Formulary Exception Criteria

EXPRESS SCRIPTS®

STANDARD FORMULARY EXCEPTION CRITERIA				
Therapy Class	**Brand Name**	**Generic Name**	**Commercial FE Criteria**	**Approval Duration**
ACE-Inhibitor/CCB Combination Product	Prestalia	perindopril arginine and amlodipine tablets	Approve if the patient has tried amlodipine/benazepril capsules (Lotrel, generics), if formulary. If amlodipine/benazepril capsules (Lotrel, generics) are non-formulary, approve if the patient has tried four different angiotensin converting enzyme (ACE) inhibitor-containing products each taken concomitantly with an amlodipine-containing product. Note: Examples of ACE inhibitors include: benazepril, captopril, enalapril (Vasotec, generics), fosinopril, lisinopril (Zestril, generics), moexipril, perindopril (Aceon, generics), quinapril (Accupril, generics), ramipril (Altace, generics), trandolapril (Mavik, generics). Note: A trial of Prestalia does not meet the above requirement.	1 year
ACE-Inhibitor/CCB Combination Product	Lotrel	amlodipine/benazepril capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Acid Sphingomyelinase Deficiency (ASMD) Agents	Xenpozyme	olipudase alfa-rpcp intravenous infusion	See standard *Enzyme Replacement Therapy – Xenpozyme Prior Authorization Policy* criteria.	See PA duration
Acne Vulgaris Agents (Topical)	Winlevi	clascoterone cream 1%	Acne Vulgaris in a patient ≥ 12 years of age. Approve if the patient meets both of the following (A and B): A. Patient has tried at least one prescription topical retinoid for the treatment of acne vulgaris **[documentation required]**; AND Note: Examples of prescription topical retinoids include adapalene (Differin, generic), Aklief (trifarotene 0.005% cream), Arazlo (tazarotene 0.045% lotion), Fabior (tazarotene 0.1% foam), tazarotene 0.1% cream and gel (Tazorac, generic), tretinoin. B. Patient has tried at least three other prescription non-retinoid topical therapies for the treatment of acne vulgaris **[documentation required]**. Note: Topical retinoids do not count. Examples of other prescription non-retinoid topical therapies for acne include: benzoyl peroxide, dapsone gel (Aczone, generic), Azelex (azelaic acid 20% cream), topical clindamycin, topical erythromycin, and topical minocycline (Amzeeq [minocycline 4% foam]). For combination products, each active chemical entity counts as one trial. Example: If one topical prescription product has 2 non-retinoids, this would fulfill a trial of 2 non-retinoid topical therapies.	1 year
Acne Vulgaris Agents (Topical)	Dapsone gel 7.5 % (brand)	dapsone 7.5 gel	Approve if the patient tried and cannot take dapsone 7.5% gel pump, if formulary. If dapsone 7.5% gel pump is non-formulary, approve if the patient has tried three different topical antibiotic products (each from a different group) from the following: 1) dapsone 5 % gel, 2) a clindamycin-containing product, 3) an erythromycin-containing product; 4) an azelaic acid-containing product (Azelex, Finacea).	1 year
Acne Vulgaris Agents (Topical)	Amzeeq	minocycline topical 4% foam	Acne vulgaris in a patient ≥ 9 years of age. Approve if the patient meets BOTH of the following (A and B): A. Patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with at least one prescription topical retinoid; AND Note: Examples of a prescription topical retinoid are adapalene (Differin generic), Aklief (trifarotene 0.005% cream), tazarotene 0.1% cream (Tazorac 0.1% cream, generic), tazarotene 0.1% gel (Tazorac 0.1% gel, generic), and tretinoin. B. Patient has tried, and according to the prescriber has experienced inadequate efficacy or significant intolerance with at least two non-retinoid topical acne therapies. Note: Topical retinoids do not count. Examples of other non-retinoid topical therapies for acne include: benzoyl peroxide, dapsone gel (Aczone, generic), Azelex (azelaic acid 20% cream), topical clindamycin, topical erythromycin, and topical minocycline (Amzeeq [minocycline 4% foam]). For combination products, each active chemical entity counts as one trial. Example: If one product has 2 non-retinoids, this would fulfill a trial of 2 non-retinoid topical therapies.	1 year
Acne Vulgaris Agents (Topical)	Azelex	azelaic acid cream 20%	**1.** Patient with rosacea: approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with at least three other topical agents for rosacea. Examples include: sodium sulfacetamide 10%/sulfur 5% products such as cleansers, gels (Rosula, generics), metronidazole 0.75% or 1% products such as gels, creams, and lotions (MetroGel, generics; MetroLotion, generics; MetroCream, generics; Noritate), Soolantra 1% cream (generics), Finacea 15% gel (generics), Finacea 15% foam. **2.** Patient with acne vulgaris: approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy or significant intolerance with at least three other prescription topical products for acne. Examples include: topical antibiotic products (e.g., clindamycin, erythromycin, benzoyl peroxide); topical retinoids (tretinoin [Atralin/generics, Avita/generics, Retin-A/generics, Retin-A Micro], adapalene (Differin/generics), tazorotene (Tazorac 0.1% cream or 0.1% gel or Fabior 0.1% foam); Finacea 15% gel (generics) / Finacea 15% foam; Aczone; sulfacetamide-containing products; combination products (Acanya, Veltin, clindamycin/tretinoin gel [Ziana, generics], other generics).	1 year
Acne Vulgaris Agents (Topical)	Clindagel 1% gel	clindamycin 1% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Acne Vulgaris Agents (Topical) – Combination Products	Epiduo Forte	adapalene 0.3%-benzoyl peroxide 2.5% (brand 60 g; generic 45g)	Approve if the patient has tried and cannot take generic adapalene 0.3%-benzoyl peroxide 2.5% gel, if formulary. If generic adapalene 0.3%-benzoyl peroxide 2.5% is non-formulary, approve if the patient has tried adapalene 0.3% gel, if formulary. If adapalene 0.3% gel is non-formulary, approve.	1 year

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Acne Vulgaris Agents (Topical) – Combination Products	Cabtreo	clindamycin phosphate, adapalene and benzoyl peroxide topical gel	Acne vulgaris in a patient ≥ 12 years of age. Approve if the patient meets BOTH of the following (A and B): A. Patient has concomitantly tried ALL three of the following products **[documentation required]**: 1) a topical benzoyl peroxide product, 2) a topical tretinoin-containing or adapalene-containing product, and 3) a topical clindamycin-containing product; AND B. According to the prescriber, there is a significant clinical concern such that the patient is unable to continue to use the products in criterion A.	1 year
Acne Vulgaris Agents (Topical) – Combination Products	Twyneo	tretinoin/benzoyl peroxide cream	Acne vulgaris in a patient ≥ 9 years of age. Approve if the patient has tried and cannot take BOTH a benzoyl peroxide- AND a tretinoin- containing product. Note: Examples of topical tretinoin product include: tretinoin gel/cream, Retin-A gel/cream, Retin-A Micro gel, Atralin, Altreno, Avita.	1 year
Acne Vulgaris Agents (Topical) – Combination Products	Acanya Gel	benzoyl peroxide 2.5% and clindamycin phosphate 1.2% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Acne Vulgaris Agents (Topical) – Combination Products	Veltin	clindamycin phosphate and tretinoin gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Aklief	trifarotene cream	Acne vulgaris in a patient ≥ 9 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with ALL of the following (A, B, and C): A. A topical adapalene product; AND Note: Examples of topical adapalene products include Differin and adapalene. B. A topical tazarotene product; AND Note: Example of topical tazarotene products include Tazorac, tazarotene, Arazlo, Fabior. C. A topical tretinoin product. Note: Examples of topical tretinoin products include Retin-A, Retin-A Micro, tretinoin, Altreno, Atralin, Avita.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Altreno	tretinoin 0.05% lotion	Approve if the patient has tried and cannot take one other topical tretinoin product. Note: Examples of topical tretinoin products include tretinoin, Retin-A, Retin-A Micro, Atralin, Avita.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Arazlo	tazarotene 0.045% lotion	Acne vulgaris in a patient ≥ 9 years of age. Approve if the patient meets BOTH of the following (A and B): A. Patient has tried and is unable to take one other topical tazarotene product; AND Note: Example of topical tazarotene products include Tazorac, tazarotene, Fabior. B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with one topical tretinoin product. Note: Examples of topical tretinoin products include Retin-A, Retin-A Micro, tretinoin, Alreno, Atralin, Avita.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Avita	tretinoin 0.025% gel	Approve if the patient has tried and cannot take one other topical tretinoin product. Note: Examples of topical tretinoin product include: tretinoin, Retin-A, Retin-A Micro, Atralin, Altreno.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Differin	adapalene 0.1% lotion	Acne vulgaris in a patient ≥ 12 years of age. Approve if the patient meets BOTH of the following (A and B): A. Patient has tried and cannot take one other topical adapalene product; AND Note: Examples of topical adapalene products include Differin cream/gels and adapalene cream/gels. B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with one topical tretinoin product. Note: Examples of topical tretinoin products include Retin-A, Retin-A Micro, tretinoin, Alreno, Atralin, Avita.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Fabior and authorized generic	tazarotene 0.1% foam	Other diagnoses (e.g., acne vulgaris). Approve if the patient meets the following (A and B): A. Patient has tried and cannot take one of tazarotene cream (Tazorac cream, generics) or tazarotene gel (Tazorac gel, generics), if one is formulary. If none are formulary, approve; AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with one topical tretinoin-containing product. Note: Examples of topical retinoid products include tretinoin cream (Retin-A cream, generics), tretinoin gel (Retin-A gel, generics). Psoriasis. Approve if the patient has tried and cannot take one of tazarotene cream (Tazorac cream, generics) or tazarotene gel (Tazorac gel, generics), if one is formulary. If none are formulary, approve.	1 year

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Acne Vulgaris Agents (Topical) – Retinoid Products	Retin-A micro gel 0.06% pump	tretinoin gel 0.06% pump	Approve if the patient has tried and cannot take one other topical tretinoin product. Note: Examples of topical tretinoin product include: tretinoin gel/cream, Retin-A gel/cream, Atralin, Altreno, Avita.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Atralin	tretinoin gel (0.05%)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Acne Vulgaris Agents (Topical) – Retinoid Products	Retin-A Micro 0.1% & 0.04% gel	tretinoin 0.1% & 0.04% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Actinic Keratosis Agents (Topical)	Carac and authorized generic 0.5%	fluorouracil 0.5% cream	Approve if the patient has tried one of the following products, if formulary: Tolak, fluorouracil 2% solution, fluorouracil 5% solution, or fluorouracil 5% cream (Efudex, generics). If none are formulary, approve.	1 year
Actinic Keratosis Agents (Topical)	Tolak	fluorouracil 4% cream	Approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): fluorouracil 0.5% cream/Carac, fluorouracil 2% solution, fluorouracil 5% solution, or fluorouracil 5% cream (Efudex, generics). If none are formulary, approve. Note: Fluorouracil 0.5% cream and Carac would count as one alternative.	1 year
Actinic Keratosis Agents (Topical)	Zyclara and generics 2.5% and 3.75%	imiquimod 2.5% and 3.75% cream	Approve if the patient has tried imiquimod 5% cream (Aldara, generics), if formulary. If imiquimod 5% cream (Aldara, generics) is non-formulary, approve.	1 year
Actinic Keratosis Agents (Topical)	Klisyri	tirbanibulin ointment 1%	Approve if the patient has tried BOTH of the following products: 1) a fluorouracil-containing product (e.g., fluorouracil cream, Carac, fluorouracil topical solution) and 2) an imiquimod-containing product (e.g., imiquimod 5% cream, Zyclara). If neither an fluorouracil-containing product nor a imiquimod-containing product are formulary, approve.	1 year
Activated Phosphoinositide 3-kinase Delta (PI3kd) Syndrome (APDS) Agents	Joenja	leniolisib tablet	See standard *Immune Disorder - Joenja Prior Authorization Policy* criteria	See PA duration
Adenosine triphosphate (ATP)-citrate lyase inhibitor	Nexletol	bempedoic acid tablet	Approve if the patient has met one of the following (A, B, or C): A. The patient has tried an atorvastatin-containing product at doses of atorvastatin ≥ 40 mg for ≥ 8 continuous weeks; OR B. The patient has tried a rosuvastatin-containing product at doses of rosuvastatin ≥ 20 mg for ≥ 8 continuous weeks; OR C. If the patient is considered to be statin intolerant, the patient has tried ezetimibe, an ezetimibe (Zetia)-containing product OR a Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitor product [e.g., Leqvio, Praluent, or Repatha).	1 year
Adenosine triphosphate (ATP)-citrate lyase inhibitor	Nexlizet	bempedoic acid and ezetimibe tablet	Approve if the patient has met one of the following (A, B, or C): A. The patient has tried an atorvastatin-containing product at doses of atorvastatin ≥ 40 mg daily for ≥ 8 continuous weeks; OR B. The patient has tried a rosuvastatin-containing product at doses of rosuvastatin ≥ 20 mg daily for ≥ 8 continuous weeks; OR C. If the patient is considered to be statin intolerant, the patient has tried ezetimibe, an ezetimibe (Zetia)-containing product OR a Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitor product [e.g., Leqvio, Praluent, or Repatha)	1 year

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Aldosterone Synthase Inhibitors	Baxfendy	baxdrostat tablets	**1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried or is currently receiving a diuretic, unless according to the prescriber, it is contraindicated; AND Note: Examples of a thiazide diuretics include chlorthalidone, chlorothiazide, hydrochlorothiazide, indapamide, and metolazone. Examples of loop diuretics include furosemide, torsemide, bumetanide, and ethacrynic acid. Examples of contraindications to diuretics include anuria, sulfonamide hypersensitivity, severe renal or hepatic impairment, symptomatic hyperuricemia/gout, hypercalcemia, electrolyte dysfunction, or increased risk of falls and syncope. B. In addition to the diuretic, the patient has tried, or is currently receiving at least two other antihypertensive agents from the following pharmacological classes (a, b, c, d, e, f, g,): a. Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB); Note: Examples of ACE inhibitors include benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, ramipril, and trandolapril. Examples of ARBs include azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, temlisartan, and valsartan. b. Non-dihydropyridine calcium channel blocker (CCB); Note: Examples of non-dihydropyridine CCBs include diltiazem and verapamil. c. Dihydropyridine calcium channel blocker (CCB); Note: Examples of dihydropyridine CCBs include amlodipine, felodipine, isradipine, nicardipine, nifedipine, and nisoldipine. d. Beta-blocker; Note: Examples of beta-blockers include acebutolol, atenolol, betaxolol, bisoprolol, carvedilol, metoprolol, nadolol, nebivolol, pindolol, propranolol, and timolol. e. Alpha-adrenergic blocker; Note: Examples of alpha-adrenergic blockers include doxazosin, prazosin, and terazosin. f. Central alpha adrenergic blocker; Note: Examples of central alpha adrenergic bockers include clonidine, guanfacine, and methyldopa. g. Direct vasodilator; Note: Examples of direct vasodilators include hydralazine and minoxidil. **2.** Approve if the patient has already been started on therapy with Baxfendy.	1 year
Alkylating Agent	Grafapex	treosulfan intravenous infusion	For allogeneic hematopoietic stem cell transplantation in patients with acute myeloid leukemia or myelodysplastic syndrome. **1.** Approve if the patient has tried OR, according to the prescriber, is unable to use one other conditioning regimen (e.g., a regimen containing busulfan, cyclophosphamide, fludarabine, or etoposide). **2.** Approve if the patient has already been started on therapy with Grafapex.	30 days
Allergen Immunotherapy	Grastek	timothy grass pollen allergen extract sublingual tablets	**1**. Approve if the patient has tried Oralair, if formulary. If Oralair is non-formulary, approve. **2.** Patient < 18 years of age, approve. **3.** Patient has been started on a current course of therapy with Grastek: approve to complete the current course.	1 year
Allergen Immunotherapy	Ragwitek	short ragweed pollen allergen extract sublingual tablets	See standard *Allergen Immunotherapy – Ragwitek Prior Authorization Policy* criteria.	See PA duration
Allergen Immunotherapy	Odactra	house dust mite allergen extract tablet for sublingual use	See standard *Allergen Immunotherapy – Odactra Prior Authorization Policy* criteria.	See PA duration
Allergen Immunotherapy	Oralair	Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass mixed pollens allergen extract sublingual tablets	**1**. Approve if the patient has tried Grastek, if formulary. If Grastek is non-formulary, approve. **2**. Patient has been started on a current course of therapy with Oralair: approve to complete the current course.	1 year
Allergen Immunotherapy	Palforzia	peanut [Arachis hypogaea] allergen powder-dnfp for oral administration	See standard *Allergen Immunotherapy – Palforzia Prior Authorization Policy* criteria.	See PA duration
Allogeneic Bone marrow-Derived Mesenchymal Stromal Cell Therapy for GVHD	Ryoncil	remestemcel-L-rknd intravenous infusion	See standard *Graft-Versus-Host Disease – Ryoncil Prior Authorization Policy* criteria.	See PA duration

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Alpha and beta-blocker	Coreg	carvedilol tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Alpha-1 Adrenoceptor Antagonist	Tezruly	terazosin oral solution	**1.** Approve if the patient tried and cannot take terazosin capsules. If terazosin capsules are non-formulary, approve. **2.** Approve if the patient is unable to swallow capsules or has difficulty swallowing capsules.	1 year
Alpha1 Proteinase Inhibitors	Aralast NP	alpha1-proteinase inhibitor [human] lyophilized powder	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis. Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Glassia, Prolastin-C, or Zemaira. If none are formulary, approve.	1 year
Alpha1 Proteinase Inhibitors	Glassia	alpha1-proteinase inhibitor [human] solution	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis. Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Aralast NP, Prolastin-C, or Zemaira. If none are formulary, approve.	1 year
Alpha1 Proteinase Inhibitors	Prolastin-C	alpha1-proteinase inhibitor [human] lyophilized powder	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis. Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Aralast NP, Glassia, or Zemaira. If none are formulary, approve.	1 year
Alpha1 Proteinase Inhibitors	Zemaira	alpha1-proteinase inhibitor [human] lyophilized powder	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis. Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Aralast NP, Glassia, or Prolastin-C. If none are formulary, approve.	1 year
Alpha-2 Agonists	Lucemyra	lofexidine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Alpha-adrenergic Agonist	Nexiclon XR and authorized generic	clonidine ER tablet and authorized generic	Approve if the patient tried and is unable to use both clonidine immediate-release tablets AND clonidine transdermal patches.	1 year
Alpha-adrenergic Agonist	Javadin	clonidine hydrochloride oral solution	**1.** Approve if the patient tried and cannot take clonidine oral tablets. If clonidine oral tablets are non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year
Alpha-adrenergic Agonist	clonidine 0.05 mg tablet (brand)	clonidine 0.05 mg tablet	Approve if the prescribed dose cannot be obtained with generic clonidine 0.1 mg, 0.2 mg, or 0.3 mg tablets. Note: The patient is NOT required to split any of the higher strength tablets in half.	1 year
