER PACK	ADALIMUMAB-ADAZ SOLN PREFILLED SYR 80 MG/0.8ML & 40 MG/0.4ML	6627001504E560	Brand
YUFLYMA 2-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 1-PEN KIT	ADALIMUMAB-AATY AUTO-INJECTOR KIT 40 MG/0.4ML	6627001503F530	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001503F830	Brand
DIMETHYL FUMARATE STARTERPACK	DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG	6240552500B320	Generic
TECFIDERA STARTER PACK	DIMETHYL FUMARATE CAPSULE DR STARTER PACK 120 MG & 240 MG	6240552500B320	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 40 MG/0.8ML	6627001504D520	Brand
HYRIMOZ	ADALIMUMAB-ADAZ SOLN PREFILLED SYRINGE 40 MG/0.8ML	6627001504E520	Brand
ENTYVIO	VEDOLIZUMAB SOLN PEN-INJECTOR 108 MG/0.68ML	5250308000D520	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001507F810	Brand
ABRILADA	ADALIMUMAB-AFZB PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001507F820	Brand
VELSIPITY	ETRASIMOD ARGININE TAB 2 MG	52504525100350	Brand
BIMZELX	BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN AUTO-INJECTOR 160 MG/ML	9025051800D520	Brand
BIMZELX	BIMEKIZUMAB-BKZX SUBCUTANEOUS SOLN PREFILLED SYR 160 MG/ML	9025051800E520	Brand
OMVOH	MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOLN AUTO-INJECTOR 100 MG/ML	5250405040D520	Brand

OMVOH	MIRIKIZUMAB-MRKZ IV SOLN 300 MG/15ML (20 MG/ML)	52504050402030	Brand
COSENTYX UNOREADY	SECUKINUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9025057500D550	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM CROHNS/UC/HS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM PSORIASIS/UVEITIS STARTER	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.8ML	6627001505F520	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML	6627001505F805	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 20 MG/0.4ML	6627001505F810	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001505F820	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 20 MG/0.2ML	6627001510E508	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN PREFILLED SYRINGE 40 MG/0.4ML	6627001510E517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 40 MG/0.4ML	6627001510D517	Brand
AMJEVITA	ADALIMUMAB-ATTO SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001510D537	Brand
YUFLYMA	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
YUFLYMA CD/UC/HS STARTER	ADALIMUMAB-AATY AUTO-INJECTOR KIT 80 MG/0.8ML	6627001503F560	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
ABRILADA 1-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
ABRILADA 2-PEN KIT	ADALIMUMAB-AFZB AUTO-INJECTOR KIT 40 MG/0.8ML	6627001507F520	Brand
HYRIMOZ SENSOREADY PENS	ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR 80 MG/0.8ML	6627001504D540	Brand

ADALIMUMAB-AACF (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 PEN)	ADALIMUMAB-AACF AUTO-INJECTOR KIT 40 MG/0.8ML	6627001502F540	Brand
IDACIO (2 SYRINGE)	ADALIMUMAB-AACF PREFILLED SYRINGE KIT 40 MG/0.8ML	6627001502F840	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand
ZYMFENTRA 2-SYRINGE	INFLIXIMAB-DYYB SOLN PREFILLED SYRINGE KIT 120 MG/ML	5250504020F830	Brand
ZYMFENTRA 1-PEN	INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML	5250504020F530	Brand
ZYMFENTRA 2-PEN	INFLIXIMAB-DYYB SOLN AUTO-INJECTOR KIT 120 MG/ML	5250504020F530	Brand
ADALIMUMAB-AATY 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
YUFLYMA 2-SYRINGE KIT	ADALIMUMAB-AATY PREFILLED SYRINGE KIT 20 MG/0.2ML	6627001503F820	Brand
ADALIMUMAB-RYVK (2 PEN)	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 1-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SIMLANDI 2-PEN KIT	ADALIMUMAB-RYVK AUTO-INJECTOR KIT 40 MG/0.4ML	6627001540F520	Brand
SPEVIGO	SPESOLIMAB-SBZO SUBCUTANEOUS SOLN PREF SYR 150 MG/ML	9025057770E530	Brand
TYENNE	TOCILIZUMAB-AAZG IV INJ 80 MG/4ML	66500070172030	Brand
TYENNE	TOCILIZUMAB-AAZG IV INJ 200 MG/10ML	66500070172035	Brand
TYENNE	TOCILIZUMAB-AAZG IV INJ 400 MG/20ML	66500070172040	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand

CYLTEZO STARTER PACKAGE FOR PSORIASIS/UVEITIS	ADALIMUMAB-ADBM AUTO-INJECTOR KIT 40 MG/0.4ML	6627001505F515	Brand
ADALIMUMAB-ADBM	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
CYLTEZO	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001505F815	Brand
OMVOH	MIRIKIZUMAB-MRKZ SUBCUTANEOUS SOL PREFILL SYRINGE 100 MG/ML	5250405040E520	Brand
FASENRA	BENRALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 10 MG/0.5ML	4460402000E515	Brand
RINVOQ LQ	UPADACITINIB ORAL SOLN 1 MG/ML	66603072002020	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML	6650007017D520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML	6650007017E520	Brand
ADBRY	TRALOKINUMAB-LDRM SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	9027308045D530	Brand
ADALIMUMAB-RYVK	ADALIMUMAB-RYVK PREFILLED SYRINGE KIT 40 MG/0.4ML	6627001540F820	Brand
OTEZLA	APREMILAST TAB 20 MG	66700015000320	Brand
OTEZLA	APREMILAST TAB STARTER THERAPY PACK 4 X 10 MG & 51 X 20 MG	6670001500B710	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 20 MG/0.25ML	9025055400E510	Brand
TALTZ	IXEKIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 40 MG/0.5ML	9025055400E515	Brand
NEMLUVIO	NEMOLIZUMAB-ILTO FOR SUBCUTANEOUS AUTO-INJECTOR 30 MG	9079355510D420	Brand

Approval Criteria

1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

2 . Revision History

Date	Notes
9/18/2024	Copy NY

Tibsovo

Prior Authorization Guideline

Guideline ID	GL-146677
Guideline Name	Tibsovo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tibsovo	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - AML is IDH1 (isocitrate dehydrogenase 1) mutation-positive

AND

3 - ONE of the following:

3.1 Disease is relapsed or refractory

OR

3.2 BOTH of the following:

3.2.1 New diagnosis of AML

AND

3.2.2 ONE of the following:

- Patient is 75 years of age or older
- Patient has comorbidities that preclude the use of intensive induction chemotherapy
- Patient is 60 years of age or older AND not a candidate for or declines intensive induction therapy
- Patient is 60 years of age or older AND receiving post-induction therapy following response to previous lower intensity therapy

Product Name: Tibsovo	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Diagnosis of chondrosarcoma

AND

2 - Susceptible IDH1 (isocitrate dehydrogenase 1) mutation-positive

AND

3 - Disease is ONE of the following:

- Conventional (grades 1-3)
- Dedifferentiated

Product Name: Tibsovo	
Diagnosis	Biliary Tract Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Diagnosis of cholangiocarcinoma

AND

2 - Susceptible IDH1 (isocitrate dehydrogenase 1) mutation-positive

AND

3 - Disease is ONE of the following:

- Locally advanced
- Unresectable
- Metastatic

AND

4 - Disease has progressed on or after systemic treatment

Product Name: Tibsovo	
Diagnosis	Oligodendroglioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Diagnosis of oligodendroglioma

AND

2 - Disease is recurrent or progressive

AND

3 - Presence of BOTH of the following:

- IDH1 mutation
- 1p19q codeletion

AND

4 - Karnofsky Performance Status (KPS) greater than or equal to 60

AND

5 - Disease is WHO grade 2 or 3

Product Name: Tibsovo	
Diagnosis	Astrocytoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Diagnosis of astrocytoma

AND

2 - Disease is recurrent or progressive

AND

3 - Presence of IDH1 mutation

AND

4 - Karnofsky Performance Status (KPS) greater than or equal to 60

AND

5 - Disease is WHO grade 2

Product Name: Tibsovo	
Diagnosis	Myelodysplastic Syndrome (MDS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Diagnosis of myelodysplastic syndrome (MDS)

AND

2 - Disease is relapsed or refractory

AND

3 - Presence of IDH1 mutation

Product Name: Tibsovo	
Diagnosis	Acute Myeloid Leukemia (AML), Bone Cancer, Biliary Tract Cancer, Oligodendroglioma, Astrocytoma, Myelodysplastic syndrome (MDS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tibsovo therapy

Product Name: Tibsovo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Tibsovo

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TIBSOVO	IVOSIDENIB TAB 250 MG	21534940000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tibsovo therapy

Tobramycin Inhalation

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146678
Guideline Name	Tobramycin Inhalation
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic tobramycin 300 mg/4mL nebu soln (generic Bethkis)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOBRAMYCIN	TOBRAMYCIN NEBU SOLN 300 MG/4ML	07000070002530	Generic

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

OR

2 - BOTH of the following:

2.1 Diagnosis of noncystic fibrosis bronchiectasis

AND

2.2 ONE of the following:

2.2.1 Three or more exacerbations per year

OR

2.2.2 Two or more exacerbations requiring hospitalization per year

Product Name: Kitabis Pak, Brand Tobi nebu soln, generic tobramycin 300 mg/5mL nebu soln, Brand Tobramycin 300mg/5mL nebu soln, Tobi Podhaler, Brand Bethkis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOBRAMYCIN	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic
TOBI	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Brand
KITABIS PAK	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic
TOBI PODHALER	TOBRAMYCIN INHAL CAP 28 MG	07000070000120	Brand
BETHKIS	TOBRAMYCIN NEBU SOLN 300 MG/4ML	07000070002530	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of cystic fibrosis (CF)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of noncystic fibrosis bronchiectasis

AND

1.2.2 ONE of the following:

1.2.2.1 Three or more exacerbations per year

OR

1.2.2.2 Two or more exacerbations requiring hospitalization per year

AND

2 - Lung infection with positive culture demonstrating Pseudomonas aeruginosa infection

AND

3 - ONE of the following:

3.1 Failure to generic tobramycin 300 mg/4mL (milligrams/milliliter) solution for inhalation (generic Bethkis) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to generic tobramycin 300 mg/4mL solution for inhalation (generic Bethkis) (please specify contraindication or intolerance)

Product Name: Kitabis Pak, Brand Tobi nebu soln, generic tobramycin 300 mg/5mL nebu soln, Brand Tobramycin 300mg/5mL nebu soln, Tobi Podhaler, Brand Bethkis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TOBRAMYCIN	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic
TOBI	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Brand
KITABIS PAK	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	Generic
TOBI PODHALER	TOBRAMYCIN INHAL CAP 28 MG	07000070000120	Brand
BETHKIS	TOBRAMYCIN NEBU SOLN 300 MG/4ML	07000070002530	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Tocilizumab

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155299
Guideline Name	Tocilizumab
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Actemra subcutaneous, Tyenne subcutaneous	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML	6650007017D520	Brand

TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML	6650007017E520	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses confirmed by claims history or submitted medical records

OR

1.2.2 History of intolerance or contraindication to ONE non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA (Food and Drug Administration)-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

AND

1.3 ONE of the following:

1.3.1 Failure of ONE of the preferred adalimumab products* confirmed by claims history or submitted medical records

OR

1.3.2 History of intolerance or contraindication to ALL preferred adalimumab products* (please specify intolerance or contraindication)

AND

1.4 If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)**

AND

1.5 Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.6 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on tocilizumab therapy as confirmed by claims history or submitted medical records

AND

2.2 Diagnosis of moderately to severely active RA

AND

2.3 Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.4 If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)**

AND

2.5 Prescribed by or in consultation with a rheumatologist

Notes	*For a list of preferred adalimumab products please reference drug co verage tools. **For a list of preferred tocilizumab products please reference drug co verage tools.

Product Name: Actemra subcutaneous, Tyenne subcutaneous	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML	6650007017D520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML	6650007017E520	Brand

Approval Criteria

1 - Diagnosis of giant cell arteritis

AND

2 - ONE of the following:

2.1 Failure to ONE glucocorticoid (e.g., prednisone) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to ALL glucocorticoids (e.g., prednisone) (please specify intolerance or contraindication)

OR

2.3 Patient is currently on tocilizumab therapy as confirmed by claims history or submitted medical records

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products (please document reason/special circumstances)**

AND

4 - Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	**For a list of preferred tocilizumab products please reference drug co verage tools.

Product Name: Actemra subcutaneous, Tyenne subcutaneous	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML	6650007017D520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML	6650007017E520	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - ONE of the following:

2.1 Failure to ONE of the preferred adalimumab products* confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to ALL of the preferred adalimumab products* (please specify intolerance or contraindication)

OR

2.3 Patient is currently on tocilizumab therapy as confirmed by claims history or submitted medical records

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products** (please document reason/special circumstances)

AND

4 - Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	*For a list of preferred adalimumab products please reference drug coverage tools. **For a list of preferred tocilizumab products please reference drug coverage tools.

Product Name: Actemra subcutaneous, Tyenne subcutaneous	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand

ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML	6650007017D520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML	6650007017E520	Brand

Approval Criteria

1 - Diagnosis of active systemic juvenile idiopathic arthritis (SJIA)

AND

2 - Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products** (please document reason/special circumstances)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	**For a list of preferred tocilizumab products please reference drug co verage tools.

Product Name: Actemra subcutaneous, Tyenne subcutaneous	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML	6650007017D520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML	6650007017E520	Brand

Approval Criteria

1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by ALL of the following:

1.1 ONE of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 At least TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)
- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud's phenomenon
- SSc-related autoantibodies (e.g., anticentromere, anti-topoisomerase I, anti-RNA polymerase III)

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

AND

2 - Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

3 - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products** (please document reason/special circumstances)

AND

4 - Prescribed by or in consultation with a pulmonologist

Notes	**For a list of preferred tocilizumab products please reference drug co verage tools.

Product Name: Actemra subcutaneous, Tyenne subcutaneous	
Diagnosis	RA, GCA, PJIA, SJIA, SSc-ILD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ACTEMRA ACTPEN	TOCILIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 162 MG/0.9ML	6650007000D520	Brand
ACTEMRA	TOCILIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 162 MG/0.9ML	6650007000E520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN AUTO-INJ 162 MG/0.9ML	6650007017D520	Brand
TYENNE	TOCILIZUMAB-AAZG SUBCUTANEOUS SOLN PREF SYR 162 MG/0.9ML	6650007017E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to tocilizumab therapy

AND **2** - Patient is NOT receiving tocilizumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]* **AND** **3** - If the request is for a non-preferred tocilizumab product, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred tocilizumab products** (please document reason/special circumstances)

Notes	* Examples of drug(s) may not be applicable based on the requested i ndication. **For a list of preferred tocilizumab products please reference drug co verage tools.

2 . Background

Benefit/Coverage/Program Information
PDL Link NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
9/19/2024	Updated safety language. Added Tyenne and renamed policy to Tocili zumab. Updated step through agents where appropriate.

Topical NSAIDs

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146920
Guideline Name	Topical NSAIDs
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand diclofenac epolamine patch, Brand Flector	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
DICLOFENAC EPOLAMINE	DICLOFENAC EPOLAMINE PATCH 1.3%	90210030205920	Generic
FLECTOR	DICLOFENAC EPOLAMINE PATCH 1.3%	90210030205920	Generic

Approval Criteria

1 - Diagnosis of acute pain due to minor strains, sprains, or contusions

AND

2 - The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

3 - ONE of the following:

3.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- diclofenac topical gel 1% [Rx (prescription) formulation]
- diclofenac topical gel 1% [OTC (over-the-counter) formulation]

OR

3.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

- diclofenac topical gel 1% (Rx formulation)
- diclofenac topical gel 1% (OTC formulation)

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Brand Pennsaid, generic diclofenac sodium soln 2%, diclofenac sodium soln 1.5%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

PENNSAID	DICLOFENAC SODIUM SOLN 2%	90210030302030	Brand
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 1.5%	90210030302025	Generic
DICLOFENAC SODIUM	DICLOFENAC SODIUM SOLN 2%	90210030302030	Generic

Approval Criteria

1 - Patient has a diagnosis of pain due to osteoarthritis of the knee(s)

AND

2 - The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

3 - ONE of the following:

3.1 If the request is for Pennsaid (diclofenac sodium soln 2%), ONE of the following:

3.1.1 Failure of BOTH of the following, as confirmed by claims history or submitted medical records:

- diclofenac topical gel 1% [Rx (prescription) or OTC (over the counter) formulation] (generic for Voltaren)
- diclofenac 1.5% topical solution

OR

3.1.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

- diclofenac topical gel 1% (Rx or OTC formulation) (generic for Voltaren)
- diclofenac 1.5% topical solution

OR

3.2 If the request is for diclofenac topical solution 1.5%, ONE of the following:

3.2.1 Failure of ONE of the following, as confirmed by claims history or submitted medical records:

- diclofenac topical gel 1% (Rx formulation) (generic for Voltaren)
- diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)

OR

3.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

- diclofenac topical gel 1% (Rx formulation) (generic for Voltaren)
- diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Voltaren (Rx and OTC formulations)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOLTAREN	DICLOFENAC SODIUM GEL 1% (1.16% DIETHYLAMINE EQUIV)	90210030304020	Brand

Approval Criteria

1 - The patient has a diagnosis of pain due to osteoarthritis of joints amenable to topical treatment, including but not limited to the hands, knees, ankles, elbows, feet, and wrists

AND

2 - ONE of the following:

2.1 If the request is for the Rx (prescription) formulation, BOTH of the following:

2.1.1 The patient did not receive adequate pain relief when treated with at least TWO preferred* non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex), as confirmed by claims history or submitted medical records. An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to BOTH of the following, as confirmed by claims history or submission of medical records:

- diclofenac topical gel 1% [Rx or OTC (over-the-counter) formulation] (generic Voltaren)
- Brand Voltaren topical gel 1% (OTC formulation)

OR

2.1.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication):

- diclofenac topical gel 1% (Rx or OTC formulation) (generic Voltaren)
- Brand Voltaren topical gel 1% (OTC formulation)

OR

2.2 If the request is for the OTC formulation, ONE of the following:

2.2.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- diclofenac topical gel 1% (Rx formulation) (generic Voltaren)
- diclofenac topical gel 1% (OTC formulation) (generic Voltaren)

OR

2.2.2 History of intolerance or contraindication to BOTH of the following (please provide intolerance or contraindication): • diclofenac topical gel 1% (Rx formulation) (generic Voltaren) • diclofenac topical gel 1% (OTC formulation) (generic Voltaren)

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

2 . Revision History

Date	Notes
5/1/2024	Added NM PDL Link

Topical Retinoid Products

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148971
Guideline Name	Topical Retinoid Products
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: generic tretinoin microsphere, Retin-A Micro, Brand Differin cream, generic adapalene cream, Differin gel (Rx only)/lotion, adapalene gel/soln/pads, Fabior, tazarotene foam, Tazorac, generic tazarotene, adapalene/benzoyl peroxide, Brand Epiduo, Brand Epiduo Forte, Brand Atralin, generic tretinoin gel, Avita, Brand Retin-A, Altreno, Aklief, Arazlo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Generic
TRETINOIN MICROSPHERE PUMP	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Generic
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Brand
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.04%	90050030204015	Brand

TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Generic
TRETINOIN MICROSPHERE PUMP	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Generic
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Brand
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.1%	90050030204030	Brand
DIFFERIN	ADAPALENE CREAM 0.1%	90050003003710	Brand
ADAPALENE	ADAPALENE CREAM 0.1%	90050003003710	Generic
DIFFERIN	ADAPALENE GEL 0.1%	90050003004010	Brand
ADAPALENE	ADAPALENE GEL 0.1%	90050003004010	Generic
ADAPALENE TREATMENT	ADAPALENE GEL 0.1%	90050003004010	Generic
DIFFERIN	ADAPALENE GEL 0.3%	90050003004030	Brand
ADAPALENE	ADAPALENE GEL 0.3%	90050003004030	Generic
ADAPALENE PUMP	ADAPALENE GEL 0.3%	90050003004030	Generic
DIFFERIN	ADAPALENE LOTION 0.1%	90050003004110	Brand
ADAPALENE	ADAPALENE SOLN 0.1%	90050003002010	Brand
ADAPALENE	ADAPALENE PADS 0.1%	90050003004310	Brand
TAZAROTENE	TAZAROTENE (ACNE) FOAM 0.1%	90050027003930	Brand
FABIOR	TAZAROTENE (ACNE) FOAM 0.1%	90050027003930	Brand
TAZORAC	TAZAROTENE CREAM 0.1%	90250070003730	Brand
TAZAROTENE	TAZAROTENE CREAM 0.1%	90250070003730	Generic
TAZORAC	TAZAROTENE GEL 0.05%	90250070004020	Brand
TAZAROTENE	TAZAROTENE GEL 0.05%	90250070004020	Generic
TAZORAC	TAZAROTENE GEL 0.1%	90250070004030	Brand
TAZAROTENE	TAZAROTENE GEL 0.1%	90250070004030	Generic
TAZORAC	TAZAROTENE CREAM 0.05%	90250070003720	Brand
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE GEL 0.1-2.5%	90059902034020	Generic
EPIDUO	ADAPALENE-BENZOYL PEROXIDE GEL 0.1-2.5%	90059902034020	Brand
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5%	90059902034030	Generic
EPIDUO FORTE	ADAPALENE-BENZOYL PEROXIDE GEL 0.3-2.5%	90059902034030	Brand
ADAPALENE/BENZOYL PEROXIDE	ADAPALENE-BENZOYL PEROXIDE PAD 0.1-2.5%	90059902034320	Brand

ATRALIN	TRETINOIN GEL 0.05%	90050030004015	Brand
TRETINOIN	TRETINOIN GEL 0.05%	90050030004015	Generic
AVITA	TRETINOIN CREAM 0.025%	90050030003703	Brand
RETIN-A	TRETINOIN CREAM 0.025%	90050030003703	Brand
AVITA	TRETINOIN GEL 0.025%	90050030004010	Brand
RETIN-A	TRETINOIN GEL 0.025%	90050030004010	Brand
TRETINOIN	TRETINOIN GEL 0.025%	90050030004010	Generic
RETIN-A	TRETINOIN CREAM 0.05%	90050030003705	Brand
RETIN-A	TRETINOIN CREAM 0.1%	90050030003710	Brand
RETIN-A	TRETINOIN GEL 0.01%	90050030004005	Brand
TRETINOIN	TRETINOIN GEL 0.01%	90050030004005	Generic
RETIN-A MICRO	TRETINOIN MICROSPHERE GEL 0.06%	90050030204017	Brand
RETIN-A MICRO PUMP	TRETINOIN MICROSPHERE GEL 0.08%	90050030204020	Brand
ALTRENO	TRETINOIN LOTION 0.05%	90050030004130	Brand
AKLIEF	TRIFAROTENE CREAM 0.005%	90050035003720	Brand
ARAZLO	TAZAROTENE (ACNE) LOTION 0.045%	90050027004120	Brand
TRETINOIN MICROSPHERE	TRETINOIN MICROSPHERE GEL 0.08%	90050030204020	Generic

Approval Criteria

1 - The patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2 - Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Patient has a diagnosis of acne vulgaris

AND

3.1.2 ONE of the following:

3.1.2.1 Failure to a trial of BOTH of the following as confirmed by claims history or submission of medical records:

- Differin OTC (over the counter)
- Tretinoin cream (generic Retin-A cream)

OR

3.1.2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Differin OTC
- Tretinoin cream (generic Retin-A cream)

OR

3.2 BOTH of the following:

3.2.1 Patient does NOT have a diagnosis of acne vulgaris

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to a trial of at least THREE preferred* products as confirmed by claims history or submission of medical records

OR

3.2.2.2 History of intolerance or contraindication to ALL preferred* products (please specify intolerance or contraindication)	
Notes	*Step therapy is not limited to topical steroids. In instances where there are fewer than three preferred alternatives, the patient must have a history of failure, contraindication, or intolerance to ALL of the preferred products. *PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: generic tretinoin cream	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRETINOIN	TRETINOIN CREAM 0.025%	90050030003703	Generic
TRETINOIN	TRETINOIN CREAM 0.05%	90050030003705	Generic
TRETINOIN	TRETINOIN CREAM 0.1%	90050030003710	Generic

Approval Criteria

1 - Patient is less than 18 years old

OR

2 - ALL of the following:

2.1 Patient is 18 years of age or older

AND

2.2 Patient has a non-cosmetic medical condition (e.g., acne vulgaris, psoriasis, precancerous skin lesions) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

AND

2.3 Medication is not being requested solely for cosmetic purposes (e.g., photo-aging, wrinkling, hyperpigmentation, sun damage, melasma) (See Table 1 in Background for additional list of non-cosmetic medical conditions)

2 . Background

Benefit/Coverage/Program Information

Table 1: Examples of non-cosmetic medical conditions include, but are not limited to, the following:

Acanthosis nigricans	Keratoderma
Acne	Keratoderma palmaris et plantaris
Acne keloidalis nuchae	Keratosis rubra figurata
Acne rosacea	Kyrle's disease
Acne vulgaris	Lamellar ichthyosis
Actinic cheilitis	Leukoplakia
Actinic dermatitis	Lichen planus
Actinic keratosis	Mal de Meleda
	Malignancy
Basal cell carcinoma	Mendes da Costa syndrome
Bowen's disease	Molluscum contagiosum
Cystic acne	Non-bullous congenital ichthyosis
Darier's disease	Papillon-Lefevre syndrome
Darier-White Disease	Porokeratosis
Dermal mucinosis	Pseudofollicular barbae
Discoid lupus erythematosus	Pseudoacanthosis nigricans
Epidermoid cysts	Psoriasis
Epidermolytic hyperkeratosis	Psoriasis erythrodermic, palmoplantar

Erythrokeratoderma variabilis	Psoriasis pustular
Favre Racouchot disease	Psoriatic arthritis
Flat warts	Rosacea
Folliculitis	Sebaceous cysts
Fox Fordyce disease	Senile keratosis
Grover's disease	Solar keratosis
Hidradenitis suppurativa	Squamous cell carcinoma
Hyperkeratosis	Systematized epidermal nevus
Hyperkeratosis follicularis	Transient acantholytic dermatosis
Hyperkeratotic eczema	Tylotic eczema
Ichthyoses	X-linked ichthyosis
Ichthyosis vulgaris	Verruca planae
Keloid scar	Von Zumbusch pustular
Keratoacanthoma	Warts
Keratosis follicularis	Wound healing (mild)

3 . Revision History

Date	Notes
6/26/2024	Table in background was missing. Added back.

Trelegy Ellipta, Breztri

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146429
Guideline Name	Trelegy Ellipta, Breztri
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Trelegy Ellipta, Breztri Aerosphere	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT	44209903408020	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT	44209903408040	Brand
BREZTRI AEROSPHERE	BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT	44209903303220	Brand

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema

AND

2 - ONE of the following:

2.1 Failure to a 30 day trial of ONE of the following combinations as confirmed by claims history or submission of medical records:

2.1.1 ONE of the following long-acting muscarinic antagonist (LAMA) plus long-acting beta2-agonist (LABA)

- Anoro Ellipta (umeclidinium/vilanterol)
- Stiolto Respimat (tiotropium/olodaterol)

OR

2.1.2 ONE of the following inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA)

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- Anoro Ellipta (umeclidinium/vilanterol)
- Stiolto Respimat (tiotropium/olodaterol)
- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.3 Eosinophil count greater than or equal to 300 cells/microliter as confirmed by submission of medical records

Product Name: Trelegy Ellipta, Breztri Aerosphere	
Diagnosis	Asthma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 100-62.5-25 MCG/ACT	44209903408020	Brand
TRELEGY ELLIPTA	FLUTICASONE-UMECLIDINIUM-VILANTEROL AEPB 200-62.5-25 MCG/ACT	44209903408040	Brand
BREZTRI AEROSPHERE	BUDESONIDE-GLYCOPYRROLATE-FORMOTEROL AERS 160-9-4.8 MCG/ACT	44209903303220	Brand

Approval Criteria

1 - Diagnosis of asthma

AND

2 - ONE of the following:

2.1 Failure to treatment with at least a 30-day trial of ONE of the following, confirmed by claims history or submission of medical records:

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- fluticasone/salmeterol (authorized generic of AirDuo)
- fluticasone propionate/salmeterol diskus (generic Advair Diskus)
- Wixela Inhub (generic Advair Diskus)

Tremfya

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146679
Guideline Name	Tremfya
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tremfya	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TREMFYA	GUSELKUMAB SOLN PEN-INJECTOR 100 MG/ML	9025054200D520	Brand
TREMFYA	GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML	9025054200E520	Brand

Approval Criteria

1 - Diagnosis of chronic moderate to severe plaque psoriasis

AND

2 - Patient is not receiving Tremfya in combination with ANY of the following:

- Biologic DMARD [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz/XR (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Tremfya therapy as confirmed by claims history or submission of medical records

OR

4.2 All of the following:

4.2.1 One of the following:

4.2.1.1 Patient has been previously treated with a biologic or targeted synthetic DMARD (Disease-modifying antirheumatic drug) FDA-approved for the treatment of plaque psoriasis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]

OR

4.2.1.2 All of the following:

4.2.1.2.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

4.2.1.2.2 One of the following:

- Failure to ONE of the following topical therapy classes confirmed by claims history or submission of medical records: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar
- History of intolerance or contraindication to ALL of the following topical therapy classes (please specify intolerance or contraindication): Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar

AND

4.2.1.2.3 One of the following:

- Failure to a 3 month trial of methotrexate at maximally indicated dose confirmed by claims history or submitted medical records
- History of intolerance or contraindication to the methotrexate (please specify intolerance or contraindication)

AND

4.2.2 One of the following:

- Failure to TWO of the following preferred biologic products as confirmed by claims history or submission of medical records: One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab), Ilumya (tildrakizumab)
- History of intolerance or contraindication to ALL of the following preferred biologic products (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab), Ilumya (tildrakizumab)

AND

4.2.3 One of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Tremfya	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TREMFYA	GUSELKUMAB SOLN PEN-INJECTOR 100 MG/ML	9025054200D520	Brand
TREMFYA	GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML	9025054200E520	Brand

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is not receiving Tremfya in combination with ONE of the following:

- Biologic DMARD [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz/XR (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with one of the following:

- Rheumatologist
- Dermatologist

AND

4 - One of the following:

4.1 Patient is currently on Tremfya therapy as confirmed by claims history or submission of medical records

OR

4.2 ALL of the following:

4.2.1 One of the following:

- Failure to a 3 month trial of methotrexate at the maximally indicated dose, confirmed by claims history or submitted medical records
- History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)
- Patient has been previously treated with a biologic or targeted synthetic DMARD (Disease-modifying antirheumatic drug) FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab, Stelara (ustekinumab), Xeljanz/XR (tofacitinib), Otezla (apremilast)]

AND

4.2.2 One of the following:

- Failure to TWO of the following preferred biologic products as confirmed by claims history or submitted medical records: One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab)
- History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication): One of the preferred adalimumab products*, Enbrel (etanercept), Cimzia (certolizumab)

AND

4.2.3 One of the following:

- Failure to Cosentyx (secukinumab) as confirmed by claims history or submitted medical records
- History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

Notes	*For a list of preferred adalimumab products please reference drug co verage tools.

Product Name: Tremfya	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TREMFYA	GUSELKUMAB SOLN PEN-INJECTOR 100 MG/ML	9025054200D520	Brand
TREMFYA	GUSELKUMAB SOLN PREFILLED SYRINGE 100 MG/ML	9025054200E520	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tremfya therapy

AND

2 - Patient is not receiving Tremfya in combination with any of the following:

- Biologic DMARD [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz/XR (tofacitinib), Olumiant (baricitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Trikafta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151756
Guideline Name	Trikafta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Trikafta	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 100-50-75 MG &IVACAFTOR 150 MG TBPK	4530990340B740	Brand
TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 50-25-37.5 MG & IVACAFTOR 75 MG TBPK	4530990340B720	Brand
TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 80-40-60 MG& IVACAF 59.5MG THPK GRAN	4530990340B120	Brand

TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 100-50-75 MG& IVACAF 75MG THPK GRAN	4530990340B140	Brand

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results documenting that the patient has at least ONE of the following mutations in the CFTR gene:

- F508del mutation
- A mutation that is responsive based on in vitro data (see chart in Table 1 of background section)

AND

3 - The patient is greater than or equal to 2 years of age

AND

4 - Prescribed by, or in consultation with, a provider who specializes in the treatment of CF

Product Name: Trikafta	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 100-50-75 MG &IVACAFTOR 150 MG TBPK	4530990340B740	Brand
TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 50-25-37.5 MG & IVACAFTOR 75 MG TBPK	4530990340B720	Brand

TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 80-40-60 MG& IVACAF 59.5MG THPK GRAN	4530990340B120	Brand
TRIKAFTA	ELEXACAF-TEZACAF-IVACAF 100-50-75 MG& IVACAF 75MG THPK GRAN	4530990340B140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Trikafta therapy (e.g., improved lung function, stable lung function)

2 . Background

Benefit/Coverage/Program Information

Table 1

List of *CFTR* gene mutations that are responsive to Trikafta

3141del9	*E822K*	*G1069R*	*L967S*	*R117L*	*S912L*
546insCTA	*F191V*	*G1244E*	*L997F*	*R117P*	*S945L*
A46D	*F311del*	*G1249R*	*L1077P*	*R170H*	*S977F*
A120T	*F311L*	*G1349D*	*L1324P*	*R258G*	*S1159F*
A234D	*F508C*	*H139R*	*L1335P*	*R334L*	*S1159P*
A349V	*F508C;S1251N* †	*H199Y*	*L1480P*	*R334Q*	*S1251N*
A455E	*F508del* *	*H939R*	*M152V*	*R347H*	*S1255P*
A554E	*F575Y*	*H1054D*	*M265R*	*R347L*	*T338I*
A1006E	*F1016S*	*H1085P*	*M952I*	*R347P*	*T1036N*
A1067T	*F1052V*	*H1085R*	*M952T*	*R352Q*	*T1053I*
D110E	*F1074L*	*H1375P*	*M1101K*	*R352W*	*V201M*
D110H	*F1099L*	*I148T*	*P5L*	*R553Q*	*V232D*
D192G	*G27R*	*I175V*	*P67L*	*R668C*	*V456A*

D443Y	*G85E*	*I336K*	*P205S*	*R751L*	*V456F*
D443Y;G576A;R668C †	*G126D*	*I502T*	*P574H*	*R792G*	*V562I*
D579G	*G178E*	*I601F*	*Q98R*	*R933G*	*V754M*
D614G	*G178R*	*I618T*	*Q237E*	*R1066H*	*V1153E*
D836Y	*G194R*	*I807M*	*Q237H*	*R1070Q*	*V1240G*
D924N	*G194V*	*I980K*	*Q359R*	*R1070W*	*V1293G*
D979V	*G314E*	*I1027T*	*Q1291R*	*R1162L*	*W361R*
D1152H	*G463V*	*I1139V*	*R31L*	*R1283M*	*W1098C*
D1270N	*G480C*	*I1269N*	*R74Q*	*R1283S*	*W1282R*
E56K	*G551D*	*I1366N*	*R74W*	*S13F*	*Y109N*
E60K	*G551S*	*K1060T*	*R74W;D1270N* †	*S341P*	*Y161D*
E92K	*G576A*	*L15P*	*R74W;V201M* †	*S364P*	*Y161S*
E116K	*G576A;R668C* †	*L165S*	*R74W;V201M; D1270N* †	*S492F*	*Y563N*
E193K	*G622D*	*L206W*	*R75Q*	*S549N*	*Y1014C*
E403D	*G628R*	*L320V*	*R117C*	*S549R*	*Y1032C*
E474K	*G970D*	*L346P*	*R117G*	*S589N*	
E588V	*G1061R*	*L453S*	*R117H*	*S737F*	

* *F508del* is a responsive *CFTR* mutation based on both clinical and *in vitro* data.

† Complex/compound mutations where a single allele of the *CFTR* gene has multiple mutations; these exist independent of the presence of mutations on the other allele.

3 . Revision History

Date	Notes

8/14/2024	Removed prescriber requirement from reauthorization criteria. Increa sed initial authorization approval duration to 12 months.

Triptans

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152691
Guideline Name	Triptans
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: generic naratriptan	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 1 MG (BASE EQUIV)	67406050100310	Generic
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV)	67406050100320	Generic

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - ONE of the following:

2.1 Failure to sumatriptan (generic Imitrex) tablets at a minimum dose of 50 mg (milligrams) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to sumatriptan (generic Imitrex) tablets (please specify intolerance or contraindication)

Product Name: almotriptan, generic eletriptan, Brand Relpax, generic frovatriptan, Brand Frova, Onzetra XSail, generic rizatriptan, Brand Maxalt, generic rizatriptan ODT, Brand Maxalt-MLT, Imitrex Statdose System, sumatriptan auto-inj, Brand Imitrex nasal spr/tabs, generic sumatriptan nasal spr/tabs/inj, Brand Imitrex Statdose Refill, generic sumatriptan refill, generic sumatriptan/naproxen, Brand Treximet, Zembrace Symtouch, generic zolmitriptan tabs/nasal spr, Brand Zomig tabs/nasal spr, Brand Zolmitriptan nasal spr, zolmitriptan ODT, Tosymra

Diagnosis	Non-Preferred Products*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic
ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Generic
RELPAX	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Brand
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Generic

RELPAX	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Brand
FROVATRIPTAN SUCCINATE	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Generic
FROVA	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Brand
ONZETRA XSAIL	SUMATRIPTAN SUCCINATE EXHALER POWDER 11 MG/NOSEPIECE	6740607010G420	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 5 MG (BASE EQUIVALENT)	67406060100310	Generic
MAXALT	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Generic
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 5 MG (BASE EQ)	67406060107220	Generic
MAXALT-MLT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Brand
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Generic
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML	67406070102010	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Brand
SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Brand
SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Brand

SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Generic
SUMATRIPTAN/NAPROXEN SODIUM	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Generic
TREXIMET	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Brand
ZEMBRACE SYMTOUCH	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 3 MG/0.5ML	6740607010D505	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Generic
ZOMIG	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 5 MG	67406080000330	Generic
ZOMIG	ZOLMITRIPTAN TAB 5 MG	67406080000330	Brand
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 2.5 MG	67406080007220	Generic
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 5 MG	67406080007230	Generic
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Brand
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Generic
TOSYMRA	SUMATRIPTAN NASAL SPRAY 10 MG/ACT	67406070002020	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Generic

Approval Criteria

1 - If the requested medication is non-preferred*, BOTH of the following:

1.1 Diagnosis of migraine headaches with or without aura

AND

1.2 ONE of the following:

1.2.1 Patient has failure to ALL of the following as confirmed by claims history or submission of medical records:

- Naratriptan
- Rizatriptan
- One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection

OR

1.2.2 Patient has a history of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- Naratriptan
- Rizatriptan
- One of the following sumatriptan formulations: tablets, nasal spray, 4 mg injection, or 6 mg injection

Notes	*PDL links in Background.

Product Name: Imitrex Statdose System, sumatriptan auto-inj, sumatriptan inj, Brand Imitrex Statdose Refill, generic sumatriptan refill	
Diagnosis	Migraine Headaches
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic

IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Generic
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML	67406070102010	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Generic

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - Currently receiving prophylactic therapy with at least ONE of the following as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

3.3 Provider provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA for the diagnosis indicated

AND

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background. *Timolol, candesartan are non-preferred and should not be included in denial to provider. **This is a medical benefit, should not be included in denial to provider.

Product Name: Imitrex Statdose System, sumatriptan auto-inj, sumatriptan inj, Brand Imitrex Statdose Refill, generic sumatriptan refill	
Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 4 MG/0.5ML	6740607010D510	Generic
IMITREX STATDOSE SYSTEM	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 6 MG/0.5ML	6740607010D520	Generic
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE INJ 6 MG/0.5ML	67406070102010	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5ML	6740607010E210	Generic
IMITREX STATDOSE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Brand
SUMATRIPTAN SUCCINATE REFILL	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 6 MG/0.5ML	6740607010E220	Generic

Approval Criteria

1 - Diagnosis of cluster headaches

AND

2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer’s prescribing information

OR

3.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

3.3 Provider provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA for the diagnosis indicated

AND

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background.

