



NEW NON- PREFERRED DRUGS	
THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED
Analgesic Agents: Gout	Colchicine Cap
Analgesic Agents: NSAIDS	Licart Patch
Analgesic Agents: Opioids	Qdolo
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Granix Udenyca
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors	Nuwiq Sevenfact
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Verquvo
Central Nervous System (CNS) Agents: Alzheimer’s Agents	Galantamine Sol
Central Nervous System (CNS) Agents: Anti Migraine Agents, Prophylaxis	Nurtec ODT
Central Nervous System (CNS) Agents: Anticonvulsants	Elepsia XR
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	Diazepam Gel
Central Nervous System (CNS) Agents: Atypical Antipsychotics	Zyprexa Relprevv
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Methylphenidate ER (generic of Aptensio XR, Relexxii) Vyvanse Chewable Tab
Central Nervous System (CNS) Agents: Multiple Sclerosis	Ponvory
Central Nervous System (CNS) Agents: Sedative - Hypnotics, Non-Barbiturate	Ramelteon
Endocrine Agents: Diabetes – Hypoglycemia Treatments	Glucagon Emerg Kit [Labeler 00548 & 63323]
Endocrine Agents: Diabetes-Insulin	Humalog U-200 Humulin R U-100 Novolin 70-30 Novolin R U-100
Endocrine Agents: Diabetes – Non-Insulin	Bydureon Bcise Symlinpen
Endocrine Agents: Growth Hormone	Genotropin
Endocrine Agents: Uterine Fibroids	Myfembree
Gastrointestinal Agents: Anti-Emetics	Bonjesta
Gastrointestinal Agents: Ulcerative Colitis	Zeposia
Genitourinary Agents: Urinary Antispasmodics	Gemtesa Vesicare LS
Infectious Disease Agents: Antibiotics – Inhaled	Kitabis Pak
Infectious Disease Agents: Antibiotics – Macrolides	Eryped Erythrocin Stearate



NEW NON- PREFERRED DRUGS	
THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED
	Erythromycin
Infectious Disease Agents: Antivirals – HIV	Norvir Cap Norvir Pow Norvir Sol
Respiratory Agents: Antihistamines-Second Generation	Cetirizine Chewable
Respiratory Agents: Cystic Fibrosis	Bronchitol
Respiratory Agents: Inhaled Agents	Albuterol HFA Bevespi Aerosphere Proair Respiclick
Topical Agents: Corticosteroids	Fluocinolone Acetonide Oil 0.01%

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	NO PA REQUIRED PREFERRED
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Bystolic Olmesartan Olmesartan/Hydrochlorothiazide Olmesartan/Amlodipine/ Hydrochlorothiazide
Central Nervous System (CNS) Agents: Alzheimer’s Agents	Donepezil ODT Exelon Patch
Central Nervous System (CNS) Agents: Anticonvulsants	Banzel
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	Diastat
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Dextroamphetamine Sol Clonidine ER Focalin XR Concerta Methylphenidate Sol Quillichew ER Quillivant XR Ritalin LA
Central Nervous System (CNS) Agents: Atypical Antipsychotics	Invega Risperdal Geodon
Central Nervous System (CNS) Agents: Medicated Assisted Treatment of Opioid Addiction	Bunavail
Central Nervous System (CNS) Agents: Multiple Sclerosis	Dimethyl Fumarate (excluding labeler 00378 & 69097)
Endocrine Agents: Diabetes – Hypoglycemia Treatments	Gvoke Hypopen Gvoke PFS Zegalogue



NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	NO PA REQUIRED PREFERRED
Endocrine Agents: Diabetes – Insulin	Apidra Humalog U-100 Novolog 70-30 Novolog U-100 Toujeo
Endocrine Agents: Diabetes – Non-Insulin	Actoplus Met XR Byetta Farxiga Invokamet Invokana Janumet Janumet XR Januvia Jardiance Jentadueto Miglitol Synjardy Tradjenta Trulicity Victoza
Gastrointestinal Agents: Anti-Emetics	Diclegis
Genitourinary Agents: Urinary Antispasmodics	Gelnique Myrbetriq Toviaz Solifenacin
Infectious Disease Agents: Antivirals – HIV	Efavirenz/Emtricitabine/Tenofovir Emtricitabine/Tenofovir Disoproxil Fumarate
Ophthalmic Agents: Glaucoma Agents	Rhopressa Rocklatan
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	Cortisporin-TC
Respiratory Agents: Inhaled Agents	Advair Diskus Advair HFA Anoro Ellipta Incruse Ellipta ProAir HFA Stiolto Striverdi Respimat Ventolin HFA
Topical Agents: Corticosteroids	Derma-Smoothe/FS Flurandrenolide



NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	CLINICAL PA REQUIRED "PREFERRED"
Analgesic Agents: Gout	Probenecid/Colchicine
Blood Agents: Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	Mircera
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Neupogen
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors	Adynovate Eloctate Esperoct Idelvion
Cardiovascular Agents: Lipotropics	Praluent Repatha
Endocrine Agents: Growth Hormone	Omnitrope
Immunomodulator Agents for Systemic Inflammatory Disease	Kineret Otezla Xeljanz IR 10 mg
Infectious Disease Agents: Antivirals – HIV	Rukobia ER
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Xolair

NEW STEP THERAPY REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	STEP THERAPY REQUIRED "PREFERRED"
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Qelbree
Immunomodulator Agents for Systemic Inflammatory Disease	Taltz
Topical Agents: Immunomodulators	Elidel

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Analgesic Agents: NSAIDs
Analgesic Agents: Gout
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating factors
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet
Cardiovascular Agents: Angina, Hypertension & Heart Failure
Cardiovascular Agents: Lipotropics
Central Nervous System (CNS) Agents: Alzheimer's Agents
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute
Central Nervous System (CNS) Agents: Anticonvulsant Rescue
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents



THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA

Table listing therapeutic categories: Central Nervous System (CNS) Agents: Medicated Assisted Treatment of Opioid Addiction, Endocrine Agents: Diabetes – Hypoglycemia, Endocrine Agents: Diabetes – Non-Insulin, Endocrine Agents: Uterine Fibroids, Gastrointestinal Agents: Crohn’s Disease, Genitourinary Agents: Urinary Antispasmodics, Infectious Disease Agents: Antivirals: HIV, Infectious Disease Agents: Hepatitis C, Respiratory Agents: Antihistamines-Second Generation, Respiratory Agents: Cystic Fibrosis, Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-Ige, Respiratory Agents: Other Agents

Please see below for the criteria changes

CHANGES IN CRITERIA

Main table with columns: THERAPEUTIC CLASS, SUMMARY OF CHANGE. Rows include: Analgesic Agents: NSAIDs (with sub-table for Approval Duration), Analgesic Agents: Gout (with additional information on Colchicine), Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors (with prior authorization criteria).



CHANGES IN CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor	<p><u>PRIOR AUTHORIZATION CRITERIA:</u></p> <ol style="list-style-type: none"> Has the patient failed <u>one</u> preferred medication? For extended half-life factors, prescribing physician attests that patient is not a suitable candidate for treatment with shorter-acting half-life product. If Rebinyn is requested, confirmation that it is not being used for routine prophylaxis Approval based upon diagnosis and dosage appropriate to weight, patient pharmacokinetic factors, and presence of inhibitors.
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	<p><u>INDICATION AND LENGTH OF AUTHORIZATION:</u> Requested medication must be used for an approved FDA indication and duration</p> <p><u>PRIOR AUTHORIZATION CRITERIA:</u></p> <ol style="list-style-type: none"> Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include: <ul style="list-style-type: none"> Allergy to medications not requiring prior approval Contraindication to all medications not requiring prior approval History of unacceptable/toxic side effects to medications not requiring prior approval Has the patient failed a 14 day trial with <u>two medications</u> not requiring prior approval?
Cardiovascular Agents: Angina, Hypertension & Heart Failure	<p><u>ENTRESTO CRITERIA:</u></p> <ol style="list-style-type: none"> Reduced left ventricular ejection fraction <p><u>VERQUVO CRITERIA:</u></p> <ol style="list-style-type: none"> Patient must meet all the following criteria: <ul style="list-style-type: none"> Diagnosis of symptomatic chronic heart failure (NYHA Class II-IV), and Left ventricular ejection fraction less than 45%, and Patient has been hospitalized for the treatment of heart failure within the previous 180 days or needs treatment with an outpatient intravenous diuretic within the previous 90 days, and Patient must be treated with an agent from ALL the following medication classes unless contradicted: <ul style="list-style-type: none"> Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, or an angiotensin receptor neprilysin inhibitor Beta-blocker Aldosterone antagonist and/or SGLT2 inhibitor as appropriate for renal function
Cardiovascular Agents: Lipotropics	<p><u>LENGTH OF AUTHORIZATIONS:</u> 365 days all Lipotropics</p> <p><u>ADDITIONAL CRITERIA FOR PCSK9 INHIBITORS:</u></p> <ul style="list-style-type: none"> Age \geq18 years or Age \geq 13 years and Homozygous Familial Hypercholesterolemia (HoFH) Documented adherence to prescribed lipid lowering medications for previous 90 days