Aluminum Chloride Agents	Drysol	aluminum chloride 20% topical solution	Hyperhidrosis in the axillae, palms, or soles. Approve if the patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one over-the-counter aluminum-containing product (such as Certain Dri, Bromi-lotion) **[documentation required]**.	1 year
Alzheimer's Agent - Amyloid beta-directed antibody	Kisunla	donanemab-azbt intravenous infusion	Patient meets standard *Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Kisunla Prior Authorization Policy* criteria AND one of the following (1 or 2): **1.** Approve if the patient has tried Leqembi intravenous. If Leqembi intravenous is non-formulary, approve. Note: If the patient has already tried Leqembi IQLIK, this would satisfy the requirement. **2.** Approve if the patient is currently taking Kisunla.	See PA duration
Alzheimer's Agent - Amyloid beta-directed antibody	Leqembi IV	lecanemab-irmb intravenous infusion	Patient meets standard *Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Leqembi Intravenous Prior Authorization Policy* criteria AND one of the following (1 or 2): **1.** Approve if the patient has tried Kisunla. If Kisunla is non-formulary, approve. **2.** Approve if the patient is currently taking Leqembi (intravenous or subcutaneous).	See PA duration
Alzheimer's Agent - Amyloid beta-directed antibody	Leqembi IQLIK	lecanemab-irmb subcutaneous injection	Patient meets standard *Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Leqembi IQLIK Prior Authorization Policy* criteria.	See PA duration

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Alzheimer's Disease Agents	Namzaric	donepezil and extended-release memantine capsule	Approve if the patient has tried donepezil (Aricept tablets, Aricept ODT, generics) AND memantine (Namenda XR, Namenda tablets/oral solution, generics) [taken concomitantly], if both are formulary. If only one is formulary or if none are formulary, approve.	1 year
Alzheimer's Disease Agents	Adlarity	donepezil transdermal system	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with donepezil tablets, if formulary. If donepezil tablets are non-formulary, approve. **2.** If the patient has difficulty swallowing tablets, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with donepezil orally disintegrating tablet (ODT), if formulary. If donepezil ODT is non-formulary, approve.	1 year
Alzheimer's Disease Agents	Zunveyl	benzgalantamine delayed-release tablets	**1.** Approve if the patient has tried two of the following (if formulary): 1) donepezil tablets (Aricept, generics), 2) galantamine immediate-release tablets (Razadyne, generics) or extended-release capsules (generics), or 3) rivastigmine capsules (generic) or patches (Exelon, generics) **[documentation required]**. If none are formulary, approve. Note: All products with the same chemical count as one alternative. For example, all galantamine products count as one alternative. **2.** Approve if the patient has already been started on therapy with Zunveyl.	1 year
Alzheimer's Disease Agents	Namenda XR	memantine extended-release capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Amyloidosis-associated Polyneuropathy Agents	Onpattro	patisiran for intravenous use	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR) in a patient ≥18 years of age. **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Amvuttra or Wainua, if formulary. If neither are formulary, approve. **2.** Approve if the Patient has already been started on therapy with Onpattro.	1 year
Amyloidosis-associated Polyneuropathy Agents	Wainua	eplontersen subcutaneous injection	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR) in a patient ≥18 years of age. Note: Variant Transthyretin Amyloidosis is also known as Hereditary Transthyretin Amyloidosis. **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Amvuttra, if formulary. If Amvuttra is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Wainua.	1 year
Amyloidosis-associated polyneuropathy and cardiomyopathy agents - ransthyretin-directed small interfering RNA (siRNA)	Amvuttra	vutrisiran subcutaneous injection	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR) in a patient ≥18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Wainua, if formulary. If Wainua is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Amvuttra. Cardiomyopathy of Wild-Type or Hereditary Transthyretin-Mediated Amyloidosis (ATTR-CM). Note: Variant Transthyretin Amyloidosis is also known as Hereditary Transthyretin Amyloidosis. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with one of Attruby or Vyndamax, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Amvuttra. Approve if patient has BOTH Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR) AND Cardiomyopathy of Wild-Type or Hereditary Transthyretin-Mediated Amyloidosis (ATTR-CM). Note: Variant Transthyretin Amyloidosis is also known as Hereditary Transthyretin Amyloidosis.	1 year
Amyloidosis-associated cardiomyopathy agents — selective transthyretin (TTR) stabilizer	Vyndamax	tafamidis capsules (61 mg)	Cardiomyopathy of Wild-Type or Hereditary Transthyretin-Mediated Amyloidosis (ATTR-CM) in a patient ≥ 18 years of age. Note: Variant Transthyretin Amyloidosis is also known as Hereditary Transthyretin Amyloidosis. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance one of Amvuttra or Attruby, if formulary. If neither are formulary, approve. **2.** If the patient has already been started on therapy with Vyndamax, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with Attruby, if formulary. If Attruby is non-formulary, approve.	1 year
Amyloidosis-associated cardiomyopathy agents – selective transthyretin (TTR) stabilizer	Attruby	acoramidis tablets	Cardiomyopathy of Wild-Type or Hereditary Transthyretin-Mediated Amyloidosis (ATTR-CM) in a patient ≥ 18 years of age. Note: Variant Transthyretin Amyloidosis is also known as Hereditary Transthyretin Amyloidosis. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with one of Amvuttra or Vyndamax, if formulary. If neither are formulary, approve. **2.** If the patient has already been started on therapy with Attruby, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with Vyndamax, if formulary. If Vyndamax is non-formulary, approve.	1 year
Amyotrophic Lateral Sclerosis - Riluzole Agents	Tiglutik or Teglutik	riluzole oral suspension	**1.** Approve if the patient has tried riluzole tablets (Rilutek, generics), if formulary. If riluzole tablets (Rilutek, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow tablets or has difficulty swallowing tablets.	1 year
Analgesics - Butalbital-Containing Products	Allzital tablet	butalbital 25 mg, acetaminophen 325 mg tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Analgesics - Butalbital-Containing Products	Bupap tablet	butalbital 50 mg, acetaminophen 300 mg tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year
Analgesics - Butalbital-Containing Products	butalbital 50 mg, acetaminophen 300 mg capsule	butalbital 50 mg, acetaminophen 300 mg capsule	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year
Analgesics - Butalbital-Containing Products	Esgic capsule	butalbital 50 mg, acetaminophen 325 mg, caffeine 40 mg capsule or tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year
Analgesics - Butalbital-Containing Products	Fioricet capsule	butalbital 50 mg, acetaminophen 300 mg, caffeine 40 mg capsule or tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year
Analgesics - Butalbital-Containing Products	Fiorinal capsule	butalbital 50 mg, aspirin 325 mg, caffeine 40 mg capsule	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year
Analgesics – Combination Products	Combogesic	acetaminophen 325 mg and ibuprofen 97.5 mg tablets	**1.** Patient is directed to acetaminophen AND ibuprofen, used concurrently. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use acetaminophen and ibuprofen, used concurrently.	1 year
Analgesics - Orphenadrine-Containing Products	orphenadrine citrate-aspirin-caffeine tablets (including Norgesic Forte and Orphengesic Forte)	aspirin, caffeine, orphenadrine citrate tablets	Approve if the patient has tried prescription orphenadrine citrate extended-release 100 mg tablets [documentation required] AND an over-the-counter (OTC) aspirin and caffeine-containing product **[documentation required]**. Note: Examples of OTC aspirin and caffeine combination products include Anacin tablets, Bayer Back and Body Pain caplet, BC Arthritis powder packets.	1 year
Analgesics - Sodium Channel Blockers	Journavx	suzetrigine tablets	Moderate to severe acute pain (NOT chronic pain) in a patient ≥ 18 years of age. Note: Acute pain is generally sudden in onset and is often caused by injury, trauma, or medical treatments (e.g., surgery). Approve if the patient meets BOTH of the following (1 AND 2): **1.** Approve if the patient has tried, and according to the prescriber experienced inadequate efficacy or significant intolerance with a prescription-dose nonsteroidal anti-inflammatory (NSAID) for the current pain episode OR, according to the prescriber, has a contraindication to NSAIDs; AND **2.** Approve if the patient has tried, and according to the prescriber experienced inadequate efficacy or significant intolerance with acetaminophen for the current pain episode OR, according to the prescriber, has a contraindication to acetaminophen.	1 month
Angiotensin Converting Enzyme (ACE) Inhibitors	Qbrelis	lisinopril oral solution	**1.** Approve if the patient has tried lisinopril tablets (Prinivl, Zestril, generics), if formulary. If lisinopril tablets (Prinivil, Zestril, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.	1 year
Angiotensin Converting Enzyme (ACE) Inhibitors	Epaned	enalapril maleate powder for oral solution, enalapril maleate oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers	Valsartan oral solution (previously Prexxartan)	valsartan oral solution	**1.** Direct the patient to valsartan tablets. **2.** Approve if the patient is unable to or has difficulty swallowing oral tablets.	1 year
Angiotensin Receptor Blockers (ARBs)	Arbli	losartan potassium oral suspension	**1.** Approve if the patient tried and cannot take losartan tablets. If losartan tablets are non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets. **3.** Approve if the prescribed dose cannot be obtained with whole tablets of any losartan strengths.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Angiotensin Receptor Blockers (ARBs) and CCB, thiazide-like diuretic Combination Products	Widaplik	telmisartan, amlodipine and indapamide tablets	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried, and according to the prescriber has experienced inadequate efficacy or significant intolerance with five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve; AND Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. B. Has used the above angiotensin receptor blocker(s) CONCURRENTLY with amlodipine AND indapamide.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Edarbi and azilsartan	azilsartan tablets	Approve if the patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	telmisartan-amlodipine tablets	telmisartan-amlodipine tablets	Approve if the patient has tried ONE of the following, if formulary: 1) amlodipine-olmesartan tablets (Azor, generics) OR 2) amlodipine-valsartan (Exforge, generics). If neither are formulary, approve if the patient has tried one angiotensin receptor blocker used concurrently with amlopidine. Note: Examples of angiotensin receptor blockers are: losartan (Cozaar, generics), valsartan (Diovan, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), telmisartan (Micardis, generics), candesartan (Atacand, generics). Note: If the patient has tried a brand version of a generic product, then this would satisfy the requirement.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Edarbyclor	azilsartan and chlorthalidone tablets	**1.** Approve if the patient has tried five of the following formulary angiotensin receptor blocker/diuretic combination products, if five are formulary, or four if four are formulary, or three if three are formlary, or two are formulary, or one if only one is formulary): candesartan-hydrochlorothiazide (Atacand HCT, generics), irbesartan-hydrochlorothiazide (Avalide, generics), losartan-hydrochlorothiazide (Hyzaar, generics), telmisartan-hydrochlorothiazide (Micardis HCT, generics), valsartan-hydrochlorothiazide (Diovan HCT, generics), olmesartan-hydrochlorothiazide (Benicar HCT, generics). **2.** Approve if the patient has tried chlorthalidone AND Edarbi, if Edarbi is formulary. If Edarbi is non-formulary, approve if the patient has tried five of the following formulary angiotensin receptor blockers (ARBs), if five are formulary or four if four are formulary or three if three are formulary, or two if only two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Atacand	candesartan cilexetil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Atacand HCT	candesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Avalide	irbesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Avapro	irbesartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	AZOR	amlodipine besylate/olmesartan medoxomil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Benicar	olmesartan medoxomil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Benicar HCT	olmesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Cozaar	losartan tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Angiotensin Receptor Blockers (ARBs) and Combination Products	Diovan	valsartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Diovan HCT	valsartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Exforge	valsartan/amlodipine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Exforge HCT	valsartan/amlodipine/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Hyzaar	losartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Micardis HCT	telmisartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Angiotensin Receptor Blockers (ARBs) and Combination Products	Tribenzor	olmesartan/amlodipine/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Anti-arrhythmic agents	Norpace and disopyramide capsules	disopyramide phosphate capsules	**1.** Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol). **2.** Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.	1 year
Anti-arrhythmic agents	Norpace CR	disopyramide extended-release capsule	**1.** Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol). **2.** Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.	1 year
Antibiotics (Inhaled)	Kitabis Pak and authorized generic	tobramycin inhalation solution with nebulizer	**1.** Approve if the patient has tried one inhaled tobramycin product from the following list (if one is formulary): tobramycin inhalation solution (TOBI, generics or Bethkis, generics). If neither are formulary, approve. **2.** If the patient has already been started on Kitabis Pak or Tobramycin Pak, approve.	1 year
Antibiotics (Inhaled)	Arikayce	amikacin liposome inhalation suspension for oral inhalation	See standard *Antibiotics (Inhaled) – Arikayce Prior Authorization Policy* criteria	See PA duration
Antibiotics (Inhaled)	TOBI Podhaler	tobramycin inhalation powder	**1.** Approve if the patient has tried one inhaled tobramycin product from the following list (if one is formulary): tobramycin inhalation solution (TOBI, generics), Bethkis (generics) or Kitabis Pak. If none are formulary, approve. **2.** If the patient has already been started on TOBI Podhaler, approve.	1 year
Antibiotics (Inhaled)	Cayston	aztreonam for inhalation solution	See standard *Antibiotics (Inhaled) – Cayston Prior Authorization Policy* criteria	See PA duration
Antibiotics (Inhaled)	TOBI	tobramycin solution for inhalation	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antibiotics (Oral)	Xifaxan 200 mg tablets	rifaximin 200 mg tablets	Travelers' Diarrhea. **1.** Approve if the patient has tried a fluroquinolone (e.g., ciprofloxacin, levofloxacin, ofloxacin), azithromycin, or Aemcolo. **2.** Approve if the patient has already started on Xifaxan in order to complete the course of therapy. Small Intestine Bacterial Overgrowth. Approve. Pouchitits, Recurrent Chronic Antibiotic Dependent. 1. Approve if the patient has a history of use with BOTH ciprofloxacin and metronidazole for pouchitis. Note: Recurrent pouchitis is typically considered a history of ≥ 3 pouchitis episodes within a 12 month period.	1 year
Antibiotics (Oral)	Firvanq and authorized generic vancomycin oral solution	vancomycin oral solution	**1.** Approve if the patient has tried vancomycin capsules (Vancocin oral capsule, generics) or vancomycin oral solution (Vancocin oral solution, generics), if formulary. If neither are formulary, approve. **2.** If the patient is unable to swallow or has difficulty swallowing capsules, approve if the patient has tried vancomycin oral solution (Vancocin oral solution, generics), if formulary. If vancomycin oral solution is non-formulary, approve.	1 year
Antibiotics (Oral)	Orlynvah	sulopenem etzadroxil and probenecid tablets	For Urinary Tract Infection in a Women* ≥ 18 years of age. Note: In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a woman is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression. **1.** Approve if the patient has tried or is unable to use two other antibiotics for the condition (e.g., sulfamethoxazole-trimethoprim [Bactrim, generics], nitrofurantoin monohydrate-macrocrystals [Macrobid, generics], ciprofloxacin [Cipro, generics], Fosfomycin [Monurol].) **2.** Approve if the patient is being treated for an organism that is resistant to other antibiotics, but sensitive to Orlynvah. **3.** Approve if the patient has already been started on a course of therapy with Orlynvah (to allow for completion of a course of therapy).	1 year
Antibiotics (Oral)	fosfomycin granules for solution	fosfomycin granules for solution	**1.** Approve if the patient tried, or is unable to take, ONE of the following products: a nitrofurantoin-containing product or trimethoprim-sulfamethoxazole. **2.** Approve if, per the prescriber, the patient is at risk for antimicrobial resistance. Note: Examples of risk factors for antimicrobial resistance is previous antibiotic use, a history of a urinary tract infection or known colonization with a multi-drug-resistant organisms. **3.** Approve if the patient is pregnant. 4. Approve if the patient is being treated for an organism that is resistant to other antibiotics but sensitive to fosfomycin.	1 year
Antibiotics (Oral)	Baxdela	delafloxacin tablets	**1.** Approve if the patient has tried one other oral quinolone antibiotic (e.g., ciprofloxacin [Cipro, generics], ofloxacin [generics], moxifloxacin [Avelox, generics], levofloxacin [Levaquin, generics]). **2.** Patients with suspected or confirmed methicillin-resistant staphylococcus aureus (MRSA) infections: approve if the patient has tried one of Sivextro, clindamycin capsules, clindamycin oral solution, or linezolid (Zyvox, generics), if one is formulary. If none are formulary, approve. **a.** If the patient is currently taking a medication that interacts with linezolid tablets (Zyvox, generics) [e.g., monoamine oxidase inhibitors {MAOIs} or selective serotonin reuptake inhibitors {SSRIs}]: approve if the patient has tried one of clindamycin capsules, clindamycin oral solution, Sivextro, if formulary. If none are formulary, approve. **b.** Approve if the patient is being treated for an organism that is resistant to linezolid (Zyvox, generics), clindamycin, and/or Sivextro. **3.** Approve if the patient has been started on a course of therapy with Baxdela (to allow for completion of a course of therapy).	1 year
Antibiotics (Oral)	Minolira and authorized generic	minocycline ER tablet	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve.	1 year
Antibiotics (Oral)	Ximino and authorized generic	minocycyline ER capsule	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve	1 year