Product Name: almotriptan, generic eletriptan, Brand Relpax, generic frovatriptan, Brand Frova, Onzetra XSail, generic rizatriptan, Brand Maxalt, generic rizatriptan ODT, Brand Maxalt-MLT, Brand Imitrex nasal spr/tabs, generic sumatriptan nasal spr/tabs, generic sumatriptan/naproxen, Brand Treximet, Zembrace Symtouch, generic zolmitriptan tabs/nasal spr, Brand Zomig tabs/nasal spr, Brand Zolmitriptan nasal spr, zolmitriptan ODT, Tosymra, generic naratriptan

Approval Length	12 month(s)
Guideline Type	Quantity Limit

Product Name	Generic Name	GPI	Brand/Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 6.25 MG	67406010100320	Generic
ALMOTRIPTAN	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic

ALMOTRIPTAN MALATE	ALMOTRIPTAN MALATE TAB 12.5 MG	67406010100330	Generic
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Generic
RELPAX	ELETRIPTAN HYDROBROMIDE TAB 20 MG (BASE EQUIVALENT)	67406025100320	Brand
ELETRIPTAN HYDROBROMIDE	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Generic
RELPAX	ELETRIPTAN HYDROBROMIDE TAB 40 MG (BASE EQUIVALENT)	67406025100340	Brand
FROVATRIPTAN SUCCINATE	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Generic
FROVA	FROVATRIPTAN SUCCINATE TAB 2.5 MG (BASE EQUIVALENT)	67406030100320	Brand
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 1 MG (BASE EQUIV)	67406050100310	Generic
NARATRIPTAN HCL	NARATRIPTAN HCL TAB 2.5 MG (BASE EQUIV)	67406050100320	Generic
ONZETRA XSAIL	SUMATRIPTAN SUCCINATE EXHALER POWDER 11 MG/NOSEPIECE	6740607010G420	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 5 MG (BASE EQUIVALENT)	67406060100310	Generic
MAXALT	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Brand
RIZATRIPTAN BENZOATE	RIZATRIPTAN BENZOATE TAB 10 MG (BASE EQUIVALENT)	67406060100320	Generic
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 5 MG (BASE EQ)	67406060107220	Generic
MAXALT-MLT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Brand
RIZATRIPTAN BENZOATE ODT	RIZATRIPTAN BENZOATE ORAL DISINTEGRATING TAB 10 MG (BASE EQ)	67406060107230	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Brand
SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 5 MG/ACT	67406070002010	Generic
IMITREX	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Brand
SUMATRIPTAN	SUMATRIPTAN NASAL SPRAY 20 MG/ACT	67406070002040	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Brand

SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 25 MG	67406070100305	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 50 MG	67406070100310	Generic
IMITREX	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Brand
SUMATRIPTAN SUCCINATE	SUMATRIPTAN SUCCINATE TAB 100 MG	67406070100320	Generic
SUMATRIPTAN/NAPROXEN SODIUM	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Generic
TREXIMET	SUMATRIPTAN-NAPROXEN SODIUM TAB 85-500 MG	67992002600320	Brand
ZEMBRACE SYMTOUCH	SUMATRIPTAN SUCCINATE SOLUTION AUTO-INJECTOR 3 MG/0.5ML	6740607010D505	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Generic
ZOMIG	ZOLMITRIPTAN TAB 2.5 MG	67406080000320	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN TAB 5 MG	67406080000330	Generic
ZOMIG	ZOLMITRIPTAN TAB 5 MG	67406080000330	Brand
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 2.5 MG	67406080007220	Generic
ZOLMITRIPTAN ODT	ZOLMITRIPTAN ORALLY DISINTEGRATING TAB 5 MG	67406080007230	Generic
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Brand
ZOMIG	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 5 MG/SPRAY UNIT	67406080002020	Generic
TOSYMRA	SUMATRIPTAN NASAL SPRAY 10 MG/ACT	67406070002020	Brand
ZOLMITRIPTAN	ZOLMITRIPTAN NASAL SPRAY 2.5 MG/SPRAY UNIT	67406080002010	Generic

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

2 - Currently receiving prophylactic therapy with at least ONE of the following as confirmed by claims history or submission of medical records:

- Amitriptyline (generic Elavil)
- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol*
- Candesartan* (generic Atacand)
- Divalproex sodium (generic Depakote/Depakote ER)
- OnabotulinumtoxinA (generic Botox)**
- Topiramate (generic Topamax)
- Venlafaxine (generic Effexor/Effexor XR)
- Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

3 - ONE of the following:

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

3.3 Provider provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA for the diagnosis indicated

AND

4 - Provider acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	See Table 1 in Background. *Timolol, candesartan are non-preferred and should not be included in denial to provider. **This is a medical benefit, should not be included in denial to provider.

2 . Background

Benefit/Coverage/Program Information

Table 1. Quantity Limits

Drug Name	Strength	Quantity Limit
Brand Amerge generic naratriptan	1mg, 2.5mg	9 tabs/month
Brand Frova Generic frovatriptan	2.5mg	9 tabs/month
Brand Imitrex tablets Generic sumatriptan tablets	25mg, 50mg, 100mg	9 tabs/month
Brand Maxalt Generic rizatriptan	5mg, 10mg	9 tabs/month
Brand Maxalt MLT Generic rizatriptan ODT	5mg, 10mg	9 tabs/month
Generic almotriptan	6.25mg, 12.5mg	6 tabs/month
Relpax	20mg, 40mg	6 tabs/month

Generic eletriptan		
Brand Zomig Generic zolmitriptan	2.5mg, 5mg	6 tabs/month
Brand Zomig ZMT Generic zolmitriptan ODT	2.5mg, 5mg	6 tabs/month
Brand Imitrex nasal spray Generic sumatriptan nasal spray	5mg, 20mg	6 spray devices/month
Zomig nasal spray	2.5mg, 5mg	6 spray devices/month
Treximet Generic sumatriptan/naproxen	85mg/500 mg, 10mg/60mg	9 tabs/month
Onzetra Xsail	11mg	1 box (8 units)/month
Zembrace SymTouch	3mg/0.5mL	2 boxes (8 units)/month
Brand Imitrex Generic Sumatriptan Autoinjector/Cartridge Refills	4mg/0.5mL 6mg/0.5mL	8 autoinjectors or cartridge refills/month (4 boxes/month)
Brand Imitrex Generic Sumatriptan Vials	6mg/0.5mL	10 vials/month (2 boxes/month)
Generic Sumatriptan Pre-filled Syringe	6mg/0.5mL	8 prefilled syringes (4 boxes/month)
Tosymra nasal spray	10mg	6 units per month

PDL links

CO: https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html

HI: https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html

MD: https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html

NJ: https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html

NY/NY EPP: https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-cp-pharmacy.html

PA CHIP: https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP

RI: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

3 . Revision History

Date	Notes
8/27/2024	Copy core

Truqap

Prior Authorization Guideline

Guideline ID	GL-146681
Guideline Name	Truqap
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Truqap	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRUQAP	CAPIVASERTIB TAB 160 MG	21530320000320	Brand
TRUQAP	CAPIVASERTIB TAB 200 MG	21530320000325	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Disease is ONE of the following:

- Locally advanced
- Metastatic

AND

3 - Disease is hormone receptor (HR)-positive

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - Presence of one or more PIK3CA/AKT1/PTEN-alterations

AND

6 - ONE of the following:

6.1 Has progressed on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen)

OR

6.2 Recurrence on or within 12 months of completing adjuvant therapy

AND

7 - Used in combination with fulvestrant

Product Name: Truqap	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRUQAP	CAPIVASERTIB TAB 160 MG	21530320000320	Brand
TRUQAP	CAPIVASERTIB TAB 200 MG	21530320000325	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Truqap therapy

AND

2 - Used in combination with fulvestrant

Product Name: Truqap	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRUQAP	CAPIVASERTIB TAB 160 MG	21530320000320	Brand

TRUQAP	CAPIVASERTIB TAB 200 MG	21530320000325	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Truqap	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRUQAP	CAPIVASERTIB TAB 160 MG	21530320000320	Brand
TRUQAP	CAPIVASERTIB TAB 200 MG	21530320000325	Brand

Approval Criteria

1 - Documentation of positive clinical response to Truqap therapy

Tryvio

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154415
Guideline Name	Tryvio
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	9/5/2024

1 . Criteria

Product Name: Tryvio	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRYVIO	APROCITENTAN TAB 12.5 MG	36180010000320	Brand

Approval Criteria

1 - Diagnosis of resistant hypertension

AND

2 - One of the following:

2.1 Systolic blood pressure greater than or equal to 130 mm Hg (millimeters of mercury) on two consecutive measurements

OR

2.2 Diastolic blood pressure greater than or equal to 80 mm Hg on two consecutive measurements

AND

3 - Patient is receiving concomitant therapy with all of the following confirmed by claims history or submitted medical records:

3.1 Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]

AND

3.2 Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)

AND

3.3 Maximally tolerated diuretics (e.g., hydrochlorothiazide)

AND

4 - One of the following:

4.1 Patient is receiving concomitant therapy with a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] confirmed by claims history or submitted medical records

OR

4.2 Patient has a contraindication, or intolerance to mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

AND

5 - One of the following:

5.1 Patient is receiving concomitant therapy with a beta-blocker (e.g., labetalol, carvedilol) confirmed by claims history or submitted medical records

OR

5.2 Patient has a contraindication, or intolerance to beta-blockers (e.g., labetalol, carvedilol) (please specify intolerance or contraindication)

AND

6 - Prescribed by or in consultation with a cardiologist

Product Name: Tryvio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TRYVIO	APROCITENTAN TAB 12.5 MG	36180010000320	Brand

Approval Criteria

1 - Documentation the patient is receiving clinical benefit to Tryvio therapy

AND

2 - Patient is receiving concomitant therapy with all of the following confirmed by claims history or submitted medical records:

2.1 Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]

AND

2.2 Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)

AND

2.3 Maximally tolerated diuretics (e.g., hydrochlorothiazide)

2 . Revision History

Date	Notes
9/5/2024	New guideline.

Tukysa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146682
Guideline Name	Tukysa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tukysa	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUKYSA	TUCATINIB TAB 50 MG	21170080000320	Brand
TUKYSA	TUCATINIB TAB 150 MG	21170080000340	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Disease is ONE of the following:

- Advanced unresectable
- Metastatic

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

4 - Patient has been previously treated with an anti-HER2-based regimen in the metastatic setting [e.g., trastuzumab (Herceptin, Kanjinti), pertuzumab (Perjeta), ado-trastuzumab emtansine (T-DM1)]

AND

5 - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti, Ontruzant) and capecitabine (Xeloda)

Product Name: Tukysa	
Diagnosis	CNS Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUKYSA	TUCATINIB TAB 50 MG	21170080000320	Brand
TUKYSA	TUCATINIB TAB 150 MG	21170080000340	Brand

Approval Criteria

1 - Diagnosis of brain metastases with HER2 (human epidermal growth factor receptor 2) positive breast cancer

AND

2 - Patient has been previously treated with an anti-HER2-based regimen [e.g., trastuzumab (Herceptin, Kanjinti), pertuzumab (Perjeta), ado-trastuzumab emtansine (T-DM1)]

AND

3 - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti, Ontruzant) and capecitabine (Xeloda)

Product Name: Tukysa	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUKYSA	TUCATINIB TAB 50 MG	21170080000320	Brand
TUKYSA	TUCATINIB TAB 150 MG	21170080000340	Brand

Approval Criteria

1 - Diagnosis of unresectable, advanced, or metastatic colorectal cancer [HER2-amplified and RAS (gene) and BRAF (gene) wild-type]

AND

2 - Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

3 - ONE of the following:

3.1 Patient has previously been treated with ONE of the following regimens:

- Fluoropyrimidine-based chemotherapy
- Oxaliplatin-based chemotherapy
- Irinotecan-based chemotherapy

OR

3.2 Patient is not appropriate for intensive therapy

AND

4 - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti)

Product Name: Tukysa	
Diagnosis	Breast Cancer, CNS Cancers, Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUKYSA	TUCATINIB TAB 50 MG	21170080000320	Brand
TUKYSA	TUCATINIB TAB 150 MG	21170080000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tukysa therapy

Product Name: Tukysa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUKYSA	TUCATINIB TAB 50 MG	21170080000320	Brand
TUKYSA	TUCATINIB TAB 150 MG	21170080000340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Tukysa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TUKYSA	TUCATINIB TAB 50 MG	21170080000320	Brand
TUKYSA	TUCATINIB TAB 150 MG	21170080000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tukysa therapy

Turalio

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146683
Guideline Name	Turalio
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Turalio	
Diagnosis	Tenosynovial Giant Cell Tumor (TGCT)/Pigmented Villonodular Synovitis (PVNS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TURALIO	PEXIDARTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21533045010120	Brand

Approval Criteria

1 - Patient has a diagnosis of tenosynovial giant cell tumor (TGCT)/pigmented villonodular synovitis (PVNS)

Product Name: Turalio	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TURALIO	PEXIDARTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21533045010120	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease
- Rosai-Dorfman Disease

AND

2 - Colony stimulating factor 1 receptor (CSF1R) mutation positive

Product Name: Turalio	
Diagnosis	Tenosynovial Giant Cell Tumor (TGCT)/Pigmented Villonodular Synovitis (PVNS), Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

TURALIO	PEXIDARTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21533045010120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Turalio therapy

Product Name: Turalio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TURALIO	PEXIDARTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21533045010120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Turalio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TURALIO	PEXIDARTINIB HCL CAP 200 MG (BASE EQUIVALENT)	21533045010120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Turalio therapy

Tykerb

Prior Authorization Guideline

Guideline ID	GL-146684
Guideline Name	Tykerb
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic
TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of recurrent or stage IV hormone receptor positive, human epidermal growth factor receptor 2-positive (HER2+) breast cancer

AND

1.2 Used in combination with an aromatase inhibitor [e.g., Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)]

OR

2 - BOTH of the following:

2.1 Diagnosis of recurrent or stage IV HER2+ breast cancer

AND

2.2 Used in combination with ONE of the following:

- Herceptin (trastuzumab)
- Xeloda (capecitabine)

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic

TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of recurrent, central nervous system (CNS) cancer with metastatic lesions

AND

1.2 Tykerb is active against primary (breast) tumor

AND

1.3 Used in combination with Xeloda (capecitabine)

OR

2 - ALL of the following:

2.1 Diagnosis of recurrent intracranial or spinal ependymoma (excluding subependymoma)

AND

2.2 Patient has received previous radiation therapy

AND

2.3 Patient has received ONE of the following:

- Gross total or subtotal resection
- Localized recurrence
- Evidence of metastasis (brain, spine, or cerebral spinal fluid)

AND

2.4 Used in combination with Temodar (temozolomide)

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic
TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - Diagnosis of epidermal growth factor receptor (EGFR)-positive, recurrent chordoma

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	Colon Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic
TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - Diagnosis of unresectable, advanced, or metastatic colon cancer [human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild type]

AND

2 - Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

AND

3 - ONE of the following:

3.1 Patient has previously been treated with ONE of the following regimens:

- Oxaliplatin-based therapy without irinotecan
- Irinotecan-based therapy without oxaliplatin
- FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen
- A fluoropyrimidine without irinotecan or oxaliplatin

OR

3.2 Patient is not appropriate for intensive therapy

AND

4 - Used in combination with trastuzumab

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	Rectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic
TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - Diagnosis of unresectable, advanced, or metastatic rectal cancer [human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild type]

AND

2 - Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

AND

3 - Used in combination with trastuzumab

AND

4 - ONE of the following:

4.1 Patient has previously been treated with ONE of the following regimens:

- Oxaliplatin-based therapy without irinotecan
- Irinotecan-based therapy without oxaliplatin
- FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen
- A fluoropyrimidine without irinotecan or oxaliplatin

OR

4.2 Patient is not appropriate for intensive therapy

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	Breast Cancer, Central Nervous System (CNS) Cancers, Chordoma, Colon Cancer, Rectal Cancer

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic
TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tykerb therapy

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic
TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Tykerb, generic lapatinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Generic
TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21533026100320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Tykerb therapy

Tymlos

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146685
Guideline Name	Tymlos
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Tymlos			
Approval Length	24 Months*		
Guideline Type	Prior Authorization		

Product Name	Generic Name	GPI	Brand/Generic
TYMLOS	ABALOPARATIDE SUBCUTANEOUS SOLN PEN-INJECTOR 3120 MCG/1.56ML	3004400500D230	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Patient is female
- Diagnosis of postmenopausal osteoporosis

OR

1.2 BOTH of the following:

- Patient is male
- Diagnosis of osteoporosis

AND

2 - ONE of the following:

2.1 Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than -3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%)]

OR

2.2 Patient has a history of failure, intolerance, or contraindication to other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate)

AND

3 - Treatment duration has not exceeded a total of 24 months* of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime

Notes	*Duration of coverage will be limited to 24 months of cumulative parat hyroid hormone analog therapy (e.g., Teriparatide Injection, Forteo, T ymlos) in the patient's lifetime.

Upneeq

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146431
Guideline Name	Upneeq
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Upneeq	
Diagnosis	Acquired Blepharoptosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
UPNEEQ	OXYMETAZOLINE HCL OPHTH SOLN 0.1%	86802236102020	Brand

Approval Criteria

1 - Diagnosis of acquired blepharoptosis

AND

2 - Patient has a functional impairment related to the position of the eyelid

AND

3 - ONE of the following:

3.1 Marginal reflex distance-1 (MRD-1) is less than or equal to 2 millimeters (mm) in primary gaze

OR

3.2 Marginal reflex distance-1 (MRD-1) is less than or equal to 2 mm in down gaze

OR

3.3 Superior visual field loss of at least 12 degrees or 24 percent

AND

4 - Other treatable causes of blepharoptosis have been ruled out (e.g., recent botulinum toxin injections, myasthenia gravis)

Product Name: Upneeq	
Diagnosis	Acquired Blepharoptosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

UPNEEQ	OXYMETAZOLINE HCL OPHTH SOLN 0.1%	86802236102020	Brand

Approval Criteria

1 - Documentation of a positive clinical response to therapy

Valchlor

Prior Authorization Guideline

Guideline ID	GL-146686
Guideline Name	Valchlor
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Valchlor	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALCHLOR	MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT)	90371050204030	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Chronic or smoldering T-cell leukemia/lymphoma
- Primary cutaneous marginal zone or follicle center B-cell lymphoma
- Lymphomatoid papulosis (LyP) with extensive lesions
- Mycosis fungoides (MF)/Sezary syndrome (SS)

Product Name: Valchlor	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALCHLOR	MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT)	90371050204030	Brand

Approval Criteria

1 - Diagnosis of Langerhans Cell Histiocytosis (LCH)

AND

2 - Skin disease is unifocal and isolated

Product Name: Valchlor	
Diagnosis	Primary Cutaneous Lymphomas, Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

VALCHLOR	MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT)	90371050204030	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Valchlor

Product Name: Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALCHLOR	MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT)	90371050204030	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VALCHLOR	MECHLORETHAMINE HCL GEL 0.016% (BASE EQUIVALENT)	90371050204030	Brand

Approval Criteria

1 - Documentation of positive clinical response to Valchlor therapy

Vanflyta

Prior Authorization Guideline

Guideline ID	GL-146687
Guideline Name	Vanflyta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vanflyta	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG	21533047100320	Brand
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG	21533047100325	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - Disease is FLT3 internal tandem duplication (ITD) positive

AND

3 - Vanflyta will be used in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy

Product Name: Vanflyta	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG	21533047100320	Brand
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG	21533047100325	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Vanflyta therapy

Product Name: Vanflyta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG	21533047100320	Brand
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG	21533047100325	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Vanflyta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 17.7 MG	21533047100320	Brand
VANFLYTA	QUIZARTINIB DIHYDROCHLORIDE TAB 26.5 MG	21533047100325	Brand

Approval Criteria

1 - Documentation of positive clinical response to Vanflyta therapy

Vecamyl

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146688
Guideline Name	Vecamyl
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vecamyl	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VECAMYL	MECAMYLAMINE HCL TAB 2.5 MG	36600020100310	Brand

Approval Criteria

1 - Diagnosis of moderately severe to severe essential hypertension

OR

2 - Diagnosis of uncomplicated malignant hypertension

Product Name: Vecamyl	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VECAMYL	MECAMYLAMINE HCL TAB 2.5 MG	36600020100310	Brand

Approval Criteria

1 - Documentation of a positive clinical response to Vecamyl therapy

Velsipity

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148559
Guideline Name	Velsipity
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Velsipity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VELSIPITY	ETRASIMOD ARGININE TAB 2 MG	52504525100350	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - ONE of the following:

2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

3 - ONE of the following:

3.1 Failure to one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

AND

4 - Patient is NOT receiving Velsipity in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

5 - Prescribed by or in consultation with a gastroenterologist

Notes	*For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Velsipity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VELSIPITY	ETRASIMOD ARGININE TAB 2 MG	52504525100350	Brand

Approval Criteria

1 - Documentation of positive clinical response to Velsipity therapy

AND

2 - Patient is NOT receiving Velsipity in combination with any of the following:

- Biologic disease-modifying antirheumatic drug (DMARD) [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

2 . Background

Benefit/Coverage/Program Information
PDL link

NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
6/17/2024	New program.