CHANGES IN CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
Central Nervous System (CNS) Agents: Alzheimer's Agents	Has the patient failed a therapeutic trial of at least <u>30 days</u> with at least <u>two medications</u> not requiring prior approval?
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	Nurtec ODT quantity limit is 8 per 34 days
Central Nervous System (CNS) Agents: Anticonvulsant Rescue	<p><u>LENGTH OF AUTHORIZATIONS:</u> 365 Days</p> <p><u>PRIOR AUTHORIZATION CRITERIA:</u></p> <p>1. Is there any reason the patient cannot be changed to a preferred medication? Acceptable reasons include:</p> <ul style="list-style-type: none"> ○ Allergy to medications not requiring prior approval ○ Contraindication to or drug interaction with medications not requiring prior approval ○ History of unacceptable/toxic side effects to medications not requiring prior approval <p>AR - Valtoco: a PA is required for patients younger than 6 years old AR - Nayzilam: a PA is required for patients who are younger than 12 years old</p>
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	<p><u>STEP THERAPY:</u></p> <p>1. For a drug requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than <u>30 days</u> of at least <u>two preferred</u> products.</p> <p>Note: Patients on non-preferred therapies are not required to obtain prior authorization for the use of their product until after June 30th, 2022. Providers may obtain prior authorization before June 30th, 2022.</p> <p>AR - Dextroamphetamine Solution: a PA is required for patients over 12 years old AR - Methylphenidate Solution: a PA is required for patients over 12 years old</p>
Central Nervous System (CNS) Agents: Medicated Assisted Treatment of Opioid Addiction	<p><u>Criteria for SUBCUTANEOUS BUPRENORPHINE INJECTION (SUBLOCADE™)</u></p> <ul style="list-style-type: none"> ○ Provider will attest that the patient is receiving or planning to receive counseling.
Endocrine Agents: Diabetes - Hypoglycemia	<p><u>PA REQUIRED NON-PREFERRED:</u></p> <p>A non-preferred medication will be approved after a trial with a preferred medication not requiring prior approval or the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion.</p>
Endocrine Agents: Diabetes – Non-Insulin	<p><u>NON-PREFERRED:</u></p> <p>There must have been a therapeutic failure of at least a 60-day trial and failure with three preferred products.</p> <p>Note: Inadequate clinical response after at least 60 days of recommended therapeutic dose with documented adherence to the regimen.</p>



Table with 2 columns: THERAPEUTIC CLASS and SUMMARY OF CHANGE. Rows include: Endocrine Agents: Uterine Fibroids; Gastrointestinal Agents: Crohn's Disease; Genitourinary Agents: Urinary Antispasmodics; Infectious Disease Agents: Antivirals: HIV; Infectious Disease Agents: Hepatitis C; Respiratory Agents: Antihistamines-Second Generation; Respiratory Agents: Cystic Fibrosis.



CHANGES IN CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
	<ul style="list-style-type: none"> ○ Patient meets the FDA-approved age minimum for the requested medication <p><u>ADDITIONAL CRITERIA FOR BRONCHITOL</u></p> <ul style="list-style-type: none"> ○ Bronchitol must be used as an add-on maintenance therapy ○ Patients must have passed the Bronchitol Tolerance Test <p><u>ADDITIONAL CRITERIA FOR KALYDECO, ORKAMBI, SYMDEKO AND TRIKAFTA</u></p> <ul style="list-style-type: none"> ○ Patient has documentation (must include with PA request) of the genetic mutation(s) that the FDA approved the requested medication to treat <p><u>REAUTHORIZATION CRITERIA:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chart notes submitted with stabilization OR improvement of FEV1 AND with one or more of the following: <ul style="list-style-type: none"> ○ Stabilization or improvement of weight gain ○ Stabilization or improvement in sweat chloride ○ Decrease in the number of pulmonary exacerbations or their severity ○ Decrease in the number or severity of pulmonary infections ○ Decrease in the number of hospitalizations ○ Increased Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score ○ Other documentation by the physician clearly explaining the ongoing benefit of continuing the drug based on stated and documented objective evidence of improvement or a clear stabilization in a previous decline in one of the above parameters
Respiratory Agents: Monoclonal Antibodies- Anti-IL/Anti-Ige	<p><u>ADDITIONAL CRITERIA FOR OMALIZUMAB (XOLAIR)</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Indicated for chronic urticaria if: <ul style="list-style-type: none"> ○ Patient has tried and failed two 14-day trials with two different antihistamines ○ Prescribed by or in consultation with a dermatologist or allergist/immunologist ○ Prescribed in accordance with its FDA approved labeling <input type="checkbox"/> Indicated for chronic rhinosinusitis with nasal polyposis if: <ul style="list-style-type: none"> ○ Patient is 18 years of age or older ○ Patient had an inadequate response, intolerance or contraindication to one oral corticosteroid ○ Patient had a 30-day trial and experienced an inadequate response, intolerance or contraindication to one nasal corticosteroid spray
Respiratory Agents: Other Agents	<p><u>LENGTH OF AUTHORIZATIONS:</u> For the date of service only; Daliresp evaluated with each refill</p> <p><u>PRIOR AUTHORIZATION CRITERIA:</u></p> <ol style="list-style-type: none"> 1. Daliresp must be used with a long-acting beta agonist or long-acting muscarinic antagonists 2. Daliresp evaluated with each refill



REVISED THERAPEUTIC CATEGORIES

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants

Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet

Gastrointestinal Agents: Crohn's Disease