Antibiotics (Oral)	Blujepa	gepotidacin mesylate tablets	Urinary Tract Infection in a female* ≥ 12 years of age. Note: In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a female is defined as an individual with the biological traits of a female, regardless of the individual's gender identity or gender expression. **1.** Approve if the patient has tried or is unable to take two other antibiotics for the condition: nitrofurantoin (Macrobid, Macrodantin, generics), trimethoprim-sulfamethoxazole (TMP-SMX) [Bactrim, generics], fosfomycin (Monourol, generics), a cephalosporin (e.g., cephalexin, cefadroxil), a fluroquinolone (e.g., ciprofloxacin, levofloxacin), a beta-lactam (e.g., amoxicillin, amoxicillin-clavulanate). **2.** Approve if the patient is being treated for an organism that is resistant to other antibiotics, but sensitive to Blujepa. **3.** Approve if the patient has already been started on a course of therapy with Blujepa (to allow for completion of a course of therapy). Gonorrhea treatment in a patient ≥ 12 years of age. **1.** Approve if the patient has tried or is unable to take one of the following: ceftriaxone intramuscular injection or cefixime capsules. If neither are formulary, approve. **2.** Approve if the patient has already been started on a course of therapy with Blujepa (to allow for completion of a course of therapy).	30 days
Antibiotics (Oral)	Nitrofurantoin 50 mg/5 ml suspension (brand)	nitrofurantoin 50 mg/5 ml suspension	**1.** Direct to nitrofurantoin 25 mg/5 ml oral suspension. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the nitrofurantoin 25 mg/5 ml oral suspension.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antibiotics (Oral)	Dificid	fidaxomicin tablets	**1.** Approve if the patient has tried (or has a history of a previous course of therapy of) oral vancomycin (i.e., vancomycin oral capsules or vancomycin oral solution). If neither vancomycin oral capsules nor vancomycin oral solution is formulary, approve. **2.** Approve if, according to the prescriber, Dificid is considered necessary for an initial or first recurrent *Clostridioides difficile* infection episode. **3.** Approve if the patient has been started on a course of therapy with Dificid (to allow for completion of a course of therapy).	1 year
Antibiotics (Oral)	Dificid oral suspension	fidaxomicin oral suspension	**1.** Approve if the patient has tried (or has a history of a previous course of therapy of) oral vancomycin (i.e., vancomycin oral capsules or vancomycin oral solution). If vancomycin oral solution is non-formulary, approve. **2.** Approve if, according to the prescriber, Dificid is considered necessary for an initial or first recurrent Clostridioides difficile infection episode. **3.** Approve if the patient has been started on a course of therapy with Dificid (to allow for completion of a course of therapy).	1 year
Antibiotics (Oral)	Pivya	pivmecillinam tablets	Urinary Tract Infection in a female* ≥ 18 years of age. Note: In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a female is defined as an individual with the biological traits of a female, regardless of the individual's gender identity or gender expression. **1.** Approve if the patient has tried, or is unable to take, at least two other antibiotics for the condition: nitrofurantoin (Macrobid, Macrodantin, generics), trimethoprim-sulfamethoxazole (TMP-SMX) [Bactrim, generics], fosfomycin (Monourol, generics), a cephalosporin (e.g., cephalexin, cefadroxil), a fluroquinolone (e.g., ciprofloxacin, levofloxacin), a beta-lactam (e.g., amoxicillin, amoxicillin-clavulanate). **2.** Approve if the patient is being treated for an organism that is resistant to other antibiotics, but sensitive to Pivya. **3.** Approve if the patient has already been started on a course of therapy with Pivya (to allow for completion of a course of therapy).	30 days
Antibiotics (Oral)	Doryx DR 80 mg and authorized generic	doxycycline hyclate delayed-release tablets	**1.** Direct patient to other doxycycline products. **2.** Approve if, per the prescriber, the 80 mg tablet is required to meet the prescribed dosing requirement.	1 year
Antibiotics (Oral)	Doryx MPC	doxycycline hyclate tablet, delayed-release	**1.** Direct patient to other doxycycline products. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic doxycycline product.	1 year
Antibiotics (Oral)	Likmez	metronidazole oral suspension	**1.** Direct the patient to metronidazole tablets. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year
Antibiotics (Oral)	Solosec	secnidazole oral granules	**1.** Approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): metronidazole tablets (Flagyl, generics), clindamycin capsules (Cleocin, generics), or tinidazole tablets (Tindamax, generics). If none are formulary, approve. **2.** For trichomoniasis: approve if the patient has tried metronidazole tablets (Flagyl, generics) or tinidazole tablets (Tindamax, generics), if formulary. If neither are formulary, approve. **3.** Patients who cannot swallow or have difficulty swallow tablets or capsules: approve.	1 year
Antibiotics (Oral)	Nuzyra	omadacycline tablets	**1.** Approve if the patient has tried or is unable to use one of doxycycline or tetracycline, if formulary. If neither is formulary, approve. **2.** Approve if the patient is being treated for an organism that is resistant to other antibiotics but sensitive to Nuzyra. **3.** If the patient has already been started on Nuzyra (intravenous [IV] or oral), approve to complete the course of therapy.	1 month
Antibiotics (Oral)	Sivextro	tedizolid phosphate tablets	**1.** Approve if the patient has tried linezolid tablets or oral suspension (Zyvox, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking a medication that interacts with linezolid (Zyvox, generics) [e.g., monoamine oxidase inhibitors {MAOIs} or selective serotonin reuptake inhibitors {SSRIs}]. **3.** Approve if the patient is being treated for an organism that is resistant to linezolid (Zyvox, generics), but sensitive to Sivextro. **4.** Approve if the patient has been started on a course of therapy with Sivextro (to allow for completion of a course of therapy).	1 year
Antibiotics (Oral)	metronidazole 125 mg tablets	metronidazole 125 mg tablets	**1.** Approve if the patient has tried one of metronidazole 250 mg tablets or metronidazole 500 mg tablets. If neither are formulary, approve. **2.** Approve if the prescribed dose cannot be obtained with whole tablets of the higher metronidazole strengths (i.e., 250 mg, 500 mg). **3.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use metronidazole 250mg or 500mg tablets. **4.** Approve if the patient has already started metronidazole therapy and the requested medication is being used to complete the course of therapy.	1 year
Antibiotics (Oral)	Xenleta	lefamulin tablets	**1.** Approve if the patient has tried one other antibiotic (e.g., azithromycin, clarithromycin, erythromycin, doxycycline, moxifloxacin, gemifloxacin, levofloxacin, amoxicillin, amoxicillin-clavulanate, cefdinir, cefpodoxine, cefuroxime) for the current condition. **2.** Approve if the patient is being treated for an organism that is resistant to other medications, but sensitive to Xenleta. **3.** Approve if the patient has been started on a course of therapy with Xenleta (intravenous or oral) in order to complete the course of therapy.	1 year
Antibiotics (Oral)	Fulvicin P/G	griseofulvin ultramicrosize 165 mg tablets	**1.** Approve if the patient has tried griseofulvin ultra 125 mg or 250 mg tablets, if formulary. If neither are formulary, approve. **2.** Approve if the prescribed dose cannot be obtained with whole tablets of the griseofulvin ultramicrosize 125 mg or 250 mg strengths. **3.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use griseofulvin ultra 125 mg or 250 mg tablets. 4. Approve if the patient has been started on a course of therapy with Fulvicin P/G (to allow for completion of a course of therapy).	1 year
Antibiotics (Oral)	Seysara	sarecycline tablets	Approve if the patient has tried two other oral tetracycline or tetracycline derivative (e.g., tetracycline, doxycycline, minocycline).	1 year
Antibiotics (Oral)	Doryx 50 mg, 200 mg	doxycycline hyclate delayed-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antibiotics (Oral)	Humatin 250 mg capsule	paromomycin sulfate capsule	Approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antibiotics (Topical)	Altabax	retapamulin ointment	Approve if the patient has tried one product from the following list: mupirocin 2% ointment, Centany, Centany AT, or mupirocin 2% cream, if one is formulary. If none are formulary, approve.	1 year
Antibiotics (Topical)	Centany/ Centany AT	mupirocin 2% ointment	Approve if the patient has tried one product from the following list: mupirocin 2% ointment or mupirocin 2% cream, if one is formulary. If neither are formulary, approve.	1 year
Antibiotics (Topical)	Sulfamylon	mafenide acetate topical cream 8.5%	If the product is being used for treatment of burns: approve.	1 year
Antibiotics (Topical)	Xepi	ozenoxacin cream 1%	Approve if the patient has tried one preferred formulary alternative from the following list (if one is formulary): mupirocin 2% ointment, Centany, Centany AT, mupirocin 2% cream, or Altabax. If none are formulary, approve.	1 year
Anticoagulants	Eliquis tablets for oral suspension and Eliquis capsules for oral suspension	apixaban tablets for oral suspension and apixaban sprinkle capsules for oral suspension	**1.** Approve if the patient weighs < 35 kg. **2.** Approve if the patient is unable to swallow oral dosage forms or has difficulty swallowing oral dosage forms (such as Eliquis tablets). **3.** If Eliquis tablets are non-formulary, approve. **4.** Approve if the patient is currently receiving Eliquis (any dosage form, e.g., tablets, tablets for oral suspension, or capsules for oral suspension).	1 year
Anticoagulants (Oral)	Pradaxa	dabigatran etexilate mesylate capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Anticoagulants (Oral)	Pradaxa oral pellets	dabigatran oral pellets	**1.** Approve if the patient has tried ONE of the following: 1) an Eliquis product (Eliquis tablets, Eliquis tablets for oral suspension, or Eliquis sprinkle capsules for oral suspension), 2) dabigatran capsule (Pradaxa capsules, generic), or 3) a Xarelto product (Xarelto tablets, Xarelto oral suspension). **2.** If Eliquis (any dosage form) is non-formulary, approve. **3.** Approve if the patient is unable to swallow solid oral dosage forms OR has difficulty swallowing solid oral dosage forms. **4.** Approve if the patient is < 2.6 kg. **5.** Approve if the patient is currently receiving Pradaxa oral pellets or dabigatran capsules (Pradaxa capsules, generics).	1 year
Anticoagulants (Oral)	Savaysa	edoxaban tablets	**1.** Approve if the patient has tried ONE of the following: 1) an Eliquis product (Eliquis tablets, Eliquis tablets for oral suspension, or Eliquis sprinkle capsules for oral suspension), 2) a dabigatran product (Pradaxa capsules, generic or Pradaxa oral pellets), or 3) a Xarelto product (Xarelto tablets, Xarelto oral suspension). **2.** If Eliquis tablets are non-formulary, approve. **3.** Approve if the patient is currently receiving Savaysa.	1 year
Anticoagulants (Oral)	Xarelto tablets	rivaroxaban film-coated oral tablets	**1.** Approve if the patient has tried ONE of the following: 1) an Eliquis product (Eliquis tablets, Eliquis tablets for oral suspension, or Eliquis sprinkle capsules for oral suspension), 2) a dabigatran product (Pradaxa capsules, generic or Pradaxa oral pellets), or 3) Savaysa. **2.** If Eliquis tablets are non-formulary, approve. **3.** If Xarelto is being used for thromboprophylaxis in a patient with congenital heart disease AND has undergone the Fontan procedure, approve. **4.** If Xarelto is being used for prophylaxis of venous thromboembolism (VTE) in acutely ill medical patients, approve. **5.** For Xarelto 2.5 mg tablets: approve if the patient has coronary artery disease or peripheral artery disease. **6.** Approve if the patient is currently receiving Xarelto tablets or Xarelto oral suspension.	1 year
Antidepressants - Other	Aplenzin	bupropion hydrobromide extended-release tablets	Approve if the patient has tried one product from the following list: bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics) **[documentation required]**, if formulary. If bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics) are non-formulary, approve.	1 year
Antidepressants - Other	Forfivo XL and authorized generic	bupropion hydrochloride extended-release tablets	**1.** Patient is directed to bupropion hydrochloride XL 150 mg and/or 300 mg tablets (Wellbutrin XL, generics). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the buproprion hydrochloride XL 150 mg and/or 300 mg tablets (Wellbutrin XL, generics).	1 year
Antidepressants - Other	Auvelity	dextromethorphan hydrobromide and bupropion hydrochloride extended-release tablets	**1.** Approve if the patient has tried at least two different antidepressants, one of which must be bupropion and one additional antidepressant **[documentation required]**. Note: Examples of antidepressants include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), mirtazapine, etc. **2.** For the treatment of agitation associated with dementia due to Alzheimer's disease, approve. **3.** Suicidal ideation: approve. **4.** Patient is currently taking or has taken Auvelity at any time in the past: approve **[documentation required]**.	1 year
Antidepressants - Other	protriptyline tablets	protriptyline tablets	**1.** Approve if the patient has tried one other oral tricyclic antidepressant (e.g., desipramine, nortriptyline). **2.** If neither desipramine nor nortriptyline are formulary, approve. **3.** Suicidal ideation: approve. **4.** Approve if the patient has already been started on therapy with protriptyline or has taken protriptyline at any time in the past.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antidepressants - Other	Wellbutrin SR	bupropion HCl tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antidepressants - Other	Wellbutrin XL	bupropion XL tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antidiarrheals	opium tincture 10 mg/mL	opium tincture 10 mg/mL	Approve if the patient has tried BOTH of the following: 1) diphenoxylate-atropine tablets (Lomotil, generics) AND 2) a loperamide product. If neither are formulary, approve. Note: Prescription or over-the-counter (OTC) products would count toward meeting the requirement.	1 year
Antiemetic Agents - Substance P/Neurokinin-1 (NK1) receptor antagonists (Injectable)	Emend IV	fosaprepitant dimeglumine injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiemetic Agents - Substance P/Neurokinin-1 (NK1) receptor antagonists (Injectable)	Cinvanti IV	aprepitant injectable emulsion	**1.** Approve if the patient has tried at least ONE of fosaprepitant dimeglumine injection (IV) [Emend IV, generics], Focinvez IV, or Navitrux, if formulary. If none are formulary, approve. **2.** In patients with hypersensitivities to polysorbate 80, approve if the patient has tried Focinvez IV, if formulary. If Focinvez IV is non-formulary, approve. **3.** Approve if the patient has already started Cinvanti IV to complete all cycles in the current course of chemotherapy.	1 year
Antiemetic Agents - Substance P/Neurokinin-1 (NK1) receptor antagonists (Injectable)	Focinvez IV	fosaprepitant intravenous infusion	**1.** Approve if the patient has tried at least ONE of generic fosaprepitant dimeglumine injection (IV) [Emend IV, generics], Cinvanti IV, or Navitrux, if formulary. If none are formulary, approve. **2.** Patients < 18 years of age, approve if the patient has tried at least ONE of fosaprepitant dimeglumine IV (Emend IV, generics) or Navitrux, if formulary. If neither are formulary, approve. **3.** In patients with hypersensitivities to polysorbate 80, approve if the patient has tried Cinvanti IV, if formulary. If Cinvanti IV is non-formulary, approve. a. Patient < 18 years of age, approve. **4.** Approve if the patient has already started Focinvez IV to complete all cycles in the current course of chemotherapy.	1 year
Antiemetic Agents - Substance P/Neurokinin-1 (NK1) receptor antagonists (Injectable)	Navitrux	fosaprepitant intravenous injection	**1.** Approve if the patient has tried at least ONE of generic fosaprepitant dimeglumine injection (IV) [Emend IV, generics], Focinvez IV, or Cinvanti IV, if formulary. If none are formulary, approve. **2.** Patients < 18 years of age, approve if the patient has tried at least ONE of fosaprepitant dimeglumine IV (Emend IV, generics) or Focinvez IV, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already started Navitrux to complete all cycles in the current course of chemotherapy.	1 year
Antiemetic Agents - Combination Substance P/NK1 receptor antagonist and serotonin (5-HT3) receptor antagonist. (Injectable)	Akynzeo IV	fosnetupitant/palonosetron injection	**1.** Approve if the patient has tried one formulary injectable 5-HT3 receptor antagonist: ondansetron [Zofran, generics], palonosetron [Aloxi, generics], granisetron, or Sustol, if one is formulary AND one of fosaprepitant dimeglumine injection (IV) [Emend IV, generics], Cinvanti IV, Focinvez IV, or Navitrux, if one is formulary. If no injectable 5-HT3 receptor antagonists are formulary, approve. If none of fosaprepitant dimeglumine injection (IV) [Emend IV, generics] nor Cinvanti IV, nor Focinvez IV, nor Navitrux are formulary, approve. Note: Patients with hypersensitivities to polysorbate 80 are not required to try fosaprepitant dimeglumine injection (IV) [Emend IV, generics] or Navitrux. **2.** Approve if the patient has already started Akynzeo IV to complete all cycles in the current course of chemotherapy.	1 year
Antiemetic Agents - Combination Substance P/NK1 receptor antagonist and serotonin (5-HT3) receptor antagonist. (Oral)	Akynzeo capsules	netupitant/palonsetron capsules	Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried two formulary oral or transdermal serotonin 5-HT3 receptor antagonists from the following list (if two are formulary or one if one is formulary): ondansetron oral (generics), granisetron oral (generics), or Sancuso; AND B. Patient has tried one oral formulary Substance P/NK1 antagonists from the following list: aprepitant capsules (Emend, generics) or Varubi tablets, if one is formulary; OR Note: If there are no formulary 5-HT3 receptor antagonists, approve. If there are no Substance P/NK1 antagonists, approve. **2.** Approve if the patient has already started Akynzeo to complete all cycles in the current course of chemotherapy.	1 year
Antiemetics - Serotonin (5-HT3) Receptor Antagonists (Injectable)	Posfrea and brand palonosetron intrevenous	palonosetron intravenous injection	Approve if the patient has tried and cannot take generic palonosetron injection, if formulary. If generic palonosetron injection is non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antiemetics - Serotonin (5-HT3) Receptor Antagonists (Oral)	ondansetron ODT 16 mg (brand)	ondansetron ODT 16 mg	Approve if the patient has tried ondansetron ODT 4 mg or ondansetron ODT 8 mg AND is unable to continue to use these products. If both ondansetron ODT 4 mg and ondansetron ODT 8 mg are non-formulary, approve.	1 year
Antiemetics - Serotonin Receptor Antagonists (Oral and Inejctable)	Sancuso	granisetron transdermal system	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH of the following: 1) ondansetron tablets, oral solution, or ODT (generics); and 2) granisetron tablets (generics), if formulary (or one if one is formulary). If neither are formulary, approve. **2.** Patient is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of ondansetron tablets, oral solution or ODT (generics). If neither ondansetron oral solution nor ondansetron ODT are formulary, approve. **3.** Approve if the patient has already started Sancuso to complete all cycles in the current course of chemotherapy.	1 year
Antiemetics - Serotonin Receptor Antagonists (Oral and Injectable)	Sustol	granisetron extended-release injection	**1.** Approve if the patient has tried two of the following: ondansetron injection (Zofran, generics), granisetron injection (Kytril, generics), or palonosetron injection (Aloxi, generics), if formulary (or one if one is formulary). If none are formulary, approve. **2.** Approve if the patient has already started Sustol to complete all cycles in the current course of chemotherapy.	1 year
Antiemetics - Serotonin Receptor Antagonists (Oral and Injectable)	Granisol oral solution	granisetron oral solution	**1.** Approve if the patient has tried ONE of the following: 1) granistreon tablets or 2) an ondansetron tablet, orally disintegrating tablet or oral solution, if formulary. If none are formulary approve. **2.** If the patient is unable to swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms, approve if the patient has tried ondansetron orally disintegrating tablet or ondansetron oral solution, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already started Granisol oral solution to complete all cycles in the current course of chemotherapy.	1 year