Vemlidy

Prior Authorization Guideline

Guideline ID	GL-146689
Guideline Name	Vemlidy
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vemlidy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VEMLIDY	TENOFOVIR ALAFENAMIDE FUMARATE TAB 25 MG	12352083200320	Brand

Approval Criteria

1 - ONE of the following:

1.1 Failure to entecavir (generic Baraclude) as confirmed by claims history or submission of medical records

OR

1.2 History of contraindication or intolerance to entecavir (generic Baraclude) (please specify contraindication or intolerance)

OR

1.3 Patient is not a suitable candidate for entecavir (generic Baraclude)

AND

2 - ONE of the following:

2.1 Failure to tenofovir disoproxil fumarate (generic Viread) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to tenofovir disoproxil fumarate (generic Viread) (please specify contraindication or intolerance)

OR

2.3 Patient has an estimated glomerular filtration rate below 90 mL/min (milliliters/minute)

OR

2.4 Patient has a diagnosis of osteopenia as defined by a BMD (bone mineral density) T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from one of the following with evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan [Provider must submit patient specific BMD T-scores]:

- Lumbar spine (at least two vertebral bodies)
- Hip (femoral neck, total hip)
- Radius (one-third radius site)

OR

2.5 Patient has a diagnosis of osteoporosis as defined by a BMD T-score less than or equal to -2.5 based on BMD measurements from one of the following [Provider must submit patient specific BMD T-score]:

- Lumbar spine (at least two vertebral bodies)
- Hip (femoral neck, total hip)
- Radius (one-third radius site)

OR

2.6 Patient has a prior low-trauma or non-traumatic fracture

OR

2.7 Patient is less than 20 years of age

Venclexta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-149599
Guideline Name	Venclexta
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/5/2024

1 . Criteria

Product Name: Venclexta	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand

VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)

Product Name: Venclexta	
Diagnosis	Mantle Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of mantle cell lymphoma (MCL)

AND

2 - Not used as first line therapy

Product Name: Venclexta	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of newly-diagnosed acute myeloid leukemia (AML)

AND

1.2 ONE of the following:

1.2.1 Used as treatment induction in candidates for intensive induction therapy

OR

1.2.2 Used as treatment induction in candidates for lower-intensity induction therapy

OR

1.2.3 Used as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen

OR

1.2.4 Used as consolidation therapy as continuation of lower-intensity regimen used for induction

AND

1.3 Used in combination with decitabine, azacitidine, or low-dose cytarabine

OR

2 - ALL of the following:

2.1 Diagnosis of relapsed/refractory acute myeloid leukemia (AML)

AND

2.2 Used as a component of repeating the initial successful induction regimen

AND

2.3 Greater than or equal to 12 months since induction regimen if not administered continuously

AND

2.4 Therapy was not stopped due to development of clinical resistance

OR

3 - ALL of the following:

3.1 Diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) - acute myeloid leukemia (AML)

AND

3.2 Considered systemic disease and therapy is given as palliative intent

AND

3.3 Patient has low performance and/or nutritional status (i.e., serum albumin less than 3.2 g/dL [grams/deciliter]; not a candidate for intensive remission therapy or Elzonris)

AND

3.4 Venclexta therapy to be given in combination with azacitidine, decitabine, or low-dose cytarabine

Product Name: Venclexta	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of relapsed or progressive multiple myeloma which has been previously treated

AND

2 - Patient has t(11;14) translocation

AND

3 - Venclexta therapy to be given in combination with dexamethasone

Product Name: Venclexta	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of relapsed/refractory T-cell acute lymphoblastic leukemia (T-ALL)

AND

2 - Venclexta therapy to be given in combination with ONE of the following:

- Decitabine
- Hyper-CVAD
- Nelarabine
- Mini hyper-CVD

Product Name: Venclexta

Diagnosis	Chronic Myelomonocytic Leukemia (CMML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of chronic myelomonocytic leukemia (CMML)

AND

2 - Classified as CMML-2 (less than 20% bone marrow blasts or blast equivalents)

AND

3 - Venclexta therapy to be given in combination with azacitidine or decitabine

Product Name: Venclexta	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of hairy cell leukemia

AND

2 - Disease is progressive after relapsed/refractory therapy

AND

3 - Disease is resistant to BRAF inhibitor therapy (i.e., Zelboraf, Tafinlar)

Product Name: Venclexta	
Diagnosis	Accelerated/Blast Phase Myeloproliferative Neoplasm
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of accelerated/blast phase myeloproliferative neoplasm

AND

2 - Used for management of disease progression of myeloproliferative neoplasm

AND

3 - Venclexta therapy to be given in combination with azacitidine or decitabine

Product Name: Venclexta	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of relapsed/refractory systemic light chain amyloidosis

AND

2 - Patient has t(11;14) translocation

Product Name: Venclexta	
Diagnosis	Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Diagnosis of Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma which has been previously treated

Product Name: Venclexta	
Diagnosis	All Indications except NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Venclexta therapy

Product Name: Venclexta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Venclexta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VENCLEXTA STARTING PACK	VENETOCLAX TAB THERAPY STARTER PACK 10 & 50 & 100 MG	2147008000B720	Brand
VENCLEXTA	VENETOCLAX TAB 10 MG	21470080000320	Brand
VENCLEXTA	VENETOCLAX TAB 50 MG	21470080000340	Brand
VENCLEXTA	VENETOCLAX TAB 100 MG	21470080000360	Brand

Approval Criteria **1** - Documentation of positive clinical response to Venclexta therapy

2 . Revision History

Date	Notes
7/5/2024	Updated criteria for ALL and AML based on NCCN recommendations . Updated verbiage for MM and NCCN Recommended Regimens. Ad ded criteria for CMML, hairy cell leukemia, and accelerated/blast pha se myeloproliferative neoplasms based on NCCN recommendations.

Veozah

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146433
Guideline Name	Veozah
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Veozah	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VEOZAH	FEZOLINETANT TAB 45 MG	30606030000320	Brand

Approval Criteria

1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause

AND

2 - One of the following:

2.1 Failure (after a 30-day trial) to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

Product Name: Veozah	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VEOZAH	FEZOLINETANT TAB 45 MG	30606030000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline)

Verkazia

Prior Authorization Guideline

Guideline ID	GL-146434
Guideline Name	Verkazia
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Verkazia, Cyclosporine in Klarity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERKAZIA	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand
CYCLOSPORINE IN KLARITY	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand

Approval Criteria

1 - Diagnosis of moderate to severe vernal keratoconjunctivitis

AND

2 - ONE of the following:

2.1 Failure to TWO of the following categories as confirmed by claims history or submission of medical records:

- Ophthalmic antihistamines (e.g., azelastine, olopatadine)
- Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)
- Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone)

OR

2.2 History of intolerance or contraindication to ALL of the following categories (please specify intolerance or contraindication):

- Ophthalmic antihistamines (e.g., azelastine, olopatadine)
- Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)
- Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone)

Product Name: Verkazia, Cyclosporine in Klarity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERKAZIA	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand
CYCLOSPORINE IN KLARITY	CYCLOSPORINE (OPHTH) EMULSION 0.1%	86720020001630	Brand

Approval Criteria

1 - Documentation of positive clinical response

Verquvo

Prior Authorization Guideline

Guideline ID	GL-146436
Guideline Name	Verquvo
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Verquvo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERQUVO	VERICIGUAT TAB 2.5 MG	40900085000321	Brand
VERQUVO	VERICIGUAT TAB 5 MG	40900085000330	Brand
VERQUVO	VERICIGUAT TAB 10 MG	40900085000340	Brand

Approval Criteria

1 - Diagnosis of heart failure

AND

2 - Ejection fraction is less than 45 percent

AND

3 - Heart failure is classified as ONE of the following:

- New York Heart Association Class II
- New York Heart Association Class III
- New York Heart Association Class IV

AND

4 - ONE of the following:

4.1 Hospitalization for heart failure within the past six months

OR

4.2 Outpatient IV (intravenous) diuretics for heart failure within the past three months

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) confirmed by claims history or submission of medical records

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy (please specify intolerance or contraindication)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with one of the following confirmed by claims history or submission of medical records:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., losartan)
- Angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., Entresto)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify intolerance or contraindication)

AND

7 - ONE of the following:

7.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g., spironolactone) confirmed by claims history or submission of medical records

OR

7.2 Patient has a contraindication or intolerance to aldosterone antagonist therapy (please specify intolerance or contraindication)

AND

8 - ONE of the following:

8.1 Patient is on a stabilized dose and receiving concomitant therapy with a sodium-glucose

cotransporter 2 (SGLT2) inhibitor indicated for heart failure (e.g., Farxiga) confirmed by claims history or submission of medical records

OR

8.2 Patient has a contraindication or intolerance to SGLT2 inhibitor therapy (please specify intolerance or contraindication)

AND

9 - Verquvo is prescribed by or in consultation with a cardiologist

Product Name: Verquvo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERQUVO	VERICIGUAT TAB 2.5 MG	40900085000321	Brand
VERQUVO	VERICIGUAT TAB 5 MG	40900085000330	Brand
VERQUVO	VERICIGUAT TAB 10 MG	40900085000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Verzenio

Prior Authorization Guideline

Guideline ID	GL-151148
Guideline Name	Verzenio
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/8/2024

1 . Criteria

Product Name: Verzenio	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Disease is hormone-receptor (HR)-positive

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Disease is advanced, recurrent, or metastatic

AND

4.1.2 ONE of the following:

4.1.2.1 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or Faslodex (fulvestrant)

OR

4.1.2.2 ALL of the following:

- Used as monotherapy
- Patient has disease progression following endocrine therapy
- Patient has already received at least one prior chemotherapy regimen

OR

4.2 BOTH of the following:

4.2.1 Disease is early breast cancer at high risk of recurrence (i.e., greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or both of the following: Grade 3 disease, tumor size greater than or equal to 5 centimeters)

AND

4.2.2 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or tamoxifen

Product Name: Verzenio	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Verzenio therapy

Product Name: Verzenio	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Diagnosis of recurrent or metastatic endometrial cancer

AND

2 - Tumor is estrogen receptor (ER)-positive

AND

3 - Used in combination with letrozole

Product Name: Verzenio	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Verzenio therapy

Product Name: Verzenio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Verzenio will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Verzenio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand

VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Verzenio therapy

2 . Revision History

Date	Notes
8/7/2024	Annual review. Updated background and added clinical criteria for en dometrial carcinoma per NCCN. Updated references.

Verzenio

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146691
Guideline Name	Verzenio
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Verzenio	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Disease is hormone-receptor (HR)-positive

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Disease is advanced, recurrent, or metastatic

AND

4.1.2 ONE of the following:

4.1.2.1 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or Faslodex (fulvestrant)

OR

4.1.2.2 ALL of the following:

- Used as monotherapy
- Patient has disease progression following endocrine therapy
- Patient has already received at least one prior chemotherapy regimen

OR

4.2 BOTH of the following:

4.2.1 Disease is early breast cancer at high risk of recurrence (i.e., greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or both of the following: Grade 3 disease, tumor size greater than or equal to 5 centimeters)

AND

4.2.2 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or tamoxifen

Product Name: Verzenio	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Verzenio therapy

Product Name: Verzenio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Verzenio will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Verzenio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VERZENIO	ABEMACICLIB TAB 50 MG	21531010000305	Brand
VERZENIO	ABEMACICLIB TAB 100 MG	21531010000310	Brand
VERZENIO	ABEMACICLIB TAB 150 MG	21531010000315	Brand
VERZENIO	ABEMACICLIB TAB 200 MG	21531010000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Verzenio therapy

Vijoice

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152575
Guideline Name	Vijoice
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Vijoice tablets, Vijoice granules	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIJOICE	ALPELISIB (PROS) TAB THERAPY PACK 50 MG DAILY DOSE	9948601000B720	Brand
VIJOICE	ALPELISIB (PROS) TAB THERAPY PACK 125 MG DAILY DOSE	9948601000B730	Brand
VIJOICE	ALPELISIB (PROS) PAK 250 MG DAILY DOSE (200 MG & 50 MG TABS)	9948601000B740	Brand
VIJOICE	ALPELISIB (PROS) ORAL GRANULES PACKET 50 MG	99486010003020	Brand

Approval Criteria

1 - Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS)

AND

2 - ONE of the following:

2.1 Confirmed presence of a mutation in the PIK3CA gene

OR

2.2 ONE of the following:

2.2.1 TWO or more of the following spectrum features:

- Overgrowth: adipose, muscle, nerve, skeletal
- Vascular malformations: capillary, venous, arteriovenous, lymphatic
- Epidermal nevus

OR

2.2.2 ONE or more of the following isolated features:

- Large isolated lymphatic malformation
- Isolated macrodactyly or overgrown splayed feet/ hands with overgrown limbs
- Truncal adipose overgrowth
- Hemimegalencephaly (bilateral) / dysplastic megalencephaly / focal cortical dysplasia
- Epidermal nevus
- Seborrheic keratoses
- Benign lichenoid keratoses

AND

3 - Patient is 2 years of age or older

AND

4 - Patient has severe manifestations of PROS requiring systemic therapy

AND

5 - Prescribed by, or in consultation with, a clinical geneticist or a practitioner who has specialized expertise in the management of PROS manifestations

Product Name: Vijoice tablets, Vijoice granules	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIJOICE	ALPELISIB (PROS) TAB THERAPY PACK 50 MG DAILY DOSE	9948601000B720	Brand
VIJOICE	ALPELISIB (PROS) TAB THERAPY PACK 125 MG DAILY DOSE	9948601000B730	Brand
VIJOICE	ALPELISIB (PROS) PAK 250 MG DAILY DOSE (200 MG & 50 MG TABS)	9948601000B740	Brand
VIJOICE	ALPELISIB (PROS) ORAL GRANULES PACKET 50 MG	99486010003020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Vijoice therapy

AND

2 - Prescribed by, or in consultation with, a clinical geneticist or a practitioner who has specialized expertise in the management of PIK3CA-Related Overgrowth Spectrum (PROS) manifestations

2 . Revision History

Date	Notes
8/23/2024	Added new GPI for Vijoice granules formulation. Updated product na me list and GPI table accordingly. Updated initial authorization criteri a. Updated initial authorization duration to 12 months.

Vitrakvi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146693
Guideline Name	Vitrakvi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vitrakvi	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VITRAKVI	LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT)	21533835200120	Brand
VITRAKVI	LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT)	21533835200150	Brand
VITRAKVI	LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT)	21533835202020	Brand

Approval Criteria

1 - Presence of a solid tumor

AND

2 - Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is without a known acquired resistance mutation (e.g., TRKA G595R, G623R, G696A, F617L)

AND

4 - Disease is ONE of the following:

- Metastatic
- Unresectable

Product Name: Vitrakvi	
Diagnosis	Solid tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VITRAKVI	LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT)	21533835200120	Brand
VITRAKVI	LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT)	21533835200150	Brand

VITRAKVI	LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT)	21533835202020	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Vitrakvi therapy

Product Name: Vitrakvi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VITRAKVI	LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT)	21533835200120	Brand
VITRAKVI	LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT)	21533835200150	Brand
VITRAKVI	LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT)	21533835202020	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Vitrakvi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VITRAKVI	LAROTRECTINIB SULFATE CAP 25 MG (BASE EQUIVALENT)	21533835200120	Brand

VITRAKVI	LAROTRECTINIB SULFATE CAP 100 MG (BASE EQUIVALENT)	21533835200150	Brand
VITRAKVI	LAROTRECTINIB SULFATE ORAL SOLN 20 MG/ML (BASE EQUIVALENT)	21533835202020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Vitrakvi therapy

Vivjoa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146437
Guideline Name	Vivjoa
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vivjoa	
Approval Length	4 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIVJOA	OTESECONAZOLE CAP THERAPY PACK 150 MG (12 WEEKS)	1140805000B220	Brand

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis

AND

2 - Patient is not of reproductive potential (i.e., persons who are biological females who are postmenopausal or have another reason for permanent infertility [(e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)]

AND

3 - BOTH of the following:

3.1 Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out

AND

3.2 Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months confirmed by claims history or submission of medical records.

AND

4 - Prescribed by, or in consultation with, one of the following:

- Infectious disease physician
- Obstetrician/Gynecologist

Vizimpro

Prior Authorization Guideline

Guideline ID	GL-146694
Guideline Name	Vizimpro
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vizimpro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIZIMPRO	DACOMITINIB TAB 15 MG	21360019000320	Brand
VIZIMPRO	DACOMITINIB TAB 30 MG	21360019000330	Brand
VIZIMPRO	DACOMITINIB TAB 45 MG	21360019000340	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is recurrent, advanced, or metastatic

AND

3 - Disease is positive for ONE of the following EGFR (epidermal growth factor receptor) mutations:

- Exon 19 deletion
- Exon 21 L858R substitution
- S768I
- L861Q
- G719X

Product Name: Vizimpro	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIZIMPRO	DACOMITINIB TAB 15 MG	21360019000320	Brand
VIZIMPRO	DACOMITINIB TAB 30 MG	21360019000330	Brand
VIZIMPRO	DACOMITINIB TAB 45 MG	21360019000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Vizimpro therapy

Product Name: Vizimpro	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIZIMPRO	DACOMITINIB TAB 15 MG	21360019000320	Brand
VIZIMPRO	DACOMITINIB TAB 30 MG	21360019000330	Brand
VIZIMPRO	DACOMITINIB TAB 45 MG	21360019000340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Vizimpro	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VIZIMPRO	DACOMITINIB TAB 15 MG	21360019000320	Brand
VIZIMPRO	DACOMITINIB TAB 30 MG	21360019000330	Brand
VIZIMPRO	DACOMITINIB TAB 45 MG	21360019000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Vizimpro therapy

Vonjo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-154898
Guideline Name	Vonjo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Vonjo	
Diagnosis	Myelofibrosis (MF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VONJO	PACRITINIB CITRATE CAP 100 MG	21537550100120	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis
- Accelerated/blast phase myeloproliferative neoplasm

AND

2 - One of the following:

2.1 BOTH of the following:

2.1.1 Patient has symptomatic lower-risk myelofibrosis

AND

2.1.2 Patient has a platelet count less than 50 x 10^9/L

OR

2.2 All of the following:

2.2.1 Patient has higher-risk myelofibrosis

AND

2.2.2 Patient is not a transplant candidate or transplant not currently feasible

AND

2.2.3 One of the following:

2.2.3.1 Patient has a platelet count less than 50 x 10^9/L

OR

2.2.3.2 Both of the following:

2.2.3.2.1 Patient has symptomatic splenomegaly and/or constitutional symptoms

AND

2.2.3.2.2 Patient has a platelet count greater than or equal to 50 x 10^9/L

OR

2.3 Used for treatment of myelofibrosis-associated anemia

OR

2.4 Used for splenomegaly and other disease-related symptoms in one of the following:

2.4.1 Continued near the start of conditioning therapy of transplant candidates

OR

2.4.2 Palliation in combination with hypomethylating agents (azacitidine or decitabine) as bridging therapy prior to transplant, or if not a candidate for transplant

Product Name: Vonjo	
Diagnosis	Myelofibrosis (MF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VONJO	PACRITINIB CITRATE CAP 100 MG	21537550100120	Brand