Antiemetics and Antivertigo Agents	Emend oral suspension	aprepitant oral suspension	**1.** Approve if the patient has tried one formulary alternative from the following list: aprepitant capsules (Emend, generics) or Varubi tablets. If none are formulary, approve. **2.** Patients ≥ 12 and <18 years of age: approve if the patient has tried aprepitant capsules (Emend, generics), if formulary. If aprepitant capsules (Emend, generics) are non-formulary, approve. **3.** Patients < 12 years of age: approve. **4.** Patients who cannot swallow or have difficulty swallowing capsules, approve. **5.** Approve if the patient has already started Emend oral suspension to complete all cycles in the current course of chemotherapy.	1 year
Antiemetics and Antivertigo Agents	Varubi	rolapitant tablets	**1.** Approve if the patient has tried aprepitant capsules (Emend, generics).. If aprepitant capsules (Emend, generics) are non-formulary, approve. **2.** Approve if the patient has already started Varubi to complete all cycles in the current course of chemotherapy.	1 year
Antiemetics and Antivertigo Agents	Bonjesta	doxylamine succinate and pyridoxine hydrochloride extended-release tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with doxylamine-pyridoxine (Diclegis, generics), if formulary. If doxylamine-pyridoxine (Diclegis, generics) are non-formulary, approve if the patient has tried doxylamine AND pyridoxine (Vitamin B6).	1 year
Antiemetics and Antivertigo Agents	Emend capsules and Emend Trifold Pack	aprepitant oral capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antifungals (Oral)	Oravig	miconazole buccal tablet	Approve if the patient has tried one product from the following list (if one is formulary): clotrimazole troches (generics) or nystatin oral suspension. If neither are formulary, approve.	1 year
Antifungals (Oral)	Tolsura	itraconazole capsules	**1.** Approve if the patient has tried one of itraconazole capsules (Sporanox, generics) or itraconazole oral solution (Sporanox liquid, generics). **NOTE:** A trial of either the conventional intraconazole capsules or intraconazole solution would count toward meeting criteria regardless of the formulary status of the product. **2.** Patient has been started on a current course of therapy with Tolsura (for a non-oncychomycosis diagnosis): approve to complete the current course. **3.** Deny: If the patient is requesting Tolsura for a diagnosis of onychomycosis. **NOTE:** If the patient is requesting Tolsura for a diagnosis of onychomycosis, the request should be denied regardless of what the patient has tried for the current condition or if the patient has already been started on the product.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antifungals (Oral)	Vivjoa	oteseconazole capsules	Recurrent Vulvovaginal Candidiasis in a patient ≥ 18 years of age. Approve if the patient meets the following criteria (A, B, C, and D): Note: Recurrent vulvovaginal candidiasis is defined as three or more episodes of symptomatic vulvovaginal candidiasis within a one-year period. Two prior infections in a 12 month period, plus the current infection, would satisfy the criteria. A. Patient is NOT of reproductive potential; AND Note: A person who is NOT of reproductive potential is defined as a person who is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy). B. Patient is NOT breastfeeding; AND C. Patient is NOT pregnant: AND D. Patient meets one of the following (i, ii, or iii): i. Patient has tried oral fluconazole as maintenance therapy AND had inadequate efficacy; OR Note: Maintenance dosing for fluconazole (100 mg, 150 mg or 200 mg) is once weekly for 6 months. ii. Patient meets one of the following (a, b, or c): a. Oral fluconazole is not clinically appropriate for the patient due to drug-drug interactions, as determined by the prescriber; OR b. Patient has a fluconazole allergy or intolerance, as determined by the prescriber; OR c. Patient is being treated for a Candida species that is not susceptible to fluconazole, as determined by the prescriber; OR iii. Patient has already started on Vivjoa therapy (to complete the course of treatment).	4 months
Antifungals (Oral)	Brexafemme	ibrexafungerp tablets	Treatment of vulvovaginal candidiasis. **1.** Approve if the patient has tried oral fluconazole. **2.** Approve if the patient has a fluconazole allergy or intolerance, as determined by the prescriber. **3.** Approve if the patient is being treated for a Candida species that is not susceptible to fluconazole, as determined by the prescriber. To reduce the incidence of recurrent vulvovaginal candidiasis. **1.** Approve if the patient has tried oral fluconazole as maintenance therapy. Note: Maintenance dosing for fluconazole (100 mg, 150 mg or 200 mg) is once weekly for 6 months. **2.** Approve if the patient has a fluconazole allergy or intolerance, as determined by the prescriber. **3.** Approve if the patient is being treated (or has been treated) for a Candida species that is not susceptible to fluconazole, as determined by the prescriber.	30 days - treatment; 6 months maintenance
Antifungals (Oral)	Cresemba	isavuconazonium sulfate capsules	See standard *Antifungals – Cresemba (Oral) Prior Authorization Policy* criteria.	See PA duration
Antifungals (Oral)	Noxafil PowderMix suspension	posaconazole powdermix suspension	**1.** Approve if the patient has tried one of posaconazole tablets (Noxafil tablets, generics) or posaconazole oral suspension (Noxafil oral suspension, generics), if formulary. If neither are formualry, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets. **3.** Approve if the patient is ≤ 40 kg.	1 year
Antifungals (Topical)	Ecoza foam and econazole nitrate foam	econazole nitrate topical foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year
Antifungals (Topical)	Ertaczo	sertaconazole nitrate 2% cream	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year
Antifungals (Topical)	Exelderm and authorized generic (sulconazole nitrate 1%)	sulconazole nitrate 1% (cream and solution)	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year
Antifungals (Topical)	Luzu and authorized generic (luliconazole 1% cream)	luliconazole 1% cream	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year
Antifungals (Topical)	Naftin, naftifine 1%, 2% cream and 2% gel	naftifine 1%, 2% cream and 2% gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year
Antifungals (Topical)	Oxistat Cream and oxiconazole nitrate 1% cream	oxiconazole nitrate cream	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year
Antifungals (Topical)	Oxistat lotion	oxiconazole nitrate lotion	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antifungals (Topical)	Xolegel	ketoconazole 2% gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with TWO topical antifungals. Note: Examples of topical antifungals include: clotrimazole 1% cream, econazole 1% cream, ketoconazole 2% cream, ciclopirox 0.77% cream or gel.	1 year
Antifungals (Topical)	Jublia	efinaconazole topical solution, 10%	Approve if the patient has tried one of tavaborole 5% topical solution (Kerydin, generics) or ciclopirox topical solution, 8%, if one is formulary. If neither are formulary, approve if the patient has tried one other topical or oral antifungal agent. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Antihistamines (Oral)	desloratadine solution	desloratadine solution	Approve if the patient has tried at least ONE of the following: desloratadine odt tablet, cetirizine syrup or solution, or levocetirizine solution. If none are formulary, approve.	1 year
Antihistamines (Oral)	dexchlorpheniramine oral solution	dexchlorpheniramine oral solution 2mg/5 ml	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of the following products: loratadine, fexofenadine or cetirizine AND the patient has also tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with chlorpheniramine. **NOTE:** Prescription or over-the-counter (OTC) products would count toward meeting the requirement.	1 year
Antihistamines (Oral)	clemastine oral tablet, Clemasz tablet	clemastine oral tablet	Approve if the patient has tried five oral antihistamines. Note: Examples of oral antihistamine include, but are not limited to: diphenhydramine, chlorpheniramine, carbinoxamine, hydroxyzine, cetirizine, levocetirizine, desloratadine.	1 year
Antihistamines (Oral)	clemastine syrup	clemastine syrup	**1.** Approve if the patient has tried five oral antihistamines. Note: Examples of oral antihistamine include, but are not limited to: diphenhydramine, chlorpheniramine, carbinoxamine, hydroxyzine, cetirizine, levocetirizine, desloratadine. **2.** If the patient is unable to swallow or has difficulty swallowing tablets, approve if the patient has tried at least two of the following: carbinoxamine syrup, diphenhydramine solution, or hydroxyzine solution or syrup.	1 year
Antihistamines (oral) - First-generation	carbinoxamine maleate 4 mg/5 ml oral suspension (brand) [authorized generic of Karbinal ER] and Karbinal ER	carbinoxamine maleate 4 mg/5 ml oral suspension	**1.** Approve if the patient has tried five oral antihistamines (e.g., clemastine, diphenhydramine, chlorpheniramine, carbinoxamine [generic], hydroxyzine, cetirizine, loratadine). Note: OTC products would count toward meeting the requirement. **2.** If the patient is unable to swallow or has difficulty swallowing solid dosage forms, approve if the patient has tried at least two oral liquid antihistamines (e.g., carbinoxamine solution [generic], diphenhydramine solution, hydroxyzine solution or syrup, clemastine syrup, cetirizine solution, or loratadine solution or syrup). Note: OTC products would count toward meeting the requirement.	1 year
Antimalarial Agents	Arakoda	tafenoquine tablets	**1.** Approve if the patient has tried one product from the following list: atovaquone-proguanil (Malarone, generics), chloroquine, doxycycline, mefloquine, or primaquine. If none are formulary, approve. **2.** Patient has been started on a current course of therapy with Arakoda: approve to complete the current course.	1 year
Antimalarial Agents	Coartem	artemether/lumefrantrine tablets tablets	Approve for treatment of malaria.	1 year
Antimalarial Agents	Krintafel	tafenoquine tablets	Approve if the patient has tried Primaquine, if formulary. If Primaquine is non-formulary, approve.	1 month
Antimuscarinic Agents	Transderm-Scop	scopolamine patches	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiparasitic Agents	Benznidazole	benznidazole tablets	Approve for the treatment of Chagas disease (American trypanosomiasis).	60 days
Antiparkinson Drugs	Gocovri ER	amantadine extended-release capsules	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND meets one of the following (A or B): A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber **[documentation required]**; OR B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber **[documentation required]**.	1 year
Antiparkinson Drugs	Osmolex ER	amantadine extended-release tablets	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND meets one of the following (A or B): A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber **[documentation required]**; OR B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber **[documentation required]**.	1 year
Antiparkinson Drugs - Carbidopa and/or Levodopa Agents	Dhivy	carbidopa and levodopa immediate-release tablets	Approve if dose prescribed cannot be obtained withcarbidopa-levodopa tablets (Sinemet, generics) or half-tablets. Note: Dhivy can be split into a ¼ of a tablet (i.e., 6.25 mg of carbidopa and 25 mg of levodopa).	N/A
Antiparkinson Drugs – Carbidopa and/or Levodopa Agents	Duopa	carbidopa and levodopa enteral suspension	Parkinson's Disease. Approve if the patient requires enteral administration (e.g., through a naso-jejunal tube or PEG-J tube).	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antiparkinson Drugs – Carbidopa and/or Levodopa Agents	Vyalev	foslevodopa-foscarbidopa subcutaneous infusion	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Onapgo, if formulary. If Onapgo is non formulary, approve if the patient meets ONE of the following (A or B): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following: Crexont capsules, Rytary capsules, or carbidopa-levodopa extended-release tablets, if formulary. If none are formulary, approve; OR B. Patient is unable to swallow oral dosage forms or has difficulty swallowing oral dosage forms. **2.** Approve if the patient has already been started on therapy with Vyalev.	1 year
Antiparkinson Drugs - Catechol-O-Methyltransferase Inhibitors	Ongentys	opicapone capsules	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with entacapone tablets (Comtan, generics). If entacapone tablets (Comtan, generics) are non-formulary, approve. **2.** If the patient has been on Ongentys for more than one month, approve.	1 year
Antiparkinson Drugs - Dopamine Agonists	Neupro	rotigotine transdermal system	**1.** Approve if the patient has tried both of the following, if formulary: 1) ropinirole tablets (Requip, generics) or ropinirole extended-release tablets (Requip XL, generics) AND 2) pramipexole tablets (Mirapex, generics) or pramipexole extended-release tablets (Mirapex ER, generics). If neither are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets. **3.** Patients already started on Neupro, approve.	1 year
Antiparkinson Drugs - Inhibitor of Monoamine Oxidase Type B Inhibitors	Xadago	safinamide tablets	**1.** Approve if the patient has tried one product from the following list: 1) a selegiline product (selegiline tablets/capsules or Zelapar) or 2) rasagiline tablets (Aziliect, generics). If none are formulary, approve. **2.** If the requested medication is being requested for treatment of motor fluctuations/"off" episodes, approve. **3.** Approve if the patient has already been started on therapy with Xadago.	1 year
Antiparkinson Drugs - Inhibitor of Monoamine Oxidase Type B Inhibitors	Zelapar	selegiline orally disintegrating tablets	**1.** Approve if the patient has tried one product from the following list: selegiline tablets/capsules or rasagiline tablets (Azilect, generics). If neither are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing selegiline tablets.	1 year
Antiparkinson Drugs – Apomorphine products	Apokyn	apomorphine injection	See standard *Parkinsons Disease – Apomorphine Subcutaneous (Apokyn) Prior Authorization Policy* criteria	See PA duration
Antiparkinson Drugs – Apomorphine products	Onapgo	apomorphine subcutaneous infusion	**1.** Approve if the patient has tried , and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Vyalev, if formulary. If Vyalev is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following: Crexont capsules, Rytary capsules, or carbidopa-levodopa extended-release tablets, if formulary. If none are formulary, approve; OR B. Patient is unable to swallow oral dosage forms or has difficulty swallowing oral dosage forms. **2.** Approve if the patient has already been started on therapy with Onapgo.	1 year
Antiparkinson Drugs - Adenosine A2A Receptor Antagonists	Nourianz	istradefylline tablets	**1.** Approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if only one is formulary): pramipexole, ropinirole, tolcapone, cabergoline, Apokyn, entacapone tablets (Comtan, generics), selegiline capsules/tablets, rasagiline tablets (Azilect, generics), Zelapar, Inbrija, Ongentys, or Xadago. If none are formulary, approve. **2.** Patients already started on Nourianz, approve.	1 year
Antiparkinson Drugs - Carbidopa and Levodopa Extended-Release Agents	Crexont	carbidopa and levodopa extended-release capsules	**1.** Approve if the patient has tried one of the following: Rytary or carbidopa-levodopa extended-release tablets, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Crexont.	1 year
Antiparkinson Drugs - Carbidopa and Levodopa Extended-Release Agents	Rytary and carbidopa and levodopa extended-release capsules (authorized generic to Rytary)	carbidopa and levodopa extended-release capsules	**1.** Approve if the patient has tried one of the following: Crexont or carbidopa-levodopa extended-release tablets, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Rytary.	1 year
Antiparkinson Drugs - Carbidopa and/or Levodopa Agents	Inbrija	levodopa inhalation powder for oral inhalation use	See standard *Parkinson's Disease – Inbrija Prior Authorization Policy* criteria.	See PA duration
Antiplatelet Agents	Durlaza	aspirin extended-release capsules	Approve if the patient has tried and cannot take two other single-entity oral aspirin products.	1 year
Antiplatelet Agents	Zontivity	vorapaxar tablets	**1.** Approve if the patient has tried aspirin or clopidogrel (Plavix, generics). **2.** Approve if the patient has been started on Zontivity.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antiplatelet Agents	Brilinta	ticagrelor tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiplatelet Agents	Plavix	clopidogrel bisulfaste tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiprotozoals (Oral)	Alinia oral suspension	nitazoxanide oral suspension	**1.** Approve if the patient has tried nitazoxanide tablets (Alinia tablets, generics) if formulary. If nitazoxanide tablets (Alinia tablets, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.	1 year
Antiprotozoals (Oral)	Alinia tablets	nitazoxanide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antipsychotics (Long-Acting Injectables)	Zyprexa Relprevv	olanzapine for extended release suspention	**1.** Approve if the patient has tried one of Abilify Maintena, Aristada/Aristada Initio, Invega Sustenna, Erzofri, Abilify Asimtufii, risperidone ER long-acting injection (Risperdal Consta, generics), Perseris ER, Uzedy ER, or Rykindo ER, if one is formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking oral olanzapine (Zyprexa). **3.** Approve if the patient has taken Zyprexa Relprevv at any time in the past. **4.** Approve if the patient has already been started on therapy with Zyprexa Relprevv.	1 year
Antipsychotics (Long-Acting Injectables) – Aripiprazole Based	Abilify Asimtufii	aripiprazole extended-release intramuscular injection	**1.** Approve if the patient has tried one of Aristada or Abilify Maintena, if formulary. If neither are formulary, approve. **2.** Patients with bipolar I disorder: approve if the patient has tried Abilify Maintena, if formulary. If Abilify Maintena is non-formulary, approve. **3.** Approve if the patient has taken Abilify Asimtufii at any time in the past. **4.** Approve if the patient has already been started on Abilify Asimtufii.	1 year
Antipsychotics (Long-Acting Injectables) – Aripiprazole Based	Abilify Maintena	aripiprazole for extended-release injectable suspension, for intramuscular use	**1.** Approve if the patient has tried one of Aristada or Abilify Asimtufii, if formulary. If neither are formulary, approve. **2.** Patients with bipolar I disorder: approve if the patient has tried Abilify Asimtufii, if formulary. If Abilify Asimtufii is non-formulary, approve. **3.** Approve if the patient has taken Abilify Maintena at any time in the past. **4.** Approve if the patient has already been started on Abilify Maintena.	1 year
Antipsychotics (Long-Acting Injectables) – Aripiprazole Based	Aristada	aripiprazole lauroxil extended-release injectable suspension	**1.** Approve if the patient has tried one of Abilify Maintena or Abilify Asimtufii, if formulary. If neither are formulary, approve. **2.** Approve if the patient has taken Aristada at any time in the past. **3.** Approve if the patient has already been started on Aristada or Aristada Initio.	1 year
Antipsychotics (Long-Acting Injectables) – Aripiprazole Based	Aristada Initio	aripiprazole lauroxil extended release injectable suspension	**1.** Approve if the patient meets both of the following (A and B): A. Patient has tried one of Abilify Maintena or Abilify Asimtufii, if formulary; AND Note: If neither are formulary, approve. B. The requested medication is being used to initiate or re-initiate therapy with Aristada. **2.** Approve if the patient has already been started on Aristada and the patient has missed doses, requiring re-initiation of therapy or has used Aristada at any time in the past and is re-initiating therapy with Aristada.	1 year
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Invega Hafyera	paliperidone palmitate extended-release injectable suspension	**1.** Approve if the patient has been established on therapy with Invega Sustenna for ≥ 4 months OR Invega Trinza for ≥ one 3-month cycle AND the prescriber attests the patient requires an extended dosing interval due to a demonstrated significant concern for non-adherence with a 4-week or 3-month dosing interval. **NOTE**: Invega Sustenna/Invega Trinza Formulary Exception Criteria will apply. **2.** Approve if the patient has already been started on therapy with Invega Hafyera.	1 year
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Invega Trinza	paliperidone palmitate extended-release injectable suspension	**1.** Approve if the patient has been established on therapy with Invega Sustenna for ≥ 4 months AND the prescriber attests the patient requires an extended dosing interval due to a demonstrated significant concern for non-adherence with a 4-week dosing interval. **NOTE:** Invega Sustenna Formulary Exception Criteria will apply. **2.** Approve if the patient has already been started on therapy with Invega Trinza.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Rykindo ER	risperidone extended-release intramuscular injection	**1.** Approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Invega Sustenna, Erzofri, Perseris ER, or Uzedy ER, if one is formulary. If none are formulary, approve. **2.** Patients with Bipolar I disorder: approve if the patient has tried one of 1) risperidone ER long-acting injection (Risperdal Consta, generics) or 2) Uzedy ER, if formulary. If neither are formulary, approve. **3.** If the patient is currently taking oral risperidone (Risperdal), approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Perseris ER or Uzedy ER, if formulary. If neither are formulary, approve. **4.** Approve if the patient has taken Rykindo ER at any time in the past. **5.** Approve if the patient has already been started on therapy with Rykindo ER.	1 year
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Uzedy ER	risperidone extended-release subcutaneous injection	**1.** Approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Invega Sustenna, Erzofri, Perseris ER, or Rykindo ER, if one is formulary. If none are formulary, approve. **2.** Patients with Bipolar I disorder: approve if the patient has tried one of 1) risperidone ER long-acting injection (Risperdal Consta, generics) or 2) Rykindo ER, if formulary. If neither are formulary, approve. **3.** If the patient is taking oral risperidone (Risperdal), approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Perseris ER, or Rykindo ER, if formulary. If none are formulary, approve. **4.** Approve if the patient has taken Uzedy ER at any time in the past. **5.** Approve if the patient has already been started on therapy with Uzedy ER.	1 year
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Erzofri	paliperidone palmitate extended-release injectable suspension	**1.** Approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Perseris ER, Uzedy ER, Rykindo ER, or Invega Sustenna, if one is formulary. If none are formulary, approve. **2.** Patients with schizoaffective disorder: approve if the patient has tried Invega Sustenna, if formulary. If Invega Sustenna is non-formulary, approve. **3.** Patient is currently taking oral paliperidone (Invega), approve if the patient has tried Invega Sustenna, if formulary. If Invega Sustenna is non-formulary, approve. **4.** Approve if the patient has taken Erzofri at any time in the past. **5.** Approve if the patient has already been started on therapy with Erzofri.	1 year
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Invega Sustenna	paliperidone palmitate extended-release injectable suspension	**1.** Approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Perseris ER, Uzedy ER, Rykindo ER, or Erzofri, if one is formulary. If none are formulary, approve. **2.** Patient with schizoaffective disorder: approve if the patient has tried Erzofri, if formulary. If Erzofri is non-formulary, approve. **3.** Patient is currently taking oral paliperidone (Invega), approve if the patient has tried Erzofri, if formulary. If Erzofri is non-formulary, approve. **4.** Approve if the patient has taken Invega Sustenna at any time in the past. **5.** Approve if the patient has already been started on therapy with Invega Sustenna.	1 year
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Perseris ER	risperidone extended-release injectable suspension	**1.** Approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Invega Sustenna, Erzofri, Uzedy ER, or Rykindo ER, if one is formulary. If none are formulary, approve. **2.** If the patient is taking oral risperidone (Risperdal), approve if the patient has tried one of risperidone ER long-acting injection (Risperdal Consta, generics), Uzedy ER, or Rykindo ER, if formulary. If none are formulary, approve. **3.** Approve if the patient has taken Perseris ER at any time in the past. **4.** Approve if the patient has already been started on therapy with Perseris ER.	1 year
Antipsychotics (Oral)	Abilify Mycite	aripiprazole w/ sensor tablet; kit, maintenance kit; starter kit	Approve if the patient has tried aripiprazole tablets (Abilify, generics). If aripiprazole tablets are non-formulary, approve.	1 year
Antipsychotics (Oral)	Versacloz	clozapine oral suspension	Approve if the patient has tried clozapine tablets or clozapine orally disintegrating tablets, if formulary. If neither are formulary, approve.	1 year
Antipsychotics (Oral)	Latuda	lurasidone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antipsychotics (Oral)	Opipza	aripiprazole oral film	Approve if the patient has tried and cannot take ONE of aripiprazole ODT or aripiprazole oral solution. If neither are formulary, approve.	1 year
Antipsychotics (Oral)	Quetiapine 150 mg tablets	quetiapine 150 mg tablet	**1.** Direct to quetiapine 50 mg and/or quetiapine 100 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the quetiapine 50 mg and/or 100 mg tablet.	1 year
Antipsychotics (Oral)	Bysanti	milsaperidone tablets	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotic include: quetiapine (Seroquel, generics), risperidone (Risperdal, generics), olanzapine (Zyprexa, generics), aripiprazole (Abilify, generics), ziprasidone (Geodon, generics), lurasidone (Latuda, generics), clozapine, but ANY antipsychotic would count, including injectable products. **2.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** Approve if the patient is currently taking Bysanti OR has taken Bysanti at any time in the past.	1 year
Antipsychotics (Oral)	Rexulti	brexpiprazole tablets	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotics include: risperidone(Risperdal, generics) olanzapine (Zyprexa, generics), quetiapine (Seroquel, generics), aripiprazole (Abilify, generics), ziprasidone (Geodon, generics), lurasidone (Latuda, generics), clozapine, but ANY antipsychotic would count, including injectable products. **2.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** For the treatment of agitation associated with dementia due to Alzheimer's disease, approve. **4.** Approve if the patient is currently taking Rexulti OR has taken Rexulti at any time in the past.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antipsychotics (Oral)	Lybalvi	olanzapine and samidorphan tablets	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotics include: olanzapine (Zyprexa, generics), aripiprazole (Abilify, generics), ziprasidone capsules (Geodon, generics), risperidone {Risperdal, generics}, quetiapine (Seroquel, generics), lurasidone (Latuda, generics), clozapine, but ANY antipsychotic would count, including injectable products. **2.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** Approve if the patient is currently taking Lybalvi OR the patient has taken Lybalvi at any time in the past.	1 year
Antipsychotics (Oral)	Caplyta	lumateperone capsules	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotics include: risperidone (Risperdal, generics), olanzapine (Zyprexa, generics), quetiapine (Seroquel, generics), aripiprazole (Abilify, generics), ziprasidone (Geodon, generics), lurasidone (Latuda, generics), clozapine, but ANY antipsychotic would count, including injectable products. **2.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** Approve if the patient is currently taking Caplyta OR the patient has taken Caplyta at any time in the past.	1 year
Antipsychotics (Oral)	Fanapt	iloperidone tablets and titration pack	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotics include: risperidone (Risperdal, generics), olanzapine (Zyprexa, generics), quetiapine (Seroquel, generics), aripiprazole (Abilify, generics), ziprasidone (Geodon, generics), lurasidone (Latuda, generics), clozapine, but ANY antipsychotic would count, including injectable products. **2.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** Approve if the patient is currently taking Fanapt OR the patient has taken Fanapt at any time in the past.	1 year
Antipsychotics (Oral)	Vraylar	cariprazine capsules	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotics include: risperidone (Risperdal, generics), olanzapine (Zyprexa, generics), quetiapine (Seroquel, generics), aripiprazole (Abilify, generics), ziprasidone (Geodon, generics), lurasidone (Latuda, generics), clozapine, but ANY antipsychotic would count, including injectable products. **2.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** Approve if the patient is currently taking Vraylar OR the patient has taken Vraylar at any time in the past.	1 year
Antipsychotics (Oral)	Abilify	aripiprazole tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antipsychotics (Oral)	Saphris	asenapine sublingual tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antipsychotics (Oral)	Seroquel	quetiapine fumarate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antipsychotics (Oral)	Seroquel XR	quetiapine fumarate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antipsychotics (Oral) [Muscarinic Agonist and Muscarinic Antagonist]	Cobenfy	xanomeline and trospium chloride capsules	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotics include: risperidone (Risperdal, generics), olanzapine (Zyprexa, generics), quetiapine (Seroquel, generics), aripiprazole (Abilify, generics), , ziprasidone (Geodon, generics), lurasidone (Latuda, generics) , clozapine, but ANY antipsychotic would count, including injectable products. **2.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** Approve if the patient has already started therapy with Cobenfy OR the patient has taken Cobenfy at any time in the past.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antipsychotics (Transdermal)	Secuado	asenapine transdermal system	**1.** Approve if the patient has tried at least TWO antipsychotics. Note: Examples of oral antipsychotics include: risperidone (Risperdal, generics), olanzapine (Zyprexa, generics), quetiapine (Seroquel, generics, aripiprazole (Abilify, generics), ziprasidone (Geodon, generics), lurasidone (Latuda, generics), clozapine, but ANY antipsychotic would count, including injectable products. **2.** If the patient is unable to swallow or has difficulty swallowing tablets, approve if the patient has tried at least one of risperidone ODT/solution (Risperdal, generics), olanzapine ODT (Zyprexa Zydis, generics), aripiprazole solution, or asenapine sublingual tablets (Saphris, generics). If none are formulary, approve. a. Patient with metabolic syndrome, approve if the patient has tried asenapine sublingual tablets one of (Saphris, generics) or aripiprazole solution. If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **3.** Patient with metabolic syndrome, approve if the patient has tried ONE of aripiprazole (Abilify, generics) OR ziprasidone (Geodon, generics). If neither are formulary, approve. Note: Any oral or Injectable products containing the chemicals above would also count toward approval. **4.** Approve if the patient is currently using Secuado OR the patient has used Secuado at any time in the past.	1 year
Antiseizure Medications	Primidone 125 mg (brand)	primidone 125 mg tablet	Approve if the patient's prescribed dose cannot be obtained with primidone 50 mg or 250 mg tablets. Note: The patient is NOT required to split the 250 mg tablets in half.	1 year
Antiseizure Medications	Eprontia	topiramate oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Vigafyde	vigabatrin oral solution	Approve if the patient tried and cannot take vigabatrin granules for oral solution (Sabril powder for solution, generics), if formulary. If vigabatrin granules for oral solution (Sabril powder for solution, generics) is non-formulary, approve.	1 year
Antiseizure Medications	Oxtellar XR and oxcarbazepaine extended-release tablets	oxcarbazepine extended-release tablets	If requesting brand Oxtellar XR tablets: Approve if the brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, generic oxcarbazepine extended-release tablets, if the generic is formulary. If requesting generic oxcarbazepine extended-release tablets or generic oxcarbazepine extended-release tablets are non-formulary: Approve if the patient has tried one product from the following list: immediate-release oxcarbazepine tablets/suspension (Trileptal, generics), if one is formulary. If none are formulary, approve. Note: If the patient has tried a brand version of a generic product, then this would satisfy the requirement.	1 year
Antiseizure Medications	Subvenite oral suspension	lamotrigine 10 mg/ml oral suspenison	**1.** Approve if the patient has tried lamotrigine tablets for oral suspension (dispersible tablets), if formulary. If lamotrigine tablets for oral suspension (dispersible tablets) are non-formulary, approve. Note: If the patient has tried a brand version of a generic product, then this would satisfy the requirement. **2.** Approve if the prescribed dose cannot be obtained with whole lamotrigine tablets for oral suspension (dispersible tablets). **3.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage with lamotrigine tablets for oral suspension (dispersible tablets), approve. Note: Lamotrigine tablets for oral suspension (dispersible tablets) may be swallowed whole, chewed, or dispersed in water or diluted fruit juice.	1 year
Antiseizure Medications	Elepsia XR	levetiracetam extended-release tablets	Approve if the patient has tried levetiracetam extended-release tablets (Keppra XR, generics), if formulary. If levetiracetam extended-release tablets (Keppra XR, generics) are non-formulary, approve.	1 year
Antiseizure Medications	Briviact oral solution	brivaracetam oral solution	**1.** Approve if the patient has tried one product from the following list: levetiracetam tablets (Keppra, generics) or levetiracetam oral solution (Keppra, generics), if one is formulary. If neither are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets: approve if the patient has tried levetiracetam oral solution (Keppra, generics), if formulary. If levetiracetam oral solution (Keppra, generics) are non-formulary, approve. **3.** Approve if the patient has been started on Briviact or has taken Briviact in the past.	1 year
Antiseizure Medications	Briviact tablets	brivaracetam tablets	**1.** Approve if the patient has tried one product from the following list: levetiracetam tablets/oral solution (Keppra, Keppra XR, generics), if formulary. If none are formulary approve. **2.** Approve if the patient has been started on Briviact or has taken Briviact in the past	1 year
Antiseizure Medications	Fycompa oral suspension	perampanel oral suspension	**1.** Approve if the patient has tried three other antiepileptic agents. Note: Examples include lacosamide (Vimpat tablets or oral solution), topiramate (Topamax, generics), lamotrigine (Lamictal, generics), gabapentin (Neurontin, generics), zonisamide (Zonegran, generics), Lyrica, oxcarbazepine (Trileptal, generics), levetiracetam (Keppra, Keppra XR generics), divalproex sodium (Depakote, Depakote ER, generics), Spritam, carbamazepine (Tegretol, Tegretol XR, generics), Briviact, Qudexy XR, Trokendi XR, Oxtellar XR, Fycompa tablets. **2.** Patients who cannot swallow or have difficulty swallowing oral tablets: approve if the patient has tried one of the following (if formulary): lacosamide oral solution (Vimpat oral solution, generics), levetiracetam oral solution (Keppra, generics), Spritam, lamotrigine ODT (Lamictal, generics), gabapentin oral solution (Neurontin, generics), pregabalin oral solution (Lyrica oral solution, generics), or oxcarbazepine oral suspension (Trileptal, generics). If none are formulary, approve. **3.** Approve if the patient has been started on Fycompa or has taken Fycompa in the past.	1 year
Antiseizure Medications	Spritam and authorized generic	levetiracetam orally disintegrating tablets	**1.** Approve if the patient has tried one product from the following list: levetiracetam tablets (Keppra, generics) or levetiracetam oral solution (Keppra, generics), if one is formulary. If neither are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets: approve if the patient has tried levetiracetam oral solution (Keppra, generics), if formulary. If levetiracetam oral solution (Keppra, generics) are non-formulary, approve.	1 year
Antiseizure Medications	Sympazan	clobazam oral film	Approve if the patient has tried one of clobazam tablets (Onfi, generics) or clobazam suspension (Onfi suspension, generics), if one is formulary. If neither are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antiseizure Medications	Xcopri	cenobamate tablets	**1.** Approve if the patient has tried three other antiepileptic agents. Note: Examples include lacosamide (Vimpat tablets or oral solution), topiramate (Topamax, generics), lamotrigine (Lamictal, generics), gabapentin (Neurontin, generics), zonisamide (Zonegran, generics), pregabalin (Lyrica), oxcarbazepine (Trileptal, generics), levetiracetam (Keppra, Keppra XR, generics), divalproex sodium (Depakote, Depakote ER, generics), carbamazepine (Tegretol, Tegretol XR, generics), Spritam, Fycompa, Briviact, Qudexy XR, Trokendi XR, Oxtellar XR. **2.** Approve if the patient has been started on Xcopri or has taken Xxopri in the past.	1 year
Antiseizure Medications	Fycompa tablets and generic perampanel tablets	perampanel tablets	If requesting brand Fycompa tablets: Approve if the brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent generic products, generic perampanel tablets, if the generic is formulary. If requesting generic perampanel tablets or generic perampanel tablets are non-formualry: **1.** Approve if the patient has tried three other antiepileptic agents. Note: Examples include lacosamide (Vimpat tablets or oral solution), topiramate (Topamax, generics), lamotrigine (Lamictal, generics), gabapentin (Neurontin, generics), zonisamide (Zonegran, generics), pregabalin (Lyrica, generics), oxcarbazepine (Trileptal, generics), levetiracetam (Keppra, Keppra XR generics), divalproex sodium (Depakote, Depakote ER, generics), Spritam, carbamazepine (Tegretol, Tegretol XR, generics), Briviact, topiramate ER (Qudexy XR, Trokendi XR, generics), oxcarbazepine ER (Oxtellar XR, generics). **2.** Approve if the patient has already been started on therapy with perampanel or Fycompa OR has taken perampanel or Fycompa in the past.	1 year
Antiseizure Medications	Trokendi XR and generic Trokendi XR capsules	topiramate extended-release capsules	Approve if the patient has tried one product from the following list: topiramate extended-release capsules (Qudexy XR, generics) or topiramate tablets (Topamax, generics), if formulary. If none are formulary, approve.	1 year
Antiseizure Medications	Motpoly XR	lacosamide extended-release capsules	Approve if the patient is unable to use lacosamide immediate-release tablets (Vimpat tablets, generics), if formulary. If lacosamide immediate-release tablets (Vimpat tablets, generics) are non-formulary, approve.	1 year
Antiseizure Medications	Zonisade oral suspension	zonisamide oral suspension	Approve if the patient is unable to swallow or has difficulty swallowing zonisamide capsules. If zonisamide capsules are non-formulary, approve.	1 year