Approval Criteria

1 - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Vonjo

Product Name: Vonjo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VONJO	PACRITINIB CITRATE CAP 100 MG	21537550100120	Brand

Approval Criteria

1 - Vonjo will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Vonjo	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VONJO	PACRITINIB CITRATE CAP 100 MG	21537550100120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Vonjo therapy

Votrient

Prior Authorization Guideline

Guideline ID	GL-146696
Guideline Name	Votrient
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Renal Cell Carcinoma (RCC)/Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - BOTH of the following

1.1 Diagnosis of renal cell carcinoma (RCC)

AND

1.2 ONE of the following:

- Disease has relapsed
- Stage IV disease
- Disease is advanced

OR

2 - Diagnosis of von Hippel-Lindau (VHL)-associated renal cell carcinoma

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Soft Tissue Sarcoma (STS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Angiosarcoma
- Alveolar soft part sarcoma
- Pleomorphic rhabdomyosarcoma
- Retroperitoneal/intra-abdominal disease that is unresectable, stage IV, or postoperative treatment for residual disease

- Soft tissue sarcoma of the extremity/superficial trunk or head/neck with disease that is stage IV or recurrent and has disseminated metastases
- Solitary fibrous tumor/hemangiopericytoma
- Desmoid tumors (aggressive fibromatosis)
- Dermatofibrosarcoma Protuberans (DFSP) with Fibrosarcomatous Transformation
- Dedifferentiated Chordoma

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - All of the following:

1.1 Diagnosis of one of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

1.2 One of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.3 One of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.4 One of the following:

- Disease is refractory to radioactive iodine treatment
- Distant metastatic disease not amenable to radioactive iodine treatment

OR

2 - All of the following:

2.1 Diagnosis of medullary carcinoma

AND

2.2 One of the following:

- Disease is progressive
- Disease is symptomatic with distant metastases

AND

2.3 One of the following:

2.3.1 Failure to ONE of the following, as confirmed by claims history or submission of medical records:

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

OR

2.3.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Diagnosis of uterine sarcoma

AND

2 - One of the following:

- Disease is advanced
- Disease is recurrent/metastatic
- Disease is inoperable

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - ONE of the following:

- Disease is persistent
- Disease is recurrent

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Chondrosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Diagnosis of chondrosarcoma

AND

2 - Disease is metastatic and widespread

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Diagnosis of Gastrointestinal Stromal Tumors (GIST)

AND

2 - Disease is unresectable, progressive, or metastatic

AND

3 - One of the following:

3.1 Used as first-line therapy in SDH-deficient GIST

OR

3.2 Used after progression on ALL of the following:

- Imatinib (generic Gleevac)
- Sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Standard dose Qinlock (ripretinib)

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Diagnosis of Merkel Cell Carcinoma

AND

2 - Disease is M1 disseminated

AND

3 - One of the following:

3.1 Anti-PD-L1 or anti-PD-1 therapy is contraindicated

OR

3.2 Disease has progressed on anti-PD-L1 or anti-PD-1 therapy

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	Renal Cell Carcinoma (RCC)/Kidney Cancer, Soft Tissue Sarcoma (STS), Thyroid Carcinoma, Uterine Sarcoma, Ovarian Cancer, Chondrosarcoma, Gastrointestinal Stromal Tumors (GIST), Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Votrient therapy

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Votrient will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Votrient, generic pazopanib	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Brand
PAZOPANIB HYDROCHLORIDE	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21533042100320	Generic

Approval Criteria

1 - Documentation of positive clinical response to Votrient therapy

Vowst

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146697
Guideline Name	Vowst
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vowst	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOWST	FECAL MICROBIOTA SPORES, LIVE-BRPK CAPS	52522020100120	Brand

Approval Criteria

1 - Diagnosis of recurrent Clostridioides difficile infection (rCDI) as defined by BOTH of the following:

1.1 Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days

AND

1.2 A positive stool test for Clostridioides difficile toxin

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had one or more recurrences of CDI following an initial episode of CDI

AND

4 - Patient has completed at least 10 days of ONE of the following antibiotic therapies for rCDI 2 to 4 days prior to initiating Vowst as confirmed by claims history or submission of medical records:

- Oral vancomycin
- Dificid (fidaxomicin)

AND

5 - Previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days]

AND

6 - Patient will drink magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst

AND

7 - Prescribed by or in consultation with one of the following:

- Gastroenterologist
- Infectious disease specialist

Voxzogo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146698
Guideline Name	Voxzogo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Voxzogo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOXZOGO	VOSORITIDE FOR SUBCUTANEOUS INJ 0.4 MG	30950080002120	Brand
VOXZOGO	VOSORITIDE FOR SUBCUTANEOUS INJ 0.56 MG	30950080002130	Brand
VOXZOGO	VOSORITIDE FOR SUBCUTANEOUS INJ 1.2 MG	30950080002140	Brand

Approval Criteria

1 - Patient is less than 18 years of age

AND

2 - Diagnosis of achondroplasia as confirmed by ONE of the following:

2.1 Submission of medical records documenting BOTH of the following:

2.1.1 Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis)

AND

2.1.2 Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest)

OR

2.2 Submission of medical records documenting molecular genetic testing confirmed c.1138G > A or c.1138G > C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene

AND

3 - Patient has open epiphyses

AND

4 - BOTH of the following:

4.1 Patient has not had limb-lengthening surgery in the previous 18 months

AND

4.2 Patient does not plan to have limb-lengthening surgery while on Voxzogo

AND

5 - Prescribed by ONE of the following:

- Clinical geneticist
- Endocrinologist
- A practitioner who has specialized expertise in the management of achondroplasia

Product Name: Voxzogo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOXZOGO	VOSORITIDE FOR SUBCUTANEOUS INJ 0.4 MG	30950080002120	Brand
VOXZOGO	VOSORITIDE FOR SUBCUTANEOUS INJ 0.56 MG	30950080002130	Brand
VOXZOGO	VOSORITIDE FOR SUBCUTANEOUS INJ 1.2 MG	30950080002140	Brand

Approval Criteria

1 - Documentation of positive clinical response to Voxzogo therapy [e.g., improvement in annualized growth velocity (AGV) compared to baseline]

AND

2 - Patient continues to have open epiphyses

AND

3 - Patient does not plan to have limb-lengthening surgery while on Voxzogo

AND

4 - Prescribed by or in consultation with ONE of the following:

- Clinical geneticist
- Endocrinologist
- A practitioner who has specialized expertise in the management of achondroplasia

Voydeya

Prior Authorization Guideline

Guideline ID	GL-150928
Guideline Name	Voydeya
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/5/2024

1 . Criteria

Product Name: Voydeya	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOYDEYA	DANICOPAN TAB THERAPY PACK 50 MG & 100 MG	8580852000B720	Brand
VOYDEYA	DANICOPAN TAB 100 MG	85808520000320	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by both of the following:

1.1 Flow cytometry analysis confirming presence of PNH clones

AND

1.2 Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

2 - All of the following:

2.1 Patient is currently receiving complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)

AND

2.2 Patient is experiencing extravascular hemolysis (EVH) while on complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)

AND

2.3 Patient will continue to receive complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)

AND

3 - Patient is not receiving Voydeya in combination with a complement protein C3 inhibitor [e.g., Empaveli (Pegcetacoplan)] or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)] used for the treatment of PNH

AND

4 - Prescribed by, or in consultation with one of the following:

- Hematologist
- Oncologist

Product Name: Voydeya	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VOYDEYA	DANICOPAN TAB THERAPY PACK 50 MG & 100 MG	8580852000B720	Brand
VOYDEYA	DANICOPAN TAB 100 MG	85808520000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Voydeya therapy [e.g., decrease in extravascular hemolysis (EVH), increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, etc.)]

AND

2 - Patient continues to receive Voydeya in combination with complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab) for PNH

AND

3 - Patient is not receiving Voydeya in combination with a complement protein C3 inhibitor [e.g., Empaveli (Pegcetacoplan)] or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)] used for the treatment of PNH

AND

4 - Prescribed by, or in consultation with one of the following:

- Hematologist
- Oncologist

Vtama

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146438
Guideline Name	Vtama
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vtama	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VTAMA	TAPINAROF CREAM 1%	90250075003720	Brand

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - ONE of the following:

2.1 Failure to a minimum duration of a 4-week trial to TWO of the following topical therapies as confirmed by claims history or submission of medical records:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

3 - Patient is NOT receiving Vtama in combination with any a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, a dermatologist

Product Name: Vtama

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VTAMA	TAPINAROF CREAM 1%	90250075003720	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is NOT receiving Vtama in combination with a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Vyndaqel and Vyndamax

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146699
Guideline Name	Vyndaqel and Vyndamax
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Vyndaqel, Vyndamax	
Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VYNDAQEL	TAFAMIDIS MEGLUMINE (CARDIAC) CAP 20 MG	40550080200120	Brand
VYNDAMAX	TAFAMIDIS CAP 61 MG	40550080000120	Brand

Approval Criteria

1 - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)

AND

2 - ONE of the following:

2.1 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

OR

2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of ATTR amyloid deposits

OR

2.3 ALL of the following

2.3.1 Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis

AND

2.3.2 Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*

AND

2.3.3 Absence of monoclonal protein identified in serum, urine immunofixation (IFE), serum free light chain (sFLC) assay

AND

3 - Prescribed by, or in consultation, with a cardiologist

AND

4 - Presence of clinical signs and symptoms of cardiomyopathy (e.g., heart failure, dyspnea, edema, hepatomegaly, ascites, angina, etc.)

AND

5 - Documentation of BOTH of the following:

5.1 ONE of the following:

5.1.1 Patient has New York Heart Association (NYHA) Functional Class I or II heart failure

OR

5.1.2 BOTH of the following:

5.1.2.1 Patient has New York Heart Association (NYHA) Functional Class III heart failure

AND

5.1.2.2 Patient's cardiopulmonary functional status allows patient to ambulate 100 meters or greater in six minutes or less

AND

5.2 Patient has an N-terminal pro-B-type naturetic peptide (NT-proBNP) level greater than or equal to 600 picograms/milliliter

AND

6 - One of the following:

6.1 Patient is not receiving Vyndaqel or Vyndamax in combination with either of the following:

- Onpattro (patisiran)
- Tegsedi (inotersen)

OR

6.2 If the patient is receiving Vyndaqel/Vyndamax in combination with Onpattro (patisiran) or Tegsedi (inotersen), the physician attests that he/she will coordinate care with other specialist(s) involved in the patient's amyloidosis treatment plan to determine optimal long term monotherapy** treatment regimen

Notes	NOTE: *May require prior authorization and notification ** Referring to monotherapy with Vyndaqel/Vyndamax, Onpattro, or T egsedi

Product Name: Vyndaqel, Vyndamax	
Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
VYNDAQEL	TAFAMIDIS MEGLUMINE (CARDIAC) CAP 20 MG	40550080200120	Brand
VYNDAMAX	TAFAMIDIS CAP 61 MG	40550080000120	Brand

Approval Criteria

1 - Documentation that the patient has experienced a positive clinical response to Vyndaqel or Vyndamax (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)

AND

2 - Prescribed by or in consultation with a cardiologist

AND

3 - Documentation that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Patient is not receiving Vyndaqel or Vyndamax in combination with either of the following:

- Onpattro (patisiran)
- Tegsedi (inotersen)

Wainua

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146700
Guideline Name	Wainua
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Wainua	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WAINUA	EPLONTERSEN SODIUM SUBCUTANEOUS SOLN AUTO-INJ 45 MG/0.8ML	6270102510D520	Brand

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy

AND

1.2 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Documentation of ONE of the following:

- Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb
- Patient has a baseline familial amyloidotic polyneuropathy (FAP) Stage 1 or 2
- Patient has a baseline neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130

AND

4 - Patient has NOT had a liver transplant

AND

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

AND

6 - Patient is NOT receiving Wainua in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran), Tegsedi (inotersen)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Product Name: Wainua	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WAINUA	EPLONTERSEN SODIUM SUBCUTANEOUS SOLN AUTO-INJ 45 MG/0.8ML	6270102510D520	Brand

Approval Criteria

1 - Documentation that the patient has experienced a positive clinical response to Wainua therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.)

AND

2 - Patient is NOT receiving Wainua in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran), Tegsedi (inotersen)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Wakix

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146701
Guideline Name	Wakix
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Wakix	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WAKIX	PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT)	61450070100318	Brand
WAKIX	PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT)	61450070100338	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a MSLT (Multiple Sleep Latency Test) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - One of the following:

3.1 Failure to ALL of the following, as confirmed by claims history or submission of medical records:

- An amphetamine-based stimulant (e.g., amphetamine, dextroamphetamine) OR a methylphenidate-based stimulant
- Armodafinil (generic Nuvigil) OR modafinil (generic Provigil)
- Sunosi (solriamfetol)

OR

3.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- An amphetamine-based stimulant (e.g., amphetamine, dextroamphetamine) OR a methylphenidate-based stimulant
- Armodafinil (generic Nuvigil) OR modafinil (generic Provigil)
- Sunosi (solriamfetol)

OR

3.3 Patient has a history of or potential for a substance abuse disorder

AND

4 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Psychiatrist
- Pulmonologist
- Sleep Medicine Specialist

Product Name: Wakix	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WAKIX	PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT)	61450070100318	Brand
WAKIX	PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT)	61450070100338	Brand

Approval Criteria

1 - Reduction in symptoms of excessive daytime sleepiness associated with Wakix therapy

Product Name: Wakix

Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WAKIX	PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT)	61450070100318	Brand
WAKIX	PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT)	61450070100338	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a MSLT (Multiple Sleep Latency Test) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Psychiatrist
- Pulmonologist
- Sleep Medicine Specialist

Product Name: Wakix	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WAKIX	PITOLISANT HCL TAB 4.45 MG (BASE EQUIVALENT)	61450070100318	Brand
WAKIX	PITOLISANT HCL TAB 17.8 MG (BASE EQUIVALENT)	61450070100338	Brand

Approval Criteria

1 - Reduction in frequency of cataplexy attacks associated with therapy

OR

2 - Reduction in symptoms of excessive daytime sleepiness associated with therapy

Wegovy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152718
Guideline Name	Wegovy
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Wegovy	
Diagnosis	Reduction of risk of major adverse cardiovascular events
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML	6125207000D520	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML	6125207000D525	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML	6125207000D530	Brand

WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML	6125207000D535	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML	6125207000D540	Brand

Approval Criteria

1 - Treatment is being requested to reduce the risk of major adverse cardiovascular events

AND

2 - Patient is 45 years of age or older

AND

3 - Submission of medical records documenting all the following:

3.1 BMI (body mass index) greater than or equal to 27 kg/m2 (kilograms per square meter)

AND

3.2 Established cardiovascular disease as evidenced by one of the following:

3.2.1 Prior myocardial infarction (MI)

OR

3.2.2 Prior ischemic or hemorrhagic stroke

OR

3.2.3 Symptomatic peripheral arterial disease (PAD) evidenced by one of the following:

- Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest)
- Peripheral arterial revascularization procedure

- Amputation due to atherosclerotic disease

AND

4 - Used in combination with a reduced calorie diet and increased physical activity

AND

5 - One of the following:

5.1 For patients with history of MI, one of the following:

5.1.1 Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records):

- Cholesterol lowering medication (e.g., statin, PCSK9i)
- Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)
- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.1.2 Patient has a history of intolerance or contraindication to all of the following therapeutic classes (please specify intolerance or contraindication):

- Cholesterol lowering medication (e.g., statin, PCSK9i)
- Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)
- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.2 For patients with history of ischemic or hemorrhagic stroke, or symptomatic PAD, one of the following:

5.2.1 Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records):

- Cholesterol lowering medication (e.g., statin, PCSK9i)

- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.2.2 Patient has a history of intolerance or contraindication to all of the following therapeutic classes (please specify intolerance or contraindication):

- Cholesterol lowering medication (e.g., statin, PCSK9i)
- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

AND

6 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

7 - Patient does NOT have New York Heart Association class IV heart failure

Product Name: Wegovy	
Diagnosis	Reduction of risk of major adverse cardiovascular events
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML	6125207000D520	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML	6125207000D525	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML	6125207000D530	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML	6125207000D535	Brand

WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML	6125207000D540	Brand

Approval Criteria

1 - BMI (body mass index) greater than or equal to 27 kg/m2 (kilograms per square meter)

AND

2 - Used in combination with a reduced calorie diet and increased physical activity

AND

3 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

4 - Patient does NOT have New York Heart Association class IV heart failure

Product Name: Wegovy	
Diagnosis	Weight Loss
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.25 MG/0.5ML	6125207000D520	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 0.5 MG/0.5ML	6125207000D525	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1 MG/0.5ML	6125207000D530	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 1.7 MG/0.75ML	6125207000D535	Brand
WEGOVY	SEMAGLUTIDE (WEIGHT MNGMT) SOLN AUTO-INJECTOR 2.4 MG/0.75ML	6125207000D540	Brand

Approval Criteria

1 - Wegovy when used solely for the treatment of weight loss is excluded and is to be denied as a benefit exclusion

2 . Revision History

Date	Notes
8/27/2024	New guideline

Welireg

Prior Authorization Guideline

Guideline ID	GL-155269
Guideline Name	Welireg
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Welireg	
Diagnosis	Von Hippel-Lindau (VHL) Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WELIREG	BELZUTIFAN TAB 40 MG	21421020000320	Brand

Approval Criteria

1 - Diagnosis of von Hippel-Lindau (VHL) disease

AND

2 - Patient requires therapy for ONE of the following:

- Renal cell carcinoma (RCC)
- Central nervous system (CNS) hemangioblastoma
- Pancreatic neuroendocrine tumor (pNET)

AND

3 - Patient does not require immediate surgery

Product Name: Welireg	
Diagnosis	Advanced Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WELIREG	BELZUTIFAN TAB 40 MG	21421020000320	Brand

Approval Criteria

1 - Diagnosis of advanced renal cell carcinoma (RCC)

AND

2 - Disease has progressed after treatment with BOTH of the following:

2.1 Programmed death receptor 1 (PD-1) or programmed death ligand 1 (PD-L1) checkpoint inhibitor [e.g., Keytruda (pembrolizumab), Opdivo (nivolumab)]

AND

2.2 Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) [e.g., Cabometyx (cabozantinib), Inlyta (axitinib), Lenvima (lenvatinib)]

Product Name: Welireg	
Diagnosis	Von Hippel-Lindau (VHL) Disease, Advanced Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WELIREG	BELZUTIFAN TAB 40 MG	21421020000320	Brand

Approval Criteria

1 - Patient does not show evidence of disease progression while on Welireg

Product Name: Welireg	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WELIREG	BELZUTIFAN TAB 40 MG	21421020000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Welireg	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WELIREG	BELZUTIFAN TAB 40 MG	21421020000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Welireg therapy

2 . Revision History

Date	Notes
9/19/2024	Updated examples of PD-L1 checkpoint inhibitors and VEGF-TKIs wi thin advanced RCC criteria.

Winrevair

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152475
Guideline Name	Winrevair
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Winrevair	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 45 MG	40110070206420	Brand
WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 60 MG	40110070206425	Brand
WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 45 MG	40110070206430	Brand

WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 60 MG	40110070206435	Brand

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of pulmonary arterial hypertension (PAH)

AND

1.1.2 PAH has been confirmed by right heart catheterization

AND

1.1.3 Prescriber attestation that other types of pulmonary hypertension (PH) are excluded as a diagnosis

AND

1.1.4 Pulmonary arterial hypertension is symptomatic

OR

1.2 Both of the following:

1.2.1 Diagnosis of pulmonary arterial hypertension

AND

1.2.2 Patient is currently on Winrevair therapy as documented by claims history or submission of medical records

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Patient has a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.1.2 Patient is currently taking at least ONE of the following oral therapies:

- Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]
- Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)

OR

2.2 Both of the following:

2.2.1 Patient does not have a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.2.2 Patient is currently taking oral combination therapy with BOTH of the following:

2.2.2.1 Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]

AND

2.2.2.2 One of the following:

- Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)
- Soluble guanylate cyclase stimulator (sGC) [e.g., Adempas (riociguat)]

AND

3 - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist

Product Name: Winrevair	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 45 MG	40110070206420	Brand
WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 60 MG	40110070206425	Brand
WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 45 MG	40110070206430	Brand
WINREVAIR	SOTATERCEPT-CSRK FOR SUBCUTANEOUS SOLN KIT 2 X 60 MG	40110070206435	Brand

Approval Criteria

1 - Documentation of a positive clinical response to Winrevair therapy [e.g., improvement in symptoms of right heart failure, exercise tolerance, six-minute walk distance (6MWD), resting and ambulatory oximetry]

AND

2 - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist

2 . Revision History

Date	Notes
8/21/2024	Copy core

Xalkori

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146703
Guideline Name	Xalkori
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xalkori	
Diagnosis	Inflammatory Myofibroblastic Tumor (IMT)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand

XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation

Product Name: Xalkori	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Recurrent
- Advanced

AND

3 - ONE of the following:

- Tumor is anaplastic lymphoma kinase (ALK)-positive
- Tumor is ROS1-positive
- Tumor is positive for mesenchymal-epithelial transition (MET) amplification
- Tumor is positive for MET exon 14 skipping mutation

Product Name: Xalkori	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

- Tumor is anaplastic lymphoma kinase (ALK)-positive
- Tumor is ROS1-positive

Product Name: Xalkori

Diagnosis	Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Diagnosis of anaplastic large cell lymphoma

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

AND

3 - Disease is relapsed or refractory

Product Name: Xalkori	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand

XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease
- Rosai-Dorfman Disease

AND

2 - Disease is positive for anaplastic lymphoma kinase (ALK) rearrangement

Product Name: Xalkori	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Diagnosis of metastatic or unresectable cutaneous melanoma

AND

2 - Disease is ROS1 gene fusion-positive

AND

3 - Used as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy

Product Name: Xalkori	
Diagnosis	Inflammatory Myofibroblastic Tumor (IMT), Non-Small Cell Lung Cancer (NSCLC), Central Nervous System (CNS) Cancers, Anaplastic Large Cell Lymphoma, Histiocytic Neoplasms, Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Xalkori therapy

Product Name: Xalkori	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Xalkori	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XALKORI	CRIZOTINIB CAP 200 MG	21530517000120	Brand
XALKORI	CRIZOTINIB CAP 250 MG	21530517000125	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 20 MG	21530517006820	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 50 MG	21530517006830	Brand
XALKORI	CRIZOTINIB CAP SPRINKLE 150 MG	21530517006850	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xalkori therapy

Xarelto

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146440
Guideline Name	Xarelto
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Continuation of Therapy Upon Hospital Discharge
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand

XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Xarelto will be approved as continuation of therapy upon hospital discharge

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Stroke and Systemic Embolism Prevention in Adult Patients with Non-Valvular Atrial Fibrillation (AF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of atrial fibrillation (AF)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Eliquis
- Savaysa

OR

3.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Eliquis
- Savaysa

OR

3.3 Continuation of prior Xarelto therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) after Orthopedic Surgery (Hip Replacement or Knee Replacement) in Adult Patients
Approval Length	35 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - ONE of the following:

1.1 Patient has or is scheduled to have total knee replacement surgery

OR

1.2 Patient has or is scheduled to have total hip replacement surgery

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Xarelto is being prescribed as continuation of therapy following hospitalization after orthopedic surgery

OR

3.2 Provider provides reason or special circumstance why the patient is unable to use Eliquis

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) in Adult Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

3 - ONE of the following:

3.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Eliquis
- Savaysa

OR

3.2 History on intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Eliquis
- Savaysa

OR

3.3 Continuation of prior Xarelto therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Reduction in the Risk of Recurrence of Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) in Adult Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Previous diagnosis of ONE of the following:

- Deep vein thrombosis (DVT)
- Pulmonary embolism (PE)

AND

2 - Patient does not have an artificial heart valve

AND

2 - Patient must have been treated with an anticoagulant [e.g., warfarin, Eliquis (apixaban)] for

at least 6 months prior to request as confirmed by claims history or submission of medical records

AND

4 - ONE of the following:

4.1 Failure to Eliquis as confirmed by claims history or submission of medical records

OR

4.2 History of intolerance or contraindication to Eliquis (please specify intolerance or contraindication)

OR

4.3 Continuation of prior Xarelto therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Reduction in the Risk of Major Cardiovascular Events [Cardiovascular (CV) Death, Myocardial Infarction (MI) and Stroke] in Adult Patients with Chronic Coronary Artery Disease (CAD) or Peripheral Artery Disease (PAD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Chronic coronary artery disease (CAD)
- Peripheral artery disease (PAD)

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient is on concurrent aspirin therapy

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Prophylaxis of Venous Thromboembolism (VTE) in Acutely Ill Medical Adult Patients at Risk for Thromboembolic Complications Not at High Risk of Bleeding
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Patient was admitted to the hospital for an acute medical illness

AND

2 - Patient does not have an artificial heart valve

AND

2 - Patient is at risk of thromboembolic complications due to moderate or severe restricted mobility

AND

4 - Patient is not at high risk of bleeding

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Thromboprophylaxis in Pediatric Patients with Congenital Heart Disease After the Fontan Procedure
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - Diagnosis of congenital heart disease

AND

2 - Patient does not have an artificial heart valve

AND

3 - Patient is at risk of thromboembolic complications due to Fontan procedure

AND

4 - Patient is 2 years to 17 years of age

Product Name: Xarelto tablets, Xarelto oral suspension	
Diagnosis	Treatment of VTE and Reduction in the Risk of Recurrent VTE in Pediatric Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XARELTO STARTER PACK	RIVAROXABAN TAB STARTER THERAPY PACK 15 MG & 20 MG	8337006000B720	Brand
XARELTO	RIVAROXABAN TAB 2.5 MG	83370060000310	Brand
XARELTO	RIVAROXABAN TAB 10 MG	83370060000320	Brand
XARELTO	RIVAROXABAN TAB 15 MG	83370060000330	Brand
XARELTO	RIVAROXABAN TAB 20 MG	83370060000340	Brand
XARELTO	RIVAROXABAN FOR SUSP 1 MG/ML	83370060001920	Brand

Approval Criteria

1 - The requested medication is being used for the treatment of venous thromboembolism (VTE) or the reduction in the risk of recurrent VTE

AND

2 - Patient does not have an artificial heart valve

AND

2 - Patient has received at least 5 days of initial parenteral anticoagulant treatment

AND

4 - Patient is 0 years to 17 years of age

Xdemvy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146441
Guideline Name	Xdemvy
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xdemvy	
Approval Length	6 Week(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XDEMVY	LOTILANER OPHTH SOLN 0.25%	86106050002020	Brand

Approval Criteria

1 - Diagnosis of Demodex blepharitis

AND

2 - Patient demonstrates ONE of the following signs of Demodex infestation:

- Cylindrical cuff at the root of the eyelashes
- Lid margin erythema
- Eyelash anomalies (e.g., eyelash misdirection, eyelash loss)

AND

3 - Patient demonstrates TWO of the following symptoms of Demodex infestation:

- Itching/Burning
- Foreign body sensation
- Crusting/matted lashes
- Blurry vision
- Discomfort/irritation
- Tearing/lacrimation
- Dryness
- Purulence/discharge

AND

4 - Patient is practicing good eye-lid hygiene (e.g., non-prescription tree-tea oil)

AND

5 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist

Xeljanz, Xeljanz XR, Xeljanz Oral Solution

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-155315
Guideline Name	Xeljanz, Xeljanz XR, Xeljanz Oral Solution
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name: Xeljanz tabs, Xeljanz XR	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT)	66603065107530	Brand

XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT)	66603065107550	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 One of the following:

1.2.1 Failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to one non-biologic DMARD [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

1.3 BOTH of the following:

1.3.1 ONE of the following:

1.3.1.1 Failure to THREE of the following as confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

1.3.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

1.3.1.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.3.2 One of the following:

1.3.2.1 Failure to Olumiant (baricitinib) as confirmed by claims history or submission of medical records

OR

1.3.2.2 History of intolerance or contraindication to Olumiant (baricitinib) (please specify intolerance or contraindication

AND

1.4 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Diagnosis of moderately to severely active RA

AND

2.2 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

2.3 Patient is currently on Xeljanz/Xeljanz XR therapy as confirmed by claims history or submission of medical records

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Xeljanz tabs, Xeljanz XR

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT)	66603065107530	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT)	66603065107550	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active psoriatic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to a 3 month trial of methotrexate at the maximally indicated dose as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic disease modifying anti-rheumatic drug (DMARD) FDA-approved for the treatment of psoriatic arthritis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept),

Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 One of the following:

1.3.1.1.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

OR

1.3.1.1.2 History of intolerance or contraindication ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

AND

1.3.1.2 One of the following:

1.3.1.2.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

OR

1.3.1.2.2 History of intolerance or contraindication Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

1.3.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Rinvoq (upadacitinib), Olumiant (baricitinib), Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

1.5 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Xeljanz/Xeljanz XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active psoriatic arthritis

AND

2.3 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Rinvoq (upadacitinib), Olumiant (baricitinib), Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

2.4 Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Xeljanz tabs, Xeljanz XR	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT)	66603065107530	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT)	66603065107550	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

1.2 ONE of the following:

1.2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine) as confirmed by claims history or submitted medical records

OR

1.2.2 Patient has been previously treated with a biologic or targeted synthetic disease modifying anti-rheumatic drug (DMARD) FDA-approved for the treatment of ulcerative colitis as confirmed by claims history or submission medical records [e.g., Simponi (golimumab), Stelara (ustekinumab), Rinvoq (upadacitinib)]

AND

1.3 ONE of the following:

1.3.1 Failure to one of the preferred adalimumab products* as confirmed by claims history or submission of medical records

OR

1.3.2 History of intolerance or contraindication to one of the preferred adalimumab products* (please specify intolerance or contraindication)

OR

1.3.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.5 Prescribed by or in consultation with a gastroenterologist

OR

2 - ALL of the following:

2.1 Patient is currently on Xeljanz/Xeljanz XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active UC

AND

2.3 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a gastroenterologist

Notes	PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Xeljanz tabs, Xeljanz XR	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT)	66603065107530	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT)	66603065107550	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active ankylosing spondylitis

AND

1.2 One of the following:

1.2.1 Failure to two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, as confirmed by claims history or submission of medical records

OR

1.2.2 History of intolerance or contraindication to two NSAIDs (e.g., ibuprofen, naproxen) (please specify intolerance or contraindication)

OR

1.2.3 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-

approved for the treatment of ankylosing spondylitis as confirmed by claims history or submission of medical records [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Rinvoq (upadacitinib)]

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 One of the following:

1.3.1.1.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

OR

1.3.1.1.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Cimzia (certolizumab)
- One of the preferred adalimumab products*
- Enbrel (etanercept)

AND

1.3.1.2 ONE of the following:

1.3.1.2.1 Failure to Cosentyx (secukinumab) as confirmed by claims history or submission of medical records

OR

1.3.1.2.2 History of intolerance or contraindication to Cosentyx (secukinumab) (please specify intolerance or contraindication)

OR

1.3.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.4 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.5 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Xeljanz/Xeljanz XR therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active ankylosing spondylitis

AND

2.3 Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Rinvoq (upadacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Xeljanz tabs, Xeljanz XR	
Diagnosis	Rheumatoid Arthritis (RA), Psoriatic Arthritis (PsA), Ulcerative Colitis (UC), Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 11 MG (BASE EQUIVALENT)	66603065107530	Brand
XELJANZ XR	TOFACITINIB CITRATE TAB ER 24HR 22 MG (BASE EQUIVALENT)	66603065107550	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xeljanz/Xeljanz XR therapy

AND

2 - Patient is NOT receiving Xeljanz/Xeljanz XR in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Rinvoq (upadacitinib), Olumiant (baricitinib), Otezla (apremilast)]*
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)*

Notes	* Examples of drug(s) may not be applicable based on the requested i ndication.

Product Name: Xeljanz tabs/oral soln	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ	TOFACITINIB CITRATE ORAL SOLN 1 MG/ML (BASE EQUIVALENT)	66603065102020	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of active polyarticular course juvenile idiopathic arthritis

AND

1.2 ONE of the following:

1.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- One of the preferred adalimumab products*
- Enbrel (etanercept)

- Tyenne (tocilizumab-aazg)

OR

1.2.2 History of intolerance or contraindication to ALL of the following (please specific intolerance or contraindication):

- One of the preferred adalimumab products*
- Enbrel (etanercept)
- Tyenne (tocilizumab-aazg)

OR

1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria)

AND

1.3 Patient is NOT receiving Xeljanz/Xeljanz oral solution in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

1.4 Prescribed by or in consultation with a rheumatologist

OR

2 - ALL of the following:

2.1 Patient is currently on Xeljanz/Xeljanz Oral Solution as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of active polyarticular course juvenile idiopathic arthritis

AND

2.3 Patient is NOT receiving Xeljanz/Xeljanz Oral Solution in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

2.4 Prescribed by or in consultation with a rheumatologist

Notes	PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Xeljanz tabs/oral soln	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	66603065100320	Brand
XELJANZ	TOFACITINIB CITRATE TAB 10 MG (BASE EQUIVALENT)	66603065100330	Brand
XELJANZ	TOFACITINIB CITRATE ORAL SOLN 1 MG/ML (BASE EQUIVALENT)	66603065102020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xeljanz or Xeljanz oral solution therapy

AND

2 - Patient is NOT receiving Xeljanz or Xeljanz oral solution in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

2 . Revision History

Date	Notes
9/19/2024	Updated safety language. Updated step through agents due to Tyenne and Kevzara PDL changes.

Xenazine

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146705
Guideline Name	Xenazine
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Xenazine, generic tetrabenazine	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TETRABENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Generic
XENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Brand
TETRABENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Generic
XENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Brand

Approval Criteria

1 - Diagnosis of chorea in patients with Huntington's disease

Product Name: Brand Xenazine, generic tetrabenazine	
Diagnosis	Tardive Dyskinesia (Off-Label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TETRABENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Generic
XENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Brand
TETRABENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Generic
XENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Brand

Approval Criteria

1 - Diagnosis of tardive dyskinesia

AND

2 - ONE of the following:

2.1 Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

OR

2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

AND

3 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Psychiatrist

Product Name: Brand Xenazine, generic tetrabenazine	
Diagnosis	Tourette's Syndrome (Off-Label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TETRABENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Generic
XENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Brand
TETRABENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Generic
XENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Brand

Approval Criteria

1 - Patient has tics associated with Tourette's syndrome

AND

2 - ONE of the following:

2.1 Failure of haloperidol confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to haloperidol (please specify intolerance or contraindication)

AND

3 - Prescribed by or in consultation with ONE of the following:

- Neurologist
- Psychiatrist

Product Name: Brand Xenazine, generic tetrabenazine	
Diagnosis	Tardive Dyskinesia (Off-Label), Tourette's Syndrome (Off-Label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
TETRABENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Generic
XENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	Brand
TETRABENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Generic
XENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

Xenleta

Prior Authorization Guideline

Guideline ID	GL-146442
Guideline Name	Xenleta
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xenleta	
Diagnosis	Community-acquired bacterial pneumonia
Approval Length	7 Day(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XENLETA	LEFAMULIN ACETATE TAB 600 MG	16240040100320	Brand

Approval Criteria

1 - One of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 All of the following:

1.3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Xenleta

AND

1.3.3 One of the following:

1.3.3.1 Failure to three of the following antibiotics or antibiotic regimens confirmed by claims history or submitted medical records:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

OR

1.3.3.2 History of contraindication or intolerance to all of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication):

- Amoxicillin

- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name: Xenleta	
Diagnosis	Off-Label Uses
Approval Length	Based on provider and IDSA recommended treatment durations, not to exceed 6 months
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XENLETA	LEFAMULIN ACETATE TAB 600 MG	16240040100320	Brand

Approval Criteria

1 - One of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Xermelo

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-151737
Guideline Name	Xermelo
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Xermelo	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XERMELO	TELOTRISTAT ETHYL TAB 250 MG (AS TELOTRISTAT ETIPRATE)	52570075100330	Brand

Approval Criteria

1 - Diagnosis of carcinoid syndrome diarrhea

AND

2 - Diarrhea is inadequately controlled with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot, Lanreotide), as confirmed by claims history or submission of medical records

AND

3 - Used in combination with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot, Lanreotide)

Product Name: Xermelo	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XERMELO	TELOTRISTAT ETHYL TAB 250 MG (AS TELOTRISTAT ETIPRATE)	52570075100330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xermelo

2 . Revision History

Date	Notes
8/14/2024	Updated initial authorization duration to 12 months.

Xifaxan

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-148288
Guideline Name	Xifaxan
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xifaxan 200mg	
Diagnosis	Travelers' Diarrhea
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 200 MG	16000049000320	Brand

Approval Criteria

1 - Diagnosis of travelers' diarrhea

AND

2 - ONE of the following:

2.1 Failure of ONE of the following confirmed by claims history or submitted medical records:

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

Product Name: Xifaxan 550mg	
Diagnosis	Hepatic Encephalopathy (HE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Used for prophylaxis of hepatic encephalopathy (HE) recurrence

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Used as add-on therapy to lactulose, confirmed by claims history or submitted medical records
- Patient is unable to achieve an optimal clinical response with lactulose monotherapy, confirmed by claims history or submitted medical records

OR

2.2 History of contraindication or intolerance to lactulose (please specify intolerance or contraindication)

Product Name: Xifaxan 550mg	
Diagnosis	Hepatic Encephalopathy (HE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xifaxan therapy

Product Name: Xifaxan 550mg	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	1 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

AND

2 - ONE of the following:

2.1 Failure of ONE tricyclic antidepressant (e.g. amitriptyline) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to tricyclic antidepressants (e.g. amitriptyline) (please specify intolerance or contraindication)

Product Name: Xifaxan 550mg	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 550 MG	16000049000340	Brand

Approval Criteria

1 - Patient continues to need Xifaxan and has experienced positive results with prior use

Product Name: Xifaxan 200mg	
Diagnosis	Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off-label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 200 MG	16000049000320	Brand

Approval Criteria

1 - Diagnosis of inflammatory bowel disease

AND

2 - ONE of the following:

2.1 Failure of BOTH of the following confirmed by claims history or submitted medical records:

- Ciprofloxacin (generic Cipro)
- Metronidazole (generic Flagyl)

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- Ciprofloxacin (generic Cipro)
- Metronidazole (generic Flagyl)

Product Name: Xifaxan 200mg	
Diagnosis	Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off-label)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XIFAXAN	RIFAXIMIN TAB 200 MG	16000049000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xifaxan therapy

2 . Revision History

Date	Notes
6/7/2024	Updated language from “Diagnosis of hepatic encephalopathy” to “U sed for prophylaxis of hepatic encephalopathy (HE) recurrence” to ali gn with PI; Minor cosmetic updates.