Antiseizure Medications	Diacomit	stiripentol capsules and powder for oral suspension	See standard *Antiseizure Medications – Diacomit Prior Authorization Policy* criteria.	See PA duration
Antiseizure Medications	Fintepla	fenfluramine oral solution	See standard *Antiseizure Medications – Fintepla Prior Authorization Policy* criteria.	See PA duration
Antiseizure Medications	Aptiom and generic eslicarbazepine tablets	eslicarbazepine acetate tablets	**1.** Approve if the patient has tried three other antiepileptic agents. Note: Examples inlcude lacosamide (Vimpat tablets or oral solution, generics), topiramate (Topamax, generics), lamotrigine (Lamictal, generics), gabapentin (Neurontin, generics), zonisamide (Zonegran, generics), pregabalin (Lyrica, generics), oxcarbazepine/oxcarbazepine ER (Trileptal, Oxtellar XR, generics), levetiracetam (Keppra, Keppra XR, Elepsia XR, Roweepra, Roweepra XR, Spritam, generics), divalproex sodium (Depakote, Depakote ER, generics), carbamazepine (Tegretol, Tegretol XR, generics), perampanel (Fycompa, generics), Briviact (brivaracetam tablets and oral solution), topiramate ER (Qudexy XR, Trokendi XR, generics). **2.** Approve if the patient has already been started on therapy with eslicarbazepine or Aptiom OR has taken eslicarbazepine or Aptiom in the past.	1 year
Antiseizure Medications	topiramate 50 mg sprinkle capsule	topiramate 50 mg sprinkle capsule	**1.** Approve if the patient has tried topiramate 25 mg sprinkle capsules. If topiramate 25 mg sprinkle capsules are non-formulary, approve. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use topiramate 25mg sprinkle capsules.	1 year
Antiseizure Medications	Ztalmy	ganaxolone oral suspension	See standard *Antiseizure Medications – Ztalmy Prior Authorization Policy* criteria	See PA duration
Antiseizure Medications	Banzel	rufinamide tablets and oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Keppra	levetiracetam tablets and solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Keppra XR	levetiracetam exteended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Lamictal	lamotrigine tablets and chewable tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antiseizure Medications	Lamictal ODT	lamotrigine oral disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Lamictal XR	lamotrigine extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Onfi	clobazam tablets and suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Sabril	vigabatrin tablets and powder packet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Topamax	topiramate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Trileptal	oxcarbazepine tablets and suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Vimpat	lacosamide tablets and oral solution and vials	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications	Zonegran	zonisamide capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antiseizure Medications - Buccal	Libervant	diazepam buccal film strips	**1.** Approve if the patient has tried diazepam rectal gel (Diastat, generics), if formulary. If diazepam rectal gel (Diastat, generics) is non-formulary, approve. Note: If the patient has tried a benzodiazepine nasal spray (e.g., Valtoco or Nayzilam), this would satisfy the requirement for approval. **2.** If the patient's caregiver is unable to administer diazepam rectal gel (Diastat, generics), approve.	1 year
Antiseizure Medications – Nasal	Nayzilam	midazolam nasal spray	**1.** Approve if the patient has tried Valtoco, if formulary. If Valtoco is non-formulary, approve. **2.** If the patient has previously received Nayzilam OR is currently receiving Nayzilam, approve.	1 year
Antiseizure Medications – Nasal	Valtoco	diazepam nasal spray	**1.** Approve if the patient has tried Nayzilam, if formulary. If Nayzilam is non-formulary, approve. **2.** If the patient is < 12 years of age, approve. **3.** If the patient has previously received Valtococ OR is currently receiving Valtoco, approve.	1 year
Antituberculosis Agents	Priftin	rifapentine tablets	**1.** Treatment of Tuberculosis: Approve. **2.** Tuberculosis Prophylaxis or the Treatment of Latent Tuberculosis: Approve.	1 year
Antituberculosis Agents	Pretomanid tablets	pretomanid tablets	See standard *Infectious Disease – Pretomanid Prior Authorization Policy* criteria.	See PA duration
Antituberculosis Agents	Sirturo	bedaquiline tablets	See standard *Infectious Disease – Sirturo Prior Authorization Policy* criteria.	See PA duration
Antitussive Agents	Tuzistra XR	codeine/ chlorpheniramine extended-release oral suspension	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine and promethazine syrup (Promethazine VC codeine syrup, generics), hydrocodone polistirex/chlorpheniramine polystirex pennkinetic suspension. If none are formulary, approve if the patient has tried two other prescription or over-the-counter (OTC) cough and cold products.	1 year
Antivirals (Oral)	Prevymis	letermovir tablets	**1.** Prophylaxis of Cytomegalovirus: Approve. **2.** Secondary Prophylaxis or Treatment of Cytomegalovirus: Approve. **3.** Approve if the patient has already been started on therapy with Prevymis (any dosage form).	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Antivirals (Oral)	Prevymis oral pellets	letermovir oral pellets	**1.** Prophylaxis of Cytomegalovirus: Approve. **2.** Secondary Prophylaxis or Treatment of Cytomegalovirus: Approve. **3.** Approve if the patient has already been started on therapy with Prevymis (any dosage form).	1 year
Antivirals (Oral)	Relenza	zanamivir inhalation powder	**1.** Approve if the patient has tried oseltamivir (Tamiflu, generics), if formulary. If oseltamivir (Tamiflu, generics) are non-formulary, approve. 2. If the patient has already started Relenza, approve to complete the course of therapy.	1 month
Antivirals (Oral)	Xofluza	baloxavir marboxil tablets and granules for oral suspension	Approve if the patient has tried oseltamivir (Tamiflu, generics), if formulary. If oseltamivir (Tamiflu, generics) are non-formulary, approve.	1 month
Antivirals (Oral)	Sitavig	acyclovir buccal tablets	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), penciclovir 1% cream (Denavir, generics), Xerese 5%/1% cream, acyclovir 5% cream (Zovirax 5% cream, generics), or over-the-counter (OTC) Abreva 10% cream.	1 year
Antivirals (Oral)	Livtencity	maribavir tablets	See standard *Infectious Disease – Livtencity Prior Authorization Policy* criteria	See PA duration
Antivirals (Oral)	Valtrex	valacyclovir HCl caplets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Antivirals (Topical)	Denavir and penciclovir cream 1%	penciclovir cream, 1%	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), acyclovir 5% cream (Zovirax 5% cream, generics), Xerese 5%/1% cream, or over-the-counter (OTC) Abreva 10% cream.	1 year
Antivirals (Topical)	Xerese	acyclovir and hydrocortisone cream, 5%/1%	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), acyclovir 5% cream (Zovirax 5% cream, generics), penciclovir 1% cream (Denavir, generics), Sitavig tablets, or over-the-counter (OTC) Abreva 10% cream.	1 year
Antivirals (Topical)	Zovirax ointment	acyclovir 5% ointment	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Aromatase inhibitor	Arimidex	anastrozole tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. 1. For brand Arimidex requests, approve one of the following (A or B): A) The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS); AND ii. The patient meets one of the following (a or b): a. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR b. According to the prescriber, other formulary alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.* B) The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** For generic anastrozole requests,** approve if the requested non-formulary drug is being prescribed for the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS) AND, according to the prescriber, other formulary alternatives would not be as medically appropriate for the patient as the requested non-formulary drug. *Applicable for clients who are not using Multi-Source Brand criteria. **Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year
Aromatase Inhibitors - Medications for the Primary Prevention of Breast Cancer	Aromasin	exemestane	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the requested non-formulary drug is being prescribed for the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS) AND, according to the prescriber, other formulary alternatives would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year
Aromatic L-Amino acid Decarboxylase (AADC) Deficiency Agent	Kebilidi	eladocagene exuparvovec-tneq suspension for intraputaminal infusion	See standard *Neurology – Gene Therapy – Kebilidi Prior Authorization Policy* criteria.	See PA duration
Aspirin Products (Single-entity, 81 mg)	various	various	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets all of the following criteria (i and ii): i. The requested medication is being prescribed as preventive medication after 12 weeks of gestation in a patient who is at high risk for preeclampsia; AND ii. The patient meets one of the following (a or b): a. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with the preferred formulary alternatives; OR b. According to the prescriber, other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year
Bacterial Vaginosis Agents	Cleocin Vaginal Ovules	clindamycin phosphate vaginal suppositories	**1.** Patient is ≥ 18 years of age: Approve if the patient has tried a vaginal metronidazole-containing product AND a vaginal clindamycin-containing product. **2.** If the patient is post-menarchal and < 18 years of age, approve if the patient has tried one of vaginal metronidazole-containing product or a vaginal clindamycin-containing product.	3 months
Bacterial Vaginosis Agents	Clindesse vaginal cream	clindamycin phosphate vaginal cream	**1.** Patient is ≥ 18 years of age: Approve if the patient has tried a vaginal metronidazole-containing product AND a vaginal clindamycin-containing product. **2.** If the patient is post-menarchal and < 18 years of age, approve if the patient has tried one of a vaginal metronidazole-containing product OR a vaginal clindamycin-containing product.	3 months

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bacterial Vaginosis Agents	Nuvessa	metronidazole 1.3% vaginal gel	**1.** Patient ≥ 18 years of age: Approve if the patient has tried a vaginal metronidazole-containing product AND a vaginal clindamycin-containing product. **2.** If the patient is pre-menarchal, approve if the patient has tried Xaciato, if formulary. If Xaciato is non-formulary, approve. **3.** If the patient is post-menarchal and < 18 years of age, approve if the patient has tried one of vaginal metronidazole-containing product or a vaginal clindamycin-containing product.	3 months
Bacterial Vaginosis Agents	Xaciato	clindamycin phosphate 2% vaginal gel	**1.** Patient is ≥ 18 years of age: Approve if the patient has tried a vaginal metronidazole-containing product AND a vaginal clindamycin-containing product. **2.** If the patient is pre-menarchal, approve if the patient has tried Nuvessa, if formulary. If Nuvessa is non-formulary, approve. **3.** If the patient is post-menarchal and < 18 years of age, approve if the patient has tried one of vaginal metronidazole-containing product or a vaginal clindamycin-containing product.	3 months
Barth Syndrome - Mitochondrial Cardiolipin Binder	Forzinity	elamipretide subcutaneous injection	See standard *Barth Syndrome – Forzinity Prior Authorization Policy* criteria.	See PA duration
Benign Prostatic Hyperplasia – Combination Agents	Entadfi	finasteride 5 mg and tadalafil 5 mg capsules	Benign Prostatic Hyperplasia (BPH). Approve if, according to the prescriber, the patient has a clinical reason they cannot take finasteride 5 mg and tadalafil 5 mg as separate agents.	1 year
Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Avodart	dutasteride capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Uroxatral	alfuzosin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Benzodiazepines	Loreev XR	lorazepam extended-release capsules	**1.** Direct the patient to use lorazepam tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use lorazepam immediate-release tablets.	1 year
Benzodiazepines	Klonopin	clonazepam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Benzodiazepines	Valium	diazepam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Benzodiazepines	Xanax	alprazolam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Benzodiazepines	Xanax XR	alprazolam entended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Benzodiazepines	Doral and authorized generic	quazepam tablets	Approve if the patient has tried estazolam or lorazepam, if formulary. If neither are formulary, approve.	1 year
Benzodiazepines and Combination Products	Librax	chlordiazepoxide/clidinium bromide capsules	Approve if the patient has tried clidinium-chlordiazepoxide capsules. If clidinium-chlordiazepoxide capsules are non-formulary, approve.	1 year
Beta-Blocker Products	Lopressor oral solution	metoprolol tartrate oral solution	**1.** Approve if the patient tried and cannot take metoprolol tartrate tablets. If metoprolol tartrate tablets are non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets. **3.** Approve if the prescribed dose cannot be obtained with whole tablets of the higher metoprolol tartrate tablet strengths.	1 year
Beta-Blocker Products	labetalol 400 mg tablets	labetalol 400 mg tablets	**1.** Direct the patient to labetalol 100 mg, 200 mg, or 300 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the labetalol 100 mg, 200 mg, or 300 mg tablets.	1 year

Data Class: Confidential

Formulary Exception Criteria

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Beta-Blocker Products	Lopressor 12.5 mg and metoprolol tartrate 12.5 mg (brand)	metoprolol tartrate 12.5 mg	**1.** Approve if the patient has tried generic metoprolol tartrate tablets. If generic metoprolol tartrate tablets are non-formulary, approve. Note: Generic metoprolol tartrate tablets are available in 25 mg, 37.5 mg, 50 mg, 75 mg, or 100 mg. **2.** Approve if the patient's prescribed dose cannot be obtained with the higher-strength tablets. Note: Patient is NOT required to split the higher-strength tablets in half. **3.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the higher-strength tablets.	1 year
Beta-Blocker Products	Bystolic	nebivolol tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Beta-Blocker Products	Kapspargo Sprinkle	metoprolol succinate extended-release capsules	**1.** Approve if the patient has tried metoprolol succinate extended-release tablets, if formulary. If non-formulary, approve. **2.** If the patient requires a dosage form which can be opened and sprinkled for alternative administration (e.g., for patients unable to swallow capsules, for nasogastric tube administration), approve.	1 year
Beta-Blocker Products	Hemangeol	propranolol hydrochloride 4.28 mg/mL oral solution	Proliferating infantile hemangioma. Approve if the patient has tried propranolol hydrochloride oral solution (20 mg/5mL) [NOT Hemangeol].	1 year
Beta-Blocker Products	Inderal XL	propranolol hydrochloride capsule, extended release	**1.** Direct the patient to propranolol extended-release capsules. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic propranolol extended-release capsules.	1 year
Beta-Blocker Products	Innopran XL	propranolol hydrochloride capsule, extended release	**1.** Direct the patient to propranolol extended-release capsules. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic propranolol extended-release capsules.	1 year
Beta-Blocker Products	Inderal LA	propranolol HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Beta-Blocker Products	Toprol XL	metoprolol succinate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Beta-Blockers Products	bisoprolol fumarate 2.5 mg tablets	bisoprolol fumarate 2.5 mg tablets	**1.** Approve if the prescribed dose cannot be obtained with whole bisoprolol 5 mg or 10 mg tablets. Note: The patient is NOT required to split the 5 mg or 10 mg tablets in half. **2.** Patient with bronchospastic disease, approve.	1 year
Beta-Blockers Products	Sotylize	sotalol hydrochloride oral solution	**1.** Approve if the patient has tried sotalol tablets, if formulary. If sotalol tablets are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.	1 year
Beta-Thalassemia Agents	Zynteglo	betibeglogene autotemcel intravenous infusion	Patient meets the standard *Hematology – Gene Therapy - Zynteglo Prior Authorization Policy* criteria AND Patients meets ONE of the following (1 or 2): **1.** If Casgevy is non-formulary, approve; OR 2. If Casgevy is not available at the patient's treatment facility or treatment center, approve. If the patient does not meet 1 or 2 above, direct the patient to Casgevy. All reviews (approvals and denials) will be forwarded to the Medical Director for evaluation.	See PA duration
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Aukelso	denosumab-kyqq injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1**. Patient has tried ALL of the following: Bilprevda, Bomyntra, Jubereq, Osenvelt, Wyost, Xgeva, and Xtrenbo, if formulary; AND Note: If none are formulary, approve. **2**. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Bilprevda	denosumab-nxxp injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Aukelso, Bomyntra, Jubereq, Osenvelt, Wyost, Xgeva, and Xtrenbo, if formulary; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Bomyntra	denosumab-bnht injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Aukelso, Bilprevda, Jubereq, Osenvelt, Wyost, Xgeva, and Xtrenbo, if formulary; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Jubereq	denosumab-desu injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Aukelso, Bilprevda, Bomyntra, Osenvelt, Wyost, Xgeva, and Xtrenbo, if formulary; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Osenvelt	denosumab-bmwo injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Aukelso, Bilprevda, Bomyntra, Jubereq, Wyost, Xgeva, and Xtrenbo, if formulary; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Wyost	denosumab-bbdz injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Aukelso, Bilprevda, Bomyntra, Jubereq, Osenvelt, Xgeva, and Xtrenbo, if formulary; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Xgeva	denosumab injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Aukelso, Bilprevda, Bomyntra, Jubereq, Osenvelt, Wyost, and Xtrenbo, if formulary; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Bisophosphonates and Other Bone Mineral Density Increasing Agents - Xgeva and biosimilar Agents	Xtrenbo	denosumab-qbde injection for subcutaneous use	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Aukelso, Bilprevda, Bomyntra, Jubereq, Osenvelt, Wyost, and Xgeva, if formulary; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Bone Modifiers - Bisphosphonates	Binosto	alendronate effervescent tablets	**1.** Approve if the patient has tried one product from the following list (if one is formulary): alendronate tablets (Fosamax, Fosamax Plus D, generics) or alendronate oral solution (generics). If none are formulary, approve. **2.** Patients with a gastrostomy (G-tube) or patients who cannot swallow or have difficulty swallowing tablets: approve if the patient has tried alendronate oral solution (generics), if formulary. If alendronate oral solution (generics) is non-formulary, approve.	1 year
Bone Modifiers - Bisphosphonates	Fosamax Plus D tablets	alendronate/cholecalciferol tablets	Approve if the patient has tried oral alendronate tablets (Fosamax, generics), if formulary. If non-formulary, approve.	1 year