Xolair

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150979
Guideline Name	Xolair
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/6/2024

1 . Criteria

Product Name: Xolair	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand

XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Patient has been established on therapy with Xolair for moderate to severe persistent asthma under an active UnitedHealthcare medical benefit prior authorization

AND

2 - Documentation of positive clinical response to Xolair therapy as demonstrated by at least ONE of the following

2.1 Reduction in the frequency of exacerbations

OR

2.2 Decreased utilization of rescue medications

OR

2.3 Increase in percent predicted forced expiratory volume (FEV1) from pretreatment baseline

OR

2.4 Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

AND

3 - Xolair is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

4 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name: Xolair	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Diagnosis of moderate or severe asthma

AND

2 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

2.1 Poor symptom control [e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20]

OR

2.2 Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months

OR

2.3 Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)

OR

2.4 Airflow limitation [e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted (in the face of reduced FEV1-forced vital capacity [FVC] defined as less than the lower limit of normal)]

OR

2.5 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting a baseline (pre-omalizumab treatment) serum total IgE (immunoglobulin E) level greater than or equal to 30 IU/mL (international units/milliliter) and less than or equal to 1300 IU/mL

AND

4 - Positive skin test or in vitro reactivity to a perennial aeroallergen

AND

5 - Used in combination with ONE of the following:

5.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)-long-acting beta2-agonist (LABA) product [e.g., fluticasone propionate-salmeterol (AirDuo, Advair), budesonide-formoterol (Symbicort)]

OR

5.2 Combination therapy including BOTH of the following:

5.2.1 One maximally-dosed (appropriately adjusted for age) ICS (inhaled corticosteroid) product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

AND

5.2.2 One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

6 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Product Name: Xolair	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Documentation of positive clinical response as demonstrated by at least ONE of the following:

- Reduction in frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 (forced expiratory volume in 1 second) from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing)

AND

2 - Used in combination with an ICS (inhaled corticosteroid)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name: Xolair	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Patient has been established on therapy with Xolair for chronic urticaria under an active UnitedHealthcare medical benefit prior authorization

AND

2 - Documentation of positive clinical response to Xolair therapy (e.g., reduction in exacerbations, itch severity, hives)

AND

3 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name: Xolair	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand

XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Diagnosis of chronic urticaria

AND

2 - ONE of the following:

2.1 Patient remains symptomatic despite at least a 2-week trial and failure of two H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]* (confirmed by claims history or submitted medical records)

OR

2.2 Patient remains symptomatic despite at least a 2-week trial and failure of BOTH of the following taken in combination (confirmed by claims history or submitted medical records):

2.2.1 Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

2.2.2 ONE of the following:

- Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
- First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*
- H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
- Leukotriene modifier [e.g., Singulair (montelukast)]

OR

2.3 History of contraindication or intolerance to ONE of the following (please specify contraindication or intolerance):

2.3.1 Two H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]*

OR

2.3.2 BOTH of the following taken in combination:

2.3.2.1 Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

2.3.2.2 ONE of the following:

- Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
- First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*
- H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
- Leukotriene modifier [e.g., Singulair (montelukast)]

AND

3 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by one of the following:

- Allergist
- Dermatologist

• Immunologist	
Notes	*Patients 65 years of age and older in whom first generation H1-antihi stamines are considered high risk medications to be avoided (e.g., Be ers criteria, HEDIS) should be directed to try alternatives that are not c onsidered high risk.

Product Name: Xolair	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Documentation of positive clinical response (e.g., reduction in exacerbations, itch severity, hives)

AND

2 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name: Xolair	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Patient has been established on therapy with Xolair for nasal polyps under an active UnitedHealthcare medical benefit prior authorization

AND

2 - Documentation of positive clinical response to Xolair therapy

AND

3 - Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

4 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name: Xolair	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Diagnosis of nasal polyps

AND

2 - TWO or more of the following symptoms for longer than 12 weeks duration:

- Nasal mucopurulent discharge
- Nasal obstruction, blockage, or congestion
- Facial pain, pressure, and/or fullness
- Reduction or loss of sense of smell

AND

3 - ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

4 - ONE of the following:

4.1 Patient has required prior sinus surgery

OR

4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for nasal polyps in the previous 2 years

OR

4.3 Patient has been unable to obtain symptom relief after trial of BOTH of the following confirmed by claims history or submitted medical records:

- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

- One other therapy used in management of nasal polyps [i.e., nasal saline irrigations, antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)]

AND

5 - Patient will receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

6 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by one of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Product Name: Xolair	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand

XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xolair therapy

AND

2 - Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Product Name: Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Patient has been established on therapy with Xolair for IgE-Mediated food allergy under an active UnitedHealthcare medical benefit prior authorization

AND

2 - Documentation of positive clinical response to Xolair therapy (e.g., reduction in type I allergic reactions)

AND

3 - Xolair will be used in conjunction with food allergen avoidance

AND

4 - Patient access to epinephrine

AND

5 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

6 - Prescribed by an allergist or immunologist

Product Name: Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization - Not transitioning from UHC medical benefits
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Diagnosis of IgE-mediated food allergy to one or more foods

AND

2 - Patient is at least 1 year of age

AND

3 - IgE-mediated food allergy to specific food(s) has been confirmed by both of the following:

3.1 History of type I allergic reactions (e.g., nausea, vomiting, cramping, diarrhea, flushing, pruritus, urticaria, swelling of the lips, face or throat, wheezing, lightheadedness, syncope)

AND

3.2 One of the following:

- Food specific skin prick testing (SPT)
- IgE antibody in vitro testing
- Oral food challenge (OFC)

AND

4 - Xolair will be used in conjunction with food allergen avoidance

AND

5 - Patient has access to epinephrine

AND

6 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by allergist or immunologist

Product Name: Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLAIR	OMALIZUMAB FOR INJ 150 MG	44603060002120	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 75 MG/0.5ML	4460306000E510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 150 MG/ML	4460306000E520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 75 MG/0.5ML	4460306000D510	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 150 MG/ML	4460306000D520	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN AUTO-INJECTOR 300 MG/2ML	4460306000D530	Brand
XOLAIR	OMALIZUMAB SUBCUTANEOUS SOLN PREFILLED SYRINGE 300 MG/2ML	4460306000E530	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xolair therapy (e.g., reduction in type I allergic reactions)

AND

2 - Xolair will be used in conjunction with food allergen avoidance

AND

3 - Patient has access to epinephrine

AND

4 - Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

5 - Prescribed by an allergist or immunologist

2 . Revision History

Date	Notes
8/5/2024	Expanded coverage of Xolair for IgE-mediated food allergy to all food s. Updated references.

Xolremdi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-156895
Guideline Name	Xolremdi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name: Xolremdi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLREMDI	MAVORIXAFOR CAP 100 MG	82502046000120	Brand

Approval Criteria

1 - Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome

AND

2 - Patient has a genotype-confirmed mutation of chemokine (C-X-C motif) receptor 4 (CXCR4) consistent with WHIM phenotype

AND

3 - Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells per microliter

AND

4 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Geneticist
- Hematologist
- Immunologist

Product Name: Xolremdi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOLREMDI	MAVORIXAFOR CAP 100 MG	82502046000120	Brand

Approval Criteria

1 - Documentation of positive clinical response [e.g., improvement in absolute neutrophil

counts (ANC), improvement in absolute lymphocyte counts (ALC), reduction in infections] to Xolremdi therapy

AND

2 - Prescribed by or in consultation with ONE of the following:

- Allergist
- Geneticist
- Hematologist
- Immunologist

2 . Revision History

Date	Notes
10/2/2024	New program

Xopenex Respules

Prior Authorization Guideline

Guideline ID	GL-146444
Guideline Name	Xopenex Respules
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Xopenex inhalation soln, generic levalbuterol inhalation soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Product Name	Generic Name	GPI	Brand/Generic
LEVALBUTEROL HCL	LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV)	44201045102510	Generic
LEVALBUTEROL HYDROCHLORIDE	LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV)	44201045102510	Generic
XOPENEX	LEVALBUTEROL HCL SOLN NEBU 0.31 MG/3ML (BASE EQUIV)	44201045102510	Brand
LEVALBUTEROL HCL	LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV)	44201045102520	Generic

LEVALBUTEROL HYDROCHLORIDE	LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV)	44201045102520	Generic
XOPENEX	LEVALBUTEROL HCL SOLN NEBU 0.63 MG/3ML (BASE EQUIV)	44201045102520	Brand
LEVALBUTEROL HCL	LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV)	44201045102530	Generic
LEVALBUTEROL HYDROCHLORIDE	LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV)	44201045102530	Generic
XOPENEX	LEVALBUTEROL HCL SOLN NEBU 1.25 MG/3ML (BASE EQUIV)	44201045102530	Brand
LEVALBUTEROL	LEVALBUTEROL HCL SOLN NEBU CONC 1.25 MG/0.5ML (BASE EQUIV)	44201045102560	Generic
XOPENEX CONCENTRATE	LEVALBUTEROL HCL SOLN NEBU CONC 1.25 MG/0.5ML (BASE EQUIV)	44201045102560	Brand

Approval Criteria

1 - Failure to treatment with albuterol inhalation solution, as confirmed by claims history or submission of medical records

OR

2 - History of contraindication or intolerance to albuterol inhalation solution (please specify contraindication or intolerance)

Xospata

Prior Authorization Guideline

Guideline ID	GL-146708
Guideline Name	Xospata
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xospata	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOSPATA	GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT)	21533020200320	Brand

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive

AND

3 - ONE of the following:

- Used in combination with azacitidine as low-intensity treatment induction when not a candidate for intensive induction therapy
- Follow-up after induction therapy with response to previous lower intensity therapy with the same regimen
- Post-allogeneic hematopoietic cell transplantation and in remission
- Disease is relapsed or refractory

Product Name: Xospata	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOSPATA	GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT)	21533020200320	Brand

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - ONE of the following:

2.1 Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic phase

OR

2.2 Patient has an FMS-like tyrosine kinase 3 (FLT3) rearrangement in blast phase

Product Name: Xospata	
Diagnosis	Acute Myeloid Leukemia, Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOSPATA	GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT)	21533020200320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Xospata therapy

Product Name: Xospata	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOSPATA	GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT)	21533020200320	Brand

Approval Criteria

1 - Xospata will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Xospata	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XOSPATA	GILTERITINIB FUMARATE TABLET 40 MG (BASE EQUIVALENT)	21533020200320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xospata therapy

Xphozah

Prior Authorization Guideline

Guideline ID	GL-147369
Guideline Name	Xphozah
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xphozah	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XPHOZAH	TENAPANOR HCL TAB 20 MG	30903260600325	Brand
XPHOZAH	TENAPANOR HCL TAB 30 MG	30903260600330	Brand

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - Patient is receiving dialysis

AND

3 - Serum phosphorus is greater than 6.5 mg/dL (milligrams per deciliter)

AND

4 - Patient has had an inadequate response to at least a 4-week maximally tolerated dose of both of the following phosphate binders as confirmed by claims history or submission of medical records:

4.1 calcium acetate (generic PhosLo)

AND

4.2 sevelamer carbonate (generic Renvela)

AND

5 - Xphozah will be used as add-on therapy

AND

6 - Prescribed by or in consultation with a nephrologist

Product Name: Xphozah	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XPHOZAH	TENAPANOR HCL TAB 20 MG	30903260600325	Brand
XPHOZAH	TENAPANOR HCL TAB 30 MG	30903260600330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xphozah therapy [e.g., reduction of serum phosphorus towards the normal range (3.5 to 5.5 milligrams per deciliter)]

AND

2 - Prescribed by or in consultation with a nephrologist

2 . Revision History

Date	Notes
5/14/2024	New guideline.

Xpovio

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146709
Guideline Name	Xpovio
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xpovio	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XPOVIO 80 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY)	2156006000B720	Brand
XPOVIO 60 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY)	2156006000B755	Brand

XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY)	2156006000B760	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY)	2156006000B765	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY)	2156006000B770	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY)	2156006000B775	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY)	2156006000B780	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of relapsed or refractory multiple myeloma (RRMM)

AND

1.2 Patient has received at least four prior therapies

AND

1.3 Disease is refractory to ALL of the following:

- Two proteasome inhibitors
- Two immunomodulatory agents
- An anti-CD38 monoclonal antibody

AND

1.4 Used in combination with dexamethasone

OR

2 - ALL of the following:

2.1 Diagnosis of multiple myeloma

AND

2.2 Patient has received at least one prior therapy

AND

2.3 Used in combination with ONE of the following:

- Velcade (bortezomib) and dexamethasone
- Darzalex (daratumumab) and dexamethasone
- Kyprolis (carfilzomib) and dexamethasone

OR

3 - ALL of the following:

3.1 Diagnosis of multiple myeloma

AND

3.2 Patient has received at least 2 prior therapies, including an immunomodulatory agent (e.g., lenalidomide, thalidomide) and a proteasome inhibitor (e.g., bortezomib, carfilzomib)

AND

3.3 Patient has demonstrated progression on or within 60 days of completion of the last therapy

AND

3.4 Used in combination with Pomalyst (pomalidomide) and dexamethasone

Product Name: Xpovio	
Diagnosis	Diffuse Large B-cell Lymphoma (DLBCL)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XPOVIO 80 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY)	2156006000B720	Brand
XPOVIO 60 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY)	2156006000B755	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY)	2156006000B760	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY)	2156006000B765	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY)	2156006000B770	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY)	2156006000B775	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY)	2156006000B780	Brand

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) (including histologic transformation of indolent lymphomas to DLBCL)

OR

1.2 Diagnosis of relapsed or refractory HIV (human immunodeficiency virus)-related diffuse large B-cell lymphoma, primary effusion lymphoma, or HHV8-positive diffuse large B-cell lymphoma

OR

1.3 Diagnosis of relapsed or refractory monomorphic B-Cell type post-transplant lymphoproliferative disorder

AND

2 - Patient has received at least 2 lines of systemic therapies

Product Name: Xpovio	
Diagnosis	Multiple Myeloma, Diffuse Large B-cell Lymphoma (DLBCL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XPOVIO 80 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY)	2156006000B720	Brand
XPOVIO 60 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY)	2156006000B755	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY)	2156006000B760	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY)	2156006000B765	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY)	2156006000B770	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY)	2156006000B775	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY)	2156006000B780	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Xpovio therapy

Product Name: Xpovio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XPOVIO 80 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY)	2156006000B720	Brand
XPOVIO 60 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY)	2156006000B755	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY)	2156006000B760	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY)	2156006000B765	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY)	2156006000B770	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY)	2156006000B775	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY)	2156006000B780	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Xpovio	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XPOVIO 80 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (80 MG TWICE WEEKLY)	2156006000B720	Brand
XPOVIO 60 MG TWICE WEEKLY	SELINEXOR TAB THERAPY PACK 20 MG (60 MG TWICE WEEKLY)	2156006000B755	Brand

XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG ONCE WEEKLY)	2156006000B760	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (40 MG TWICE WEEKLY)	2156006000B765	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 40 MG (80 MG ONCE WEEKLY)	2156006000B770	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 50 MG (100 MG ONCE WEEKLY)	2156006000B775	Brand
XPOVIO	SELINEXOR TAB THERAPY PACK 60 MG (60 MG ONCE WEEKLY)	2156006000B780	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xpovio therapy

Xtandi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-152523
Guideline Name	Xtandi
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name: Xtandi	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XTANDI	ENZALUTAMIDE CAP 40 MG	21402430000120	Brand
XTANDI	ENZALUTAMIDE TAB 40 MG	21402430000320	Brand
XTANDI	ENZALUTAMIDE TAB 80 MG	21402430000340	Brand

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following:

2.1 Both of the following:

2.1.1 Disease is castration-resistant

AND

2.1.2 One of the following:

- Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]
- Patient has had bilateral orchiectomy

OR

2.2 Both of the following:

2.2.1 Disease is metastatic castration-sensitive

AND

2.2.2 One of the following:

- Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]
- Patient has had bilateral orchiectomy

OR

2.3 Disease is non-metastatic castration-sensitive with biochemical recurrence at high risk for metastasis

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Disease is castration-resistant

AND

3.1.2 ONE of the following:

3.1.2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Erleada (apalutamide)
- Nubeqa (darolutamide)

OR

3.1.2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Erleada (apalutamide)
- Nubeqa (darolutamide)

OR

3.1.2.3 Continuation of ongoing Xtandi therapy

OR

3.2 BOTH of the following:

3.2.1 Disease is BOTH of the following:

- Metastatic
- Castration-sensitive

AND

3.2.2 ONE of the following:

3.2.2.1 Failure to ALL of the following as confirmed by claims history or submission of medical records:

- abiraterone (generic Zytiga)
- Erleada (apalutamide)
- Nubeqa (darolutamide)

OR

3.2.2.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- abiraterone (generic Zytiga)
- Erleada (apalutamide)
- Nubeqa (darolutamide)

OR

3.2.2.3 Continuation of ongoing Xtandi therapy

OR

3.3 BOTH of the following:

3.3.1 Disease is ALL of the following:

- Non-metastatic
- Castration-sensitive
- Recurrent

- High risk for metastasis

AND

3.3.2 ONE of the following:

3.3.2.1 Failure to abiraterone (generic Zytiga) as confirmed by claims history or submission of medical records

OR

3.3.2.2 History of contraindication or intolerance to abiraterone (generic Zytiga) (please specify contraindication or intolerance)

OR

3.3.2.3 Continuation of ongoing Xtandi therapy

Product Name: Xtandi	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XTANDI	ENZALUTAMIDE CAP 40 MG	21402430000120	Brand
XTANDI	ENZALUTAMIDE TAB 40 MG	21402430000320	Brand
XTANDI	ENZALUTAMIDE TAB 80 MG	21402430000340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Xtandi therapy

Product Name: Xtandi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XTANDI	ENZALUTAMIDE CAP 40 MG	21402430000120	Brand
XTANDI	ENZALUTAMIDE TAB 40 MG	21402430000320	Brand
XTANDI	ENZALUTAMIDE TAB 80 MG	21402430000340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Xtandi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XTANDI	ENZALUTAMIDE CAP 40 MG	21402430000120	Brand
XTANDI	ENZALUTAMIDE TAB 40 MG	21402430000320	Brand
XTANDI	ENZALUTAMIDE TAB 80 MG	21402430000340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xtandi therapy

2 . Revision History

Date	Notes
8/22/2024	Copy core

Xuriden

Prior Authorization Guideline

Guideline ID	GL-146711
Guideline Name	Xuriden
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xuriden	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XURIDEN	URIDINE TRIACETATE ORAL GRANULES PACKET 2 GM	30903875203020	Brand

Approval Criteria

1 - Diagnosis of a hereditary orotic aciduria

Product Name: Xuriden	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XURIDEN	URIDINE TRIACETATE ORAL GRANULES PACKET 2 GM	30903875203020	Brand

Approval Criteria

1 - Documentation of positive clinical response to Xuriden therapy

Xyrem, Xywav, Lumryz

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146712
Guideline Name	Xyrem, Xywav, Lumryz
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Xyrem, Sodium Oxybate, Xywav, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYWAV	CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML	62459904202020	Brand
SODIUM OXYBATE	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic
XYREM	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic

LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM	62450060203020	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM	62450060203025	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM	62450060203030	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM	62450060203035	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) on a Multiple Sleep Latency Test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications, or other sleep disorders)

AND

3 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

AND

4 - ONE of the following:

4.1 Failure to Wakix (pitolisant) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Wakix (pitolisant) (please specify intolerance or contraindication)

Product Name: Xyrem, Sodium Oxybate, Xywav, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization*
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYWAV	CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML	62459904202020	Brand
SODIUM OXYBATE	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic
XYREM	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM	62450060203020	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM	62450060203025	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM	62450060203030	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM	62450060203035	Brand

Approval Criteria

1 - Documentation demonstrating a reduction in frequency of cataplexy attacks associated with therapy

OR

2 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name: Xyrem, Sodium Oxybate, Xywav, Lumryz	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYWAV	CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML	62459904202020	Brand
SODIUM OXYBATE	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic
XYREM	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM	62450060203020	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM	62450060203025	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM	62450060203030	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM	62450060203035	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy without cataplexy (i.e., Narcolepsy Type 2) with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a Multiple Sleep Latency Test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Cataplexy is absent

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submission of medical records:

3.1.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.1.2 ONE of the following:

- Modafinil (Provigil)
- Armodafinil (Nuvigil)

OR

3.2 History of contraindication or intolerance of ALL of the following (please specify intolerance or contraindication):

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant
- Modafinil (Provigil)
- Armodafinil (Nuvigil)

AND

4 - ONE of the following:

4.1 Failure to Sunosi (solriamfetol) as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to Sunosi (solriamfetol) (please specify intolerance or contraindication)

AND

5 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist
- Pulmonologist

Product Name: Xyrem, Sodium Oxybate, Xywav, Lumryz	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYWAV	CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML	62459904202020	Brand
SODIUM OXYBATE	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic
XYREM	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	Generic
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 4.5 GM	62450060203020	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 6 GM	62450060203025	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 7.5 GM	62450060203030	Brand
LUMRYZ	SODIUM OXYBATE PACK FOR ORAL ER SUSP 9 GM	62450060203035	Brand

Approval Criteria

1 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name: Xywav	
Diagnosis	Idiopathic Hypersomnia
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYWAV	CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML	62459904202020	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of idiopathic hypersomnia with both of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of < 8 minutes and fewer than two REM (rapid eye movement) periods (SOREMPs) are found on a MSLT (multiple sleep latency test) performed according to standard techniques following a normal overnight polysomnogram, or no SOREMPs if the REM sleep latency on the preceding polysomnogram was < 15 minutes

AND

2 - Physician attestation that other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - ONE of the following:

3.1 Failure of BOTH of the following confirmed by claims history or submission of medical records:

3.1.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.1.2 ONE of the following:

- Modafinil (Provigil)
- Armodafinil (Nuvigil)

OR

3.2 History of contraindication or intolerance of ALL of the following (please specify intolerance or contraindication):

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant
- Modafinil (Provigil)
- Armodafinil (Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep medicine specialist
- Pulmonologist

Product Name: Xywav	
Diagnosis	Idiopathic Hypersomnia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
XYWAV	CALCIUM, MAG, POTASSIUM, & SOD OXYBATES ORAL SOLN 500 MG/ML	62459904202020	Brand

Approval Criteria

1 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

Yonsa

Prior Authorization Guideline

Guideline ID	GL-146714
Guideline Name	Yonsa
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Yonsa	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
YONSA	ABIRATERONE ACETATE MICRONIZED TAB 125 MG	21406010250310	Brand

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following:

2.1 Disease is metastatic

OR

2.2 Disease is regional node positive (e.g., N1)

OR

2.3 Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT)

AND

3 - Used in combination with methylprednisolone

AND

4 - ONE of the following:

4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Firmagon (degarelix)]

OR

4.2 Patient has had bilateral orchiectomy

AND

5 - ONE of the following:

5.1 Prescriber provides a reason or special circumstance the patient cannot take abiraterone (generic Zytiga)

OR

5.2 Patient is currently on Yonsa therapy

Product Name: Yonsa	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
YONSA	ABIRATERONE ACETATE MICRONIZED TAB 125 MG	21406010250310	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Yonsa therapy

Product Name: Yonsa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
YONSA	ABIRATERONE ACETATE MICRONIZED TAB 125 MG	21406010250310	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Yonsa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
YONSA	ABIRATERONE ACETATE MICRONIZED TAB 125 MG	21406010250310	Brand

Approval Criteria

1 - Documentation of positive clinical response to Yonsa therapy

Zejula

Prior Authorization Guideline

Guideline ID	GL-146715
Guideline Name	Zejula
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zejula	
Diagnosis	Ovarian Cancer (Maintenance Therapy)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEJULA	NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT)	21535550200120	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT)	21535550200320	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21535550200330	Brand

ZEJULA	NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT)	21535550200340	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - Disease is ONE of the following:

- Recurrent, with deleterious or suspected deleterious germline BRCA (breast cancer) mutation
- Advanced

AND

3 - Patient is in a complete or partial response to a platinum-based chemotherapy

AND

4 - Request is for maintenance therapy

Product Name: Zejula	
Diagnosis	Ovarian Cancer (Treatment)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEJULA	NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT)	21535550200120	Brand

ZEJULA	NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT)	21535550200320	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21535550200330	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT)	21535550200340	Brand

Approval Criteria

1 - Diagnosis of advanced, persistent, or recurrent ovarian, fallopian tube, or primary peritoneal cancer

AND

2 - Disease is platinum-sensitive

AND

3 - Used in combination with bevacizumab

Product Name: Zejula	
Diagnosis	Uterine Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEJULA	NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT)	21535550200120	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT)	21535550200320	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21535550200330	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT)	21535550200340	Brand

Approval Criteria

1 - Diagnosis of BRCA (breast cancer) altered uterine leiomyosarcoma (uLMS)

AND

2 - Disease has progressed following prior treatment with ONE of the following:

- gemcitabine plus docetaxel
- doxorubicin

Product Name: Zejula	
Diagnosis	Ovarian Cancer (Maintenance Therapy, Treatment), Uterine Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEJULA	NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT)	21535550200120	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT)	21535550200320	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21535550200330	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT)	21535550200340	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Zejula therapy

Product Name: Zejula	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEJULA	NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT)	21535550200120	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT)	21535550200320	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21535550200330	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT)	21535550200340	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Zejula	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEJULA	NIRAPARIB TOSYLATE CAP 100 MG (BASE EQUIVALENT)	21535550200120	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 100 MG (BASE EQUIVALENT)	21535550200320	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21535550200330	Brand
ZEJULA	NIRAPARIB TOSYLATE TAB 300 MG (BASE EQUIVALENT)	21535550200340	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zejula therapy

Zelboraf

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147406
Guideline Name	Zelboraf
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zelboraf	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - ONE of the following diagnoses:

- Unresectable melanoma
- Metastatic melanoma

AND

2 - Patient is positive for BRAF V600 mutation

Product Name: Zelboraf	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Patient has metastatic brain lesions
- Zelboraf is active against primary tumor (melanoma)

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of glioma

AND

1.2.2 ONE of the following:

- Incomplete resection, biopsy, or surgically inaccessible location
- Disease is recurrent or progressive

AND

2 - Cancer is positive for BRAF V600E mutation

AND

3 - Used in combination with Cotellic (cobimetinib)

Product Name: Zelboraf	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - Diagnosis of hairy cell leukemia

Product Name: Zelboraf	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Advanced
- Recurrent

AND

3 - Cancer is positive for BRAF V600E mutation

Product Name: Zelboraf	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Erdheim-Chester Disease

- Langerhans Cell Histiocytosis

AND

2 - Cancer is positive for BRAF V600 mutation

Product Name: Zelboraf	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

2 - ONE of the following:

- Unresectable locoregional recurrent disease
- Metastatic disease
- Persistent disease

AND

3 - ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

4 - Disease is refractory to radioactive iodine

AND

5 - Cancer is positive for BRAF V600 mutation

Product Name: Zelboraf	
Diagnosis	Melanoma, CNS Cancers, Hairy Cell Leukemia, NSCLC, Histiocytic Neoplasms, Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Zelboraf therapy

Product Name: Zelboraf	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Zelboraf	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZELBORAF	VEMURAFENIB TAB 240 MG	21532080000320	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zelboraf therapy

2 . Revision History

Date	Notes
5/14/2024	Under thyroid cancer initial criteria section, updated diagnosis option from Hurthle cell carcinoma to oncocytic carcinoma.

Zeposia

Prior Authorization Guideline

Guideline ID	GL-148670
Guideline Name	Zeposia
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEPOSIA 7-DAY STARTER PACK	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG	6240705020B210	Brand

ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG	6240705020B220	Brand
ZEPOSIA	OZANIMOD HCL CAP 0.92 MG	62407050200120	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG	6240705020B215	Brand

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Failure to a trial of a preferred* dimethyl fumarate product, as confirmed by claims history or submission of medical records

AND

2.1.2 Failure to a trial of at least ONE additional preferred* alternative, as confirmed by claims history or submission of medical records

OR

2.2 History of intolerance or contraindication to ALL preferred* alternatives (please specify intolerance or contraindication)

OR

2.3 Patient is currently on Zeposia therapy as confirmed by claims history or submission of medical records

Notes	*PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEPOSIA 7-DAY STARTER PACK	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG	6240705020B210	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG	6240705020B220	Brand
ZEPOSIA	OZANIMOD HCL CAP 0.92 MG	62407050200120	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG	6240705020B215	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zeposia therapy

Product Name: Zeposia	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEPOSIA 7-DAY STARTER PACK	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG	6240705020B210	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG	6240705020B220	Brand
ZEPOSIA	OZANIMOD HCL CAP 0.92 MG	62407050200120	Brand

ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG	6240705020B215	Brand

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

1.2 ONE of the following:

1.2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

1.2.2 Patient has been previously treated with a biologic or targeted synthetic disease modifying antirheumatic drug (DMARD) FDA (Food and Drug Administration)-approved for the treatment of ulcerative colitis as confirmed by claims history or submission of medical records [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

1.3 Patient is NOT receiving Zeposia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

1.4 ONE of the following:

1.4.1 Failure to ONE of the preferred adalimumab products* as confirmed by claims history or submission of medical records

OR

1.4.2 History of intolerance or contraindication to ONE of the preferred adalimumab products* (please specify intolerance or contraindication)

AND

1.5 Prescribed by or in consultation with a gastroenterologist

OR

2 - ALL of the following:

2.1 Patient is currently on Zeposia therapy as confirmed by claims history or submission of medical records

AND

2.2 Diagnosis of moderately to severely active ulcerative colitis

AND

2.3 Patient is NOT receiving Zeposia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

2.4 Prescribed by or in consultation with a gastroenterologist

Notes	*For a list of preferred adalimumab products please reference drug coverage tools. PDL Link: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

Product Name: Zeposia	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZEPOSIA 7-DAY STARTER PACK	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG	6240705020B210	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 30 X 0.92 MG	6240705020B220	Brand
ZEPOSIA	OZANIMOD HCL CAP 0.92 MG	62407050200120	Brand
ZEPOSIA STARTER KIT	OZANIMOD CAP PACK 4 X 0.23 MG & 3 X 0.46 MG & 21 X 0.92 MG	6240705020B215	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zeposia therapy

AND

2 - Patient is NOT receiving Zeposia in combination with any of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Simponi (golimumab), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

2 . Revision History

Date	Notes
6/19/2024	Added new GPI for Zeposia to GPI tables. Updated notes section. Mi nor cosmetic update.

Zilbrysq

Prior Authorization Guideline

Guideline ID	GL-146718
Guideline Name	Zilbrysq
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zilbrysq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZILBRYSQ	ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 16.6 MG/0.416ML	8580509520E520	Brand
ZILBRYSQ	ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 23 MG/0.574ML	8580509520E530	Brand
ZILBRYSQ	ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 32.4 MG/0.81ML	8580509520E540	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming ALL of the following:

1.1 Diagnosis of generalized myasthenia gravis (gMG)

AND

1.2 Positive serologic test for anti-AChR antibodies

AND

1.3 Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy

AND

1.4 Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score greater than or equal to 6 at initiation of therapy

AND

2 - ONE of the following:

2.1 History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) as confirmed by claims history or submission of medical records

OR

2.2 Patient has a history of failure of at least one immunosuppressive therapy (as confirmed by claims history or submission of medical records) and has required four or more courses of plasmapheresis/ plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control

OR

2.3 Contraindication or intolerance to at least two immunosuppressive agents (please specify contraindication or intolerance)

AND

3 - Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart,Vyvgart Hytrulo)

AND

4 - Prescribed by, or in consultation with, a neurologist

Product Name: Zilbrysq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZILBRYSQ	ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 16.6 MG/0.416ML	8580509520E520	Brand
ZILBRYSQ	ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 23 MG/0.574ML	8580509520E530	Brand
ZILBRYSQ	ZILUCOPLAN SODIUM SUBCUTANEOUS SOLN PREF SYR 32.4 MG/0.81ML	8580509520E540	Brand

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by at least ALL of the following:

1.1 Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline

AND **1.2** Reduction in signs and symptoms of myasthenia gravis **AND** **1.3** Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Zilbrysq* **AND** **2** - Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart,Vyvgart Hytrulo) **AND** **3** - Prescribed by, or in consultation with, a neurologist	
Notes	*Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Zilbrysq therapy will be considered as treatment failure

Zokinvy

Prior Authorization Guideline

Guideline ID	GL-146719
Guideline Name	Zokinvy
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zokinvy	
Diagnosis	Hutchinson-Gilford Progeria Syndrome
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOKINVY	LONAFARNIB CAP 50 MG	99463045000120	Brand
ZOKINVY	LONAFARNIB CAP 75 MG	99463045000130	Brand

Approval Criteria

1 - Diagnosis of Hutchinson-Gilford Progeria Syndrome

Product Name: Zokinvy	
Diagnosis	Progeroid Laminopathies
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOKINVY	LONAFARNIB CAP 50 MG	99463045000120	Brand
ZOKINVY	LONAFARNIB CAP 75 MG	99463045000130	Brand

Approval Criteria

1 - Diagnosis of processing deficient Progeroid Laminopathies

AND

2 - Documentation of ONE of the following:

- Heterozygous LMNA (gene) mutation with progerin-like protein accumulation
- Homozygous or compound heterozygous ZMPSTE24 (gene) mutations

Zolinza

Prior Authorization Guideline

Guideline ID	GL-146720
Guideline Name	Zolinza
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zolinza	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOLINZA	VORINOSTAT CAP 100 MG	21531575000120	Brand

Approval Criteria

1 - Diagnosis of cutaneous T-cell lymphoma (CTCL)

AND

2 - Patient has progressive, persistent, or recurrent disease on or following two systemic therapies [e.g., Adcetris (brentuximab vedotin), bexarotene, interferon alfa-db, interferon gamma-1b, methotrexate, Poteligeo (mogamulizumab), romidepsin]

Product Name: Zolinza	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOLINZA	VORINOSTAT CAP 100 MG	21531575000120	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Zolinza therapy

Product Name: Zolinza	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOLINZA	VORINOSTAT CAP 100 MG	21531575000120	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Zolinza	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZOLINZA	VORINOSTAT CAP 100 MG	21531575000120	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zolinza therapy

Zoryve

Prior Authorization Guideline

Guideline ID	GL-146446
Guideline Name	Zoryve
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zoryve cream	
Diagnosis	Plaque Psoriasis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST CREAM 0.3%	90250045003720	Brand

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - ONE of the following:

2.1 Submission of medical records or claims history confirming failure to a minimum duration of a 4-week trial to TWO of the following topical therapies:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

3 - Patient is not receiving Zoryve cream in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (Secukinumab), Stelara (Ustekinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, a dermatologist

Product Name: Zoryve cream	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST CREAM 0.3%	90250045003720	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Zoryve cream in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (Secukinumab), Stelara (Ustekinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Product Name: Zoryve foam	
Diagnosis	Seborrheic dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ZORYVE	ROFLUMILAST FOAM 0.3%	90300045003920	Brand

Approval Criteria

1 - Diagnosis of seborrheic dermatitis

AND

2 - ONE of the following:

2.1 Submission of medical records or claims history confirming failure to a minimum duration of a 4-week trial to TWO of the following topical therapies:

- Topical corticosteroids (e.g., betamethasone, hydrocortisone)
- Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, itraconazole)
- Topical calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

OR

2.2 History of intolerance or contraindication to ALL of the following topical therapies (please specify intolerance or contraindication):

- Topical corticosteroids (e.g., betamethasone, hydrocortisone)
- Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, itraconazole)
- Topical calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

3 - Patient is not receiving Zoryve foam in combination with ONE of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Zoryve foam	
Diagnosis	Seborrheic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZORYVE	ROFLUMILAST FOAM 0.3%	90300045003920	Brand

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Zoryve foam in combination with ONE of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Zurzuvae

Prior Authorization Guideline

Guideline ID	GL-146447
Guideline Name	Zurzuvae
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zurzuvae	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZURZUVAE	ZURANOLONE CAP 20 MG	58060090000120	Brand
ZURZUVAE	ZURANOLONE CAP 25 MG	58060090000125	Brand
ZURZUVAE	ZURANOLONE CAP 30 MG	58060090000130	Brand

Approval Criteria

1 - Diagnosis of postpartum depression (PPD)

AND

2 - Onset of current depressive episode was during the third trimester or within 4 weeks postpartum

Zydelig

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146721
Guideline Name	Zydelig
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zydelig	
Diagnosis	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYDELIG	IDELALISIB TAB 100 MG	21538040000320	Brand
ZYDELIG	IDELALISIB TAB 150 MG	21538040000330	Brand

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia (CLL)/ small lymphocytic lymphoma (SLL)

AND

2 - ONE of the following:

- Disease has relapsed
- Disease is refractory

Product Name: Zydelig	
Diagnosis	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYDELIG	IDELALISIB TAB 100 MG	21538040000320	Brand
ZYDELIG	IDELALISIB TAB 150 MG	21538040000330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Zydelig therapy

Product Name: Zydelig	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYDELIG	IDELALISIB TAB 100 MG	21538040000320	Brand
ZYDELIG	IDELALISIB TAB 150 MG	21538040000330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Zydelig	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYDELIG	IDELALISIB TAB 100 MG	21538040000320	Brand
ZYDELIG	IDELALISIB TAB 150 MG	21538040000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zydelig therapy

Zykadia

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146722
Guideline Name	Zykadia
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Zykadia	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

- Disease is metastatic
- Disease is recurrent
- Disease is advanced

AND

3 - ONE of the following:

- Tumor is ALK (anaplastic lymphoma kinase)-positive
- Tumor is ROS-1 (gene) positive

Product Name: Zykadia	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation

Product Name: Zykadia	
Diagnosis	Central Nervous System (CNS) Cancers

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC)

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

Product Name: Zykadia	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Diagnosis of Erdheim-Chester Disease

AND

2 - Disease is positive for anaplastic lymphoma kinase (ALK) rearrangement

Product Name: Zykadia	
Diagnosis	Inflammatory Myofibroblastic Tumor (IMT)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Diagnosis of advanced, recurrent, metastatic, or inoperable inflammatory myofibroblastic tumor (IMT)

AND

2 - Disease is positive for anaplastic lymphoma kinase (ALK) translocation

Product Name: Zykadia	
Diagnosis	Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Diagnosis of anaplastic large cell lymphoma

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

AND

3 - Disease is relapsed or refractory

AND

4 - Used as palliative intent therapy or second-line and subsequent therapy

Product Name: Zykadia	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Soft Tissue Sarcoma, Central Nervous System (CNS) Cancers, Histiocytic Neoplasms, Inflammatory Myofibroblastic Tumor (IMT), Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Zykadia therapy

Product Name: Zykadia	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic

ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Zykadia	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYKADIA	CERITINIB TAB 150 MG	21530514000330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zykadia therapy

Zytiga

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-150964
Guideline Name	Zytiga
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	8/5/2024

1 . Criteria

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic

ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following:

2.1 Disease is metastatic

OR

2.2 Disease is regional node positive (Any T, N1, M0)

OR

2.3 Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT)

OR

2.4 Positive pelvic persistence/recurrence after prostatectomy

AND

3 - Used in combination with prednisone or dexamethasone

AND

4 - ONE of the following:

4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g.,

Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

4.2 Patient has had bilateral orchiectomy

AND

5 - If the request is for the 500 mg (milligram) tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on the requested therapy

AND

2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Used in combination with prednisone

AND

3 - Androgen receptor positive recurrent disease

AND

4 - If the request is for the 500mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Zytiga therapy

AND

2 - If the request is for the 500mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

AND

2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zytiga therapy

AND

2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Zytiga

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-146723
Guideline Name	Zytiga
Formulary	• Medicaid - Community & State New Mexico SP

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic

ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following:

2.1 Disease is metastatic

OR

2.2 Disease is regional node positive (Any T, N1, M0)

OR

2.3 Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT)

OR

2.4 Positive pelvic persistence/recurrence after prostatectomy

AND

3 - Used in combination with prednisone or dexamethasone

AND

4 - ONE of the following:

4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g.,

Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

4.2 Patient has had bilateral orchiectomy

AND

5 - If the request is for the 500 mg (milligram) tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Patient does not show evidence of progressive disease while on the requested therapy

AND

2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

AND

2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Product Name: Brand Zytiga, generic abiraterone	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	Brand

ABIRATERONE ACETATE	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Generic
ZYTIGA	ABIRATERONE ACETATE TAB 500 MG	21406010200330	Brand

Approval Criteria

1 - Documentation of positive clinical response to Zytiga therapy

AND

2 - If the request is for the 500 mg tablet, the prescriber provides a reason or special circumstance the patient cannot take abiraterone 250 mg

Zyvox

Prior Authorization Guideline

Guideline ID	GL-146448
Guideline Name	Zyvox
Formulary	• Medicaid - Community & State New Mexico

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name: Brand Zyvox, generic linezolid	
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
ZYVOX	LINEZOLID TAB 600 MG	16230040000330	Brand
LINEZOLID	LINEZOLID TAB 600 MG	16230040000330	Generic
ZYVOX	LINEZOLID FOR SUSP 100 MG/5ML	16230040001920	Brand
LINEZOLID	LINEZOLID FOR SUSP 100 MG/5ML	16230040001920	Generic

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - ONE of the following diagnoses:

- Nosocomial pneumonia
- Community-acquired pneumonia
- Skin and skin structure infections (complicated and uncomplicated)

OR

4 - Invasive infection caused by or likely to be caused by vancomycin-resistant Enterococcus faecium (VRE)

OR

5 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Notes	Approval Duration: For vancomycin-resistant Enterococcus faecium, authorization will be issued for 28 days. For osteomyelitis, authorization will be issued for the requested duration, not to exceed 6 weeks. All other approvals are for 14 days.