Bone Modifiers - Other	Forteo	teriparatide injection	Approve if the patient has tried generic teriparatide (generic Forteo), if formulary. If generic teriparatide (generic Forteo) is non-formulary or if generic teriparatide (generic Forteo) is being requested, approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried one of brand teriparatide or Bonsity, if formulary. If neither are formulary, approve if patient has tried Tymlos, if formulary. If Tymlos is non-formulary, approve. **2.** Approve if the patient has tried one of brand teriparatide or Bonsity, if formulary. If neither are formulary, patients with glucocorticoid-induced osteoporosis (GIO): approve. Note: For approvals above: Use of teriparatide (Forteo [generics] or teriparatide) exceeding 2 years during a patient's lifetime, approve if the patient is at high risk for fracture as determined by the prescriber.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bone Modifiers - Other	teriparatide (brand) and Bonsity	teriparatide injector	**1.** Approve if the patient has tried teriparatide pen (Forteo, generic), if formulary. If teriparatide pen (Forteo, generic) is non-formulary, approve if patient has tried Tymlos, if formulary. If Tymlos is non-formulary, approve. **2.** Approve if the patient has tried teriparatide pen (Forteo, generic), if formulary. If teriparatide pen (Forteo, generic) is non-formulary, patients with glucocorticoid-induced osteoporosis (GIO): approve. **NOTE**: For approvals above under criteria (1 and 2): Use of teriparatide (Forteo [generics] or teriparatide) exceeding 2 years during a patient's lifetime, approve if the patient is at high risk for fracture as determined by the prescriber.	1 year
Bone Modifiers - Other	Tymlos	abaloparatide injection	Approve if patient has tried one of teriparatide pen (Forteo, generic), brand teriparatide, or Bonsity, if formulary. If none are formulary, approve. **NOTE:** Approval should only be granted if the patient has NOT received more than 2 years of cumulative therapy with Tymlos.	1 year
Bone Modifiers - Other	Evenity	romosozumab-aqqg injection for subcutaneous use	**1**. Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics], a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Prolia. **2**. Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3**. According to the prescriber, patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/min). **4**. Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5**. Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position (post oral bisphosphonate administration), or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia].	1 year
Bone Modifiers - Other - Prolia and biosimilars	Bildyos	denosumab-nxxp injection for subcutaneous use	If any of the products are formulary: Bosaya, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, or Stoboclo, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bosaya, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, and Stoboclo, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bosaya, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, or Stoboclo are formulary, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4.** Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5.** Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6.** Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7.** Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8.** Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9.** Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bone Modifiers - Other - Prolia and biosimilars	Bosaya	denosumab-kyqq	If any of the products are formulary: Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, or Stoboclo, approve if the patient meets BOTH of the following (1 and 2): **1**. Patient has tried ALL of the following: Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, and Stoboclo, if formulary; AND **2**. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, or Stoboclo are formulary, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1**. Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2**. Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3**. According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4**. Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5**. Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6**. Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7**. Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8**. Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9**. Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year
Bone Modifiers - Other - Prolia and biosimilars	Conexxence	denosumab- bnht injection for subcutaneous use	If any of the products are formulary: Bosaya, Bildyos, Enoby, Jubbonti, Osvyrti, Prolia, or Stoboclo, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bosaya, Bildyos, Enoby, Jubbonti, Osvyrti, Prolia, and Stoboclo, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bosaya, Bildyos, Enoby, Jubbonti, Osvyrti, Prolia, or Stoboclo are formulary, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4.** Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5.** Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6.** Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7.** Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8.** Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9.** Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bone Modifiers - Other - Prolia and biosimilars	Enoby	denosumab-qbde injection, for subcutaneous use	If any of the products are formulary: Bosaya, Bildyos, Conexxence, Jubbonti, Osvyrti, Prolia, or Stoboclo, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bosaya, Bildyos, Conexxence, Jubbonti, Osvyrti, Prolia, and Stoboclo, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bosaya, Bildyos, Conexxence, Jubbonti, Osvyrti, Prolia, or Stoboclo are formulary, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4.** Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5.** Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6.** Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7.** Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8.** Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9.** Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year
Bone Modifiers - Other - Prolia and biosimilars	Jubbonti	denosumab-bbdz injection for subcutaneous use	If any of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Stoboclo, Osvyrti, or Prolia, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bosaya, Bildyos, Conexxence, Enoby, Stoboclo, Osvyrti, and Prolia, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Stoboclo, Osvyrti, or Prolia, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4.** Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5.** Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6.** Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7.** Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8.** Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9.** Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bone Modifiers - Other - Prolia and biosimilars	Ospomyv or CDV Ospomvy	denosumab-dssb injection for subcutaneous use	If any of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, or Stoboclo, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bosaya, Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, Prolia, and Stoboclo, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Jobbonti, Osvyrti, Prolia, or Stoboclo, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4.** Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5.** Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6.** Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard [leuprolide acetate for injectable suspension], Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7.** Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8.** Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9.** Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year
Bone Modifiers - Other - Prolia and biosimilars	Osvyrti	denosumab-desu injection for subcutaneous use	If any of the products are formulary: Bildyos, Bosaya, Conexxence, Enoby, Jubbonti, Prolia, or Stoboclo, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bildyos, Bosaya, Conexxence, Enoby, Jubbonti, Prolia, and Stoboclo, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bildyos, Bosaya, Conexxence, Enoby, Jubbonti, Prolia, or Stoboclo are formulary, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4.** Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5.** Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6.** Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7.** Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8.** Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9.** Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bone Modifiers - Other - Prolia and biosimilars	Prolia	denosumab injection for subcutaneous use	If any of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, or Stoboclo, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bosaya, Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, and Stoboclo, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Jobbonti, Osvyrti, or Stoboclo, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1**. Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2**. Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4**. Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5**. Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6**. Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7**. Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8**. Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9**. Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year
Bone Modifiers - Other - Prolia and biosimilars	Stoboclo	denosumab-bmwo injection for subcutaneous use	If any of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, or Prolia, approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ALL of the following: Bosaya, Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, and Prolia, if formulary; AND **2.** Patient cannot continue to use each of the formulary alternatives(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the products are formulary: Bosaya, Bildyos, Conexxence, Enoby, Jubbonti, Osvyrti, or Prolia, approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, 7, 8, or 9): **1.** Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2.** Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4.** Patients who have had an osteoporotic fracture or a fragility fracture OR the patient has a very low T-score < -3.0: approve. **5.** Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6.** Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy: approve. Note: Examples of androgen deprivation therapy are: Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7.** Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Camcevi/Camcevi ETM (leuprolide subcutaneous injectable emulsion), Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Firmagon (degarelix subcutaneous injection), Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8.** Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9.** Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Botulinum Toxin Products	Daxxify	daxibotulinumtoxinA-lanm for injection	Cervical Dystonia in a patient ≥ 18 years of age. Note: Cervical dystonia is also referred to as spasmodic torticollis. **1.** Approve if the patient has tried ONE of Botox, Dysport, or Xeomin, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Botox or Xeomin, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Daxxify. Daxxify is not covered in the following situations: Cosmetic Uses. Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year
Botulinum Toxin Products	Myobloc	rimabotulinumtoxinB for injection	Spasticity, upper limb in a patient ≥ 18 years of age. **1.** Approve if the patient has tried one of Botox, Xeomin, or Dysport, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Xeomin or Botox, if formulary. If neither are formulary approve. **3.** Approve if the patient has already been started on therapy with Myobloc. Sialorrhea, chronic, in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Xeomin, if formulary. If Xeomin is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Myobloc. Cervical dystonia in a patient ≥ 18 years of age. Note: Cervical dystonia is also referred to as spasmodic torticollis. **1.** Approve if the patient has tried Dysport, if formulary. If Dysport is non-formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Approve if the patient has already been started on therapy with Myobloc. Myobloc is not covered in the following situations: Cosmetic Uses. Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year
Botulinum Toxin Products	Xeomin	incobotulinumtoxinA for injection	Blepharospasm in a patient ≥ 18 years of age. Note: This includes blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders. **1.** Approve if the patient has tried Botox, if formulary. If Botox is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Xeomin. Cervical Dystonia in a patient ≥ 18 years of age. Note: Cervical dystonia is also referred to as spasmodic torticollis. **1.** Approve if the patient has tried one of Botox, Dysport, or Daxxify, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Botox or Daxxify, if formulary. If neither are formulary approve. **3.** Approve if the patient has already been started on therapy with Xeomin. Spasticity, upper limb, in a patient ≥ 2 years of age. **1.** Approve if the patient has tried one of Botox or Dysport, if formulary. If neither are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried Botox, if formulary. If Botox is non-formulary approve. 3. Approve if the patient has already been started on therapy with Xeomin. Sialorrhea, Chronic, in a patient ≥ 2 years of age. **1.** Approve if the patient has tried Myobloc, if formulary. If Myobloc is non-formulary, approve. **2.** Patient < 18 years of age, approve. **3.** Approve if the patient has already been started on therapy with Xeomin. Xeomin is not covered in the following situations: Cosmetic Uses. Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Botulinum Toxin Products	Dysport	abobotulinumtoxinA for injection	Cervical Dystonia in a patient ≥ 18 years of age: Approve Note: Cervical dystonia is also referred to as spasmodic torticollis. Spasticity, Limb(s), in a patient ≥ 2 years of age. **1.** Approve if the patient has tried one of Botox or Xeomin, if formulary. If neither are formulary, approve. **2.** Patients with lower limb spasticity, approve if the patient has tried Botox, if formulary. If Botox is non-formulary, approve. **3.** Approve if the patient has already been started on therapy with Dysport. Blepharospasm in a patient ≥ 18 years of age. Note: This includes blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders. **1.** Approve if the patient has tried one of Botox or Xeomin, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Dysport. Sialorrhea, Chronic, in a patient ≥ 18 years of age. **1.** Approve if the patient has tried one of Xeomin, Botox, or Myobloc, if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Dysport. Anal Fissure, Chronic, in a patient ≥ 18 years of age.D292 **1.** Approve if the patient has tried Botox, if formulary. If Botox is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Dysport. Hemifacial Spasm in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Botox, if formulary. If Botox is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Dysport. Oromandibular Dystonia in a patient ≥ 18 years of age. 1. Approve if the patient has tried Botox, if formulary. If Botox is non-formulary, approve. 2. Approve if the patient has already been started on therapy with Dysport. Dysport is not covered in the following situations: Cosmetic Uses. Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Botulinum Toxin Products - Botox	Botox (NOT cosmetic) [2 of 2]	onabotulinumtoxinA for injection	Sialorrhea, Chronic, in a patient ≥ 18 years of age. **1.** Approve if the patient has tried one of Dysport, Xeomin, or Myobloc, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Xeomin or Myobloc, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Botox. Anal Fissure, Chronic, in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Dysport, if formulary. If Dysport is non-formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Approve if the patient has already been started on therapy with Botox. Hemifacial Spasm in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Dysport, if formulary. If Dysport is non-formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Approve if the patient has already been started on therapy with Botox. Oromandibular Dystonia in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Dysport, if formulary. If Dysport is non-formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Approve if the patient has already been started on therapy with Botox. Neurogenic Detrusor Overactivity in patient ≥ 5 years of age; Overactive Bladder with Symptoms of Urge Urinary Incontinence, Urgency, and Frequency in a patient ≥ 18 years of age; Urinary Incontinence Due to Detrusor Overactivity Associated with a Neurological Condition in a patient ≥ 18 years of age; Achalasia in a patient ≥ 18 years of age; Essential Tremor in a patient ≥ 18 years of age; Hyperhidrosis, Gustatory (also referred to as Frey's Syndrome) in a patient ≥ 18 years of age; Dystonia, Focal Upper Limb in a patient ≥ 18 years of age; Laryngeal Dystonia (Spasmodic Dysphonia) in a patient ≥ 18 years of age: Approve. Botox is not covered in the following situations: Cosmetic Uses. Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Botulinum Toxin Products - Botox	Botox (NOT cosmetic) [1 of 2]	onabotulinumtoxin A for injection (continued)	Hyperhidrosis, Primary Axillary , in a patient ≥ 18 years of age. Approve if the patient has tried at least one prescription topical agent for axillary hyperhidrosis. Note: Examples of prescription topical agents for the treatment of axillary hyperhidrosis include Drysol (aluminum chloride 20% topical solution), Qbrexza (glycopyrronium cloth 2.4% for topical use), Sofdra (glycopyrronium 12.45% topical gel). Hyperhidrosis, Primary Palmar/Plantar and Crainiofacial , in a patient ≥ 18 years of age. Approve if the patient has tried at least one topical agent for the treatment of hyperhidrosis (e.g., aluminum chloride). Chronic Migraine Headache Prevention in a patient ≥ 18 years of age. **1.** Approve if the patient has tried one of Aimovig, Ajovy, Emgality, Vyepti, or Qulipta **[documentation required],** if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Botox. Blepharospasm in a patient ≥ 12 years of age. Note: This includes blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders. **1.** Approve if the patient has tried Xeomin, if formulary. If Xeomin is non-formulary, approve. **2.** If the patient is < 18 years of age, approve. **3.** Approve if the patient has already been started on therapy with Botox. Strabismus in a patient ≥ 12 years of age: Approve. Note: Common types of strabismus include esotropia, exotropia, hypertropia, hypotropia. Cervical Dystonia in a patient ≥ 18 years of age. Note: Cervical dystonia is also referred to as spasmodic torticollis. **1.** Approve if the patient has tried one of Dysport, Xeomin, or Daxxify, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Xeomin or Daxxify, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Botox. Spasticity, Limb(s), in a patient ≥ 2 years of age. **1.** Approve if the patient has tried one of Dysport or Xeomin, if formulary. If neither are formulary, approve. **2.** Patients with lower limb spasticity, approve if the patient has tried Dysport. If Dysport is non-formulary, approve. a. Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried Xeomin, if formulary. If Xeomin is non-formulary, approve. **4.** Approve if the patient has already been started on therapy with Botox.	1 year (continued)
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based Preparations	Plenvu	polyethylene glycol; electrolytes; ascorbic acid powder for solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR ii. Patients with phenylketonuria. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i, ii, or iii): i. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR ii. Patients with phenylketonuria; OR iii. Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based Preparations	Moviprep	PEG-3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate, ascorbic acid	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for a use OTHER THAN bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Bowel Evacuants – Low Volume – Sodium Picosulfate-based Preparations	Clenpiq	sodium picosulfate; magnesium oxide; anhydrous citric acid solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient meets one of the following (a or b): a. Patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve; OR b. Patient is < 12 years of age. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, c, or d): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. The patient is less than 18 years of age; OR c. Patients with phenylketonuria; OR d. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient meets one of the following (a or b): a. Patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve; OR b. Patient is < 12 years of age. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, c, or d): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. The patient is less than 18 years of age; OR c. Patients with phenylketonuria; OR d. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bowel Evacuants – Low Volume – Sodium Sulfate-Based Preparations	Suprep	magnesium sulfate; potassium sulfate; sodium sulfate solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for a use OTHER THAN bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based Preparations	Suflave	polyethylene glycol 3350, sodium sulfate, potassium chloride, magnesium sulfate, and sodium chloride for oral solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Bowel Evacuants – Low Volume – Sodium Sulfate-based Preparations	Sutab	sodium sulfate, magnesium sulfate, and potassium chloride tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month
Bowel Evacuants for Bowel Preparation as Part of a Colorectal Cancer Screening Procedure	Various	Various	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required.* Approve if the patient meets one of the following criteria (i or ii): i. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with the preferred formulary alternatives; OR ii. The patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. According to the prescriber, other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year
Breast Cancer agent (intravenous)	Datroway	datopotamab deruxtecan-dlnk injection for intravenous use	See standard *Oncology (Injectable – Antibody-Drug Conjugate – Trop-2) – Datroway Prior Authorization Policy* criteria.	See PA duration
Breast Cancer agent (intravenous)	Margenza	margetuximab injection for intravenous use	Human epidermal growth factor receptor 2 (HER2)-positive disease breast cancer. Approve if the patient meets all of the following (A or B): A) The patient has tried at least THREE prior anti-HER2 regimens; OR Note: Some examples of anti-HER2 regimens are Perjeta (pertuzumab intravenous infusion) + trastuzumab + docetaxel, Perjeta + trastuzumab + paclitaxel; Kadcyla (ado-trastuzumab emtansine intravenous infusion), Enhertu (fam-trastuzumab deruxtecan-nxki intravenous infusion), Tukysa (tucatinib tablets) + trastuzumab + capecitabine, trastuzumab + lapatinib, trastuzumab + docetaxel, trastuzumab + vinorelbine, Nerlynx (neratinib tablets) + capecitabine. B) The patient has already been started on therpy with Margenza.	1 year
Breast Cancer agent (intravenous)	Trodelvy	sacituzumab govitecan-hziy injection for intravenous use	See standard *Oncology (Injectable – Antibody-Drug Conjugate – Trop-2) – Trodelvy PA Policy* criteria.	See PA duration
Breast Cancer agent (intravenous)	Enhertu	fam-trastuzumab deruxtecan-nxki injection for intravenous use	See standard *Oncology (Injectable – Antibody-Drug Conjugate – HER2) – Enhertu Prior Authorization Policy* criteria.	See PA duration
Breast Cancer agent (subcutaneous)	Phesgo	pertuzumab, trastuzumab, and hyaluronidase-zzxf injection for subcutaneous use	Human epidermal growth factor receptor 2 (HER2)-positive disease breast cancer (patient is ≥ 18 years of age). **1.** Approve if the patient has tried Perjeta intravenous AND one of the following: Herceptin, Hercessi, Herzuma, Kanjinti, Ogivri, Ontruzant, or Trazimera. If Perjeta is non-formulary, approve. If none of Herceptin, Hercessi, Herzuma, Kanjinti, Ogivri, Ontruzant, nor Trazimera are formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** If the patient has already been started on therapy with Phesgo, approve.	1 year
Breast Cancer Agents – Kinase inhibitor	Tukysa	tucatinib tablets	See standard *Oncology (Oral) - Tukysa Prior Authorization Policy* criteria	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Buprenorphine extended-release – Monthly Agents	Brixadi Monthly	buprenorphine extended-release subcutaneous injection 64 mg/0.18 mL, 96 mg/0.27 mL, and 128 mg/0.36 mL	Approve if the patient has tried Sublocade, if formulary. If Sublocade is non-formulary, approve.	1 year
Buprenorphine extended-release – Monthly Agents	Sublocade	buprenorphine extended-release subcutaneous injection	Approve if the patient has tried Brixadi Monthly, if formulary. If Brixadi Monthly is non-formulary, approve.	1 year
Buprenorphine extended-release – Weekly Agents	Brixadi Weekly	buprenorphine extended-release subcutaneous injection 8 mg/0.16 mL, 16 mg/0.32 mL, 24 mg/0.48 mL, and 32 mg/0.64 mL	**1.** Approve if the patient has tried a buprenorphine-containing sublingual tablets. **2.** Approve if the patient is not a candidate for a monthly buprenorphine extended-release product (e.g., Brixadi Monthly or Sublocade).	1 year
Buspirone Products	Bucapsol capsules	buspirone hcl capsules 10 mg, 15 mg, 7.5 mg, 5 mg	**1.** Approve if the patient has tried and cannot take generic buspirone tablets, if formulary. If generic buspirone tablets are non-formulary, approve. Note: Generic buspirone tablets are available in 5 mg, 7.5 mg, 10 mg, 15 mg, and 30 mg. **2.** Approve if the patient cannot swallow tablets or has difficulty swallowing tablets.	1 year
Buspirone Products	buspirone 2.5 mg & 12.5 mg tablets (branded)	buspirone 2.5 mg & 12.5 mg tablets	Approve if the prescribed dose cannot be obtained with whole generic buspirone tablets. If generic buspirone tablets are non-formulary, approve. Note: Generic buspirone tablets are available in 5 mg, 7.5 mg, 10 mg, 15 mg, and 30 mg. Note: The patient is NOT required to split tablets in half.	1 year
C type Natriuretic Peptide Analog	Voxzogo	vosoritide subcutaneous injection	Achondroplasia in a patient < 18 years of age. **1.** Approve if the patient has tried Yuviwel, if formulary. If Yuviwel is non-formulary, approve. **2.** Patient < 2 years of age, approve.	1 year
C type Natriuretic Peptide Analog	Yuviwel	navepegritide subcutaneous injection	Achondroplasia in a patient ≥ 2 years of age AND < 18 years of age. Approve if the patient has tried Voxzogo, if formulary. If Voxzogo is non-formulary, approve.	1 year
Calcium Channel Blocker Nasal Spray	Cardamyst	etripamil nasal spray	See standard *Cardiology – Cardamyst Prior Authorization Policy* criteria.	See PA duration
Calcium Channel Blockers (CCBs)	Nymalize	nimodipine oral solution and oral syringe	Approve if the patient has tried nimodipine oral capsules or is unable to have the nimodipine oral capsules appropriately administered.	1 year
Calcium Channel Blockers (CCBs)	Conjupri and levamlodipine	levamlodipine tablets	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four formulary products from the following list: amlodipine, felodipine, nifedipine LA, nisoldipine (if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary). **2.** If the patient is < 18 years of age, approve if the patient has tried amlodipine, if formulary. If amlodipine is non-formulary, approve.	1 year
Calcium Channel Blockers (CCBs)	Norvasc	amlodipine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Calcium Channel Blockers (CCBs) – Liquid Amlodipine	Katerzia	amlodipine oral suspension 1 mg/mL	**1.** Direct the patient to amlodipine tablets. **2.** If the patient is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the patient has tried ONE of Norliqva oral solution or Sdamlo oral solution, if formulary. If neither are formulary, approve..	1 year
Calcium Channel Blockers (CCBs) – Liquid Amlodipine	Norliqva	amlodipine oral solution 1 mg/mL	**1.** Direct the patient to amlodipine tablets. **2.** If the patient is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the patient has tried ONE of Katerzia oral suspension or Sdamlo oral solution, if formulary. If neither are formulary, approve.	1 year
Calcium Channel Blockers (CCBs) – Liquid Amlodipine	Sdamlo	amlodipine oral solution 2.5 mg, 5 mg, 10 mg (powder for solution)	**1.** Direct the patient to amlodipine tablets. **2.** If the patient is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the patient has tried ONE of Norliqva oral solution or Katerzia oral suspension, if formulary. If neither are formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Calcium Channel Blockers (CCBs)/Non-Steroidal Anti-inflammatories (NSAIDs)	Consensi	amlodipine and celecoxib tablets	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with two dihydropyridine calcium channel blockers (for example, amlodipine, felodipine, nifedipine LA, nisoldipine) both used concomitantly with celecoxib. If celecoxib is non-formulary, approve.	1 year
Cancer – ROS1 Inhibitors	Jideytro	zidesamtinib tablets	ROS1-positive non-small cell lung cancer. **1.** Approve if the patient has tried at least one of Augtyro, Ibtrozi, or Rozlytrek. If none are formulary, approve. Note: A trial of Xalkori would also count as an approval. **2.** If the patient has a ROS1 G2032R resistance mutation, approve if the patient has tried at least one of Augtyro or Ibtrozi. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Jideytro.	1 year
Cancer – Asparginase Products	Oncaspar	pegaspargase injection for intramuscular and intravenous use	Acute Lymphoblastic Leukemia. **1.** Approve if the patient has tried Asparlas. If Asparlas is non-formulary, approve. **2.** If the patient is less than 1 month of age, approve. **3.** If the patient is 21 years of age or older, approve. **4.** If the patient has an inability to obtain and/or maintain intravenous access and will be using Oncaspar via the intramuscular route, approve. **5.** Approve if the patient has already started therapy with Oncaspar. Extranodal NK/T-cell Lymphoma, approve.	1 year
Cancer – Asparginase Products	Erwinase	asparaginase erwinia chrysanthemi powder for injection	Acute Lymphoblastic Leukemia. **1.** If the patient developed a systemic allergic reaction or anaphylaxis to a pegylated asparaginase product (e.g., Oncaspar, Asparlas), approve if the patient has tried Rylaze. If Rylaze is non-formulary, approve. **2.** For induction therapy in patients ≥ 65 years of age, approve. **3.** Approve if the patient has already started therapy with Erwinase.	1 year
Cancer – Asparginase Products	Rylaze	asparaginase erwinia chrysanthemi [recombinant] intramuscular injection	Acute Lymphoblastic Leukemia. **1.** If the patient developed a systemic allergic reaction or anaphylaxis to a peglyated asparaginase product (e.g., Oncaspar, Asparlas), approve if the patient has tried Erwinase. If Erwinase is non-formulary, approve. **2.** Approve if the patient is < 1 year of age. **3.** Approve if there are availability issues with Erwinase. **4.** Approve if the patient has already been started on therapy with Rylaze. Lymphoblastic Lymphoma. If the patient developed a systemic allergic reaction or anaphylaxis to a pegylated asparaginase product (e.g., Oncaspar, Asparlas), approve. Extranodal NK/T-Cell Lymphoma. If the patient developed a systemic allergic reaction or anaphylaxis to a pegylated asparaginase product (e.g., Oncaspar), approve.	1 year
Cancer – Asparginase Products	Asparlas	calaspargase pegol-mknl injection for intravenous use	Acute Lymphoblastic Leukemia. **1.** Approve if the patient has tried Oncaspar. If Oncaspar is non-formulary, approve. **2.** If the patient is ≥ 1 month of age and ≤ 21 years of age, approve. **3.** Approve if the patient has already started therapy with Asparlas.	1 year
Cancer – CD123-Directed Medications	Decnupaz	pivekimab sunirine-pvzy intravenous infusion	Blastic Plasmacytoid Dendritic Cell Neoplasm. **1.** Approve if the patient has tried Elzonris. If Elzonris is non-formulary, approve. **2.** Approve if, according to the prescriber, Elzonris is not clinically appropriate for the patient (e.g., if the patient has inadequate cardiac function or a low serum albumin level). **3.** Approve if Elzonris is NOT used or not available through the patient's/prescriber's treatment center. 4. Approve if the patient has already been started on therapy with Decnupaz.	1 year
Cancer – CD123-Directed Medications	Elzonris	tagraxofusp-erzs intravenous infusion	Blastic Plasmacytoid Dendritic Cell Neoplasm. **1.** Approve if the patient has tried Decnupaz. If Decnupaz is non-formulary, approve. **2.** Approve if the patient is < 18 years of age. **3.** Approve if, according to the prescriber, Decnupaz is not clinically appropriate for the patient (e.g., patient with hepatic impairment or at risk of hepatic impairment, preexisting edema, history of sulfite sensitivity). **4.** Approve if Decnupaz is NOT used or not available through the patient's/prescriber's treatment center. **5.** Approve if the patient has already been started on therapy with Elzonris.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer – Estrogen Receptor Degraders for Breast Cancer	Veppanu	vepdegestrant tablets	Hormone receptor positive (HR+), human epidermal growth factor receptor 2 (HER2)-negative, estrogen receptor 1 gene (ESR1)-mutated breast cancer in a patient ≥ 18 years of age. **1.** Approve if, according to the prescriber, the patient is unable to use BOTH of Inluriyo or Orserdu (or one if one is formulary). If both Inluriyo and Orserdu are non-formulary, approve. **2.** If the patient has dyslipidemia or, according to the prescriber, has a high risk for dyslipidemia, approve if, according to the prescriber, the patient is unable to use Inluriyo. If Inluriyo is non-formulary, approve. **3.** Approve if the patient has already been started on therapy with Veppanu.	1 year
Cancer – Hypoxia-inducible factor inhibitor	Welireg	belzutifan tablets	See standard *Oncology (Oral) – Welireg Prior Authorization Policy* criteria.	See PA duration
Cancer – Multiple Myeloma – Bispecific CD3 T-Cell Engagers	Talvey	talquetamab-tgvs subcutaneous injection	See standard *Oncology (Injectable – Bispecific – GPRC5D-Directed) – Talvey Prior Authorization Policy* criteria.	See PA duration
Cancer – Multiple Myeloma – Bispecific CD3 T-Cell Engagers	Tecvayli	teclistamab-cqyv subcutaneous injection	See standard *Oncology (Injectable – Bispecific – BCMA-Directed) – Tecvayli Prior Authorization Policy* criteria.	See PA duration
Cancer – Multiple Myeloma – Bispecific CD3 T-Cell Engagers	Elrexfio	elranatamab-bcmm subcutaneous injection	Multiple myeloma. **1.** Approve if the patient has tried Tecvayli. If Tecvayli is non-formulary, approve. **2.** Approve if the patient has tried Talvey. If Talvey is non-formulary, approve. Note: If the patient has already tried Lynozyfic, approve. **3.** Approve if the patient has already been started on therapy with Elrexfio..	1 year
Cancer – Multiple Myeloma – Bispecific CD3 T-Cell Engagers	Lynozyfic	linvoseltamab-gcpt intravenous infusion	Multiple myeloma. **1.** Approve if the patient has tried Tecvayli. If Tecvayli is non-formulary, approve. **2.** Approve if the patient has tried Talvey. If Talvey is non-formulary, approve. Note: If the patient has already tried Elrexfio, approve. **3.** Approve if the patient has already been started on therapy with Lynozyfic.	1 year
Cancer – ROS1 Inhibitors	Ibtrozi	taletrectinib capsules	ROS1-positive non-small cell lung cancer. **1.** Approve if the patient has tried one of Augtyro or Rozlytrek. If neither are formulary, approve. **2.** If Ibtrozi has not been tried previously, approve if the patient has symptomatic systemic progression (multiple lesions) on Rozlytrek (entrectinib capsules and pellet packet), Xalkori (crizotinib capsules), or Augtyro (repotrectinib capsules), approve. **3.** If the patient has a ROS1 G2032R resistance mutation, approve if the patient has tried Augtyro. If Augtyro is non-formulary, approve. **4.** If the patient has congestive heart failure, approve if the patient has tried Augtyro. If Augtyro is non-formulary, approve. **5.** Approve if, according to the prescriber, the patient is at risk for central nervous system adverse events such as dizziness, ataxia, cognitive impairment, mood disorders, and sleep disorders. **6.** Approve if the patient has already been started on therapy with Ibtrozi.	1 year
Cancer – Selective Estrogen Receptor Degraders for Breast Cancer (Oral)	Orserdu	elacestrant tablets	Hormone receptor positive (HR+), human epidermal growth factor receptor 2 (HER2)-negative, estrogen receptor 1 gene (ESR1)-mutated breast cancer in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Inluriyo. If Inluriyo is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Orserdu.	1 year
Cancer – Selective Estrogen Receptor Degraders for Breast Cancer (Oral)	Inluriyo	imlunestrant tablets	Hormone receptor positive (HR+), human epidermal growth factor receptor 2 (HER2)-negative, estrogen receptor 1 gene (ESR1)-mutated breast cancer in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Orserdu. If Orserdu is non-formulary, approve. **2.** Approve if the patient is a premenopausal woman* OR peri-menopausal woman*. Note: In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a woman is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression. **3.** Approve if the patient has NOT previously tried a cyclin-dependent kinase (CDK) 4/6 inhibitor. **4.** Approve if the patient will be using Inluriyo in combination with Verzenio. **5.** Approve if the patient has dyslipidemia or, according to the prescriber, has a high risk for dyslipidemia. **6.** Approve if the patient has already been started on therapy with Inluriyo. **7.** Hormone receptor positive (HR+), human epidermal growth factor receptor 2 (HER2)-negative (WITH NO estrogen receptor 1 gene (ESR1)-mutated) breast cancer in combination with Verzenio in a patient ≥ 18 years of age: Approve.	1 year
Cancer - Trabectedin Intravenous Products	Evdi	trabectedin intravenous infusion	Approve if the patient has tried and cannot take Yondelis. If Yondelis is non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer - Trabectedin Intravenous Products	Yondelis	trabectedin intravenous infusion	Approve if the patient has tried and cannot take Evdi. If Evdi is non-formulary, approve.	1 year
Cancer (Injectable)	Kadcyla	ado-trastuzumab emtansine intravenous infusion	See standard *Oncology (Injectable – Antibody-Drug Conjugate – HER2) – Kadcyla Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Blincyto	blinatumomab intravenous infusion	See standard *Oncology (Injectable) – Blincyto Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Poteligeo	mogamulizumab-kpkc injection for	See standard *Oncology (Injectable) – Poteligeo Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Aliqopa	copanlisib intravenous infusion	Follicular Lymphoma; Marginal Zone Lymphoma: approve if the patient has already been started on Aliqopa therapy.	1 year
Cancer (Injectable)	Vyloy	zolbetuximab-clzb intravenous infusion	See standard *Oncology (Injectable) – Vyloy Prior Authorization Policy* criteria.	See PA duration
Cancer (Injectable)	Gazyva	obinutuzumab intravenous infusion	See standard *Oncology (Injectable) – Gazyva Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Vyxeos	daunorubicin and cytarabine liposome for intravenous injection	See standard *Oncology (Injectable) – Vyxeos Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Unituxin	dinutuximab injection, for intravenous use	See standard *Oncology (Injectable) – Unituxin Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Yervoy	ipilimumab injection	See standard *Oncology (Injectable – CTLA-4 Antibody) – Yervoy Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Onivyde	irinotecan liposome injection	See standard *Oncology (Injectable – Topoisomerase Inhibitor) – Onivyde Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Halaven	eribulin mesylate injection for intravenous use	See standard *Oncology (Injectable – Microtubule Inhibitor) – Halaven Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Adcetris	brentuximab intravenous infusion	See standard *Oncology (Injectable) – Adcetris Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Kyprolis	carfilzomib injection	See standard *Oncology (Injectable – Proteasome Inhibitor) – Kyprolis Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Cyramza	ramucirumab intravenous infusion	See standard *Oncology (Injectable) – Cyramza Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Besponsa	inotuzumab ozogamicin injection	See standard *Oncology (Injectable) – Besponsa Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Mylotarg	gemtuzumab ozogamicin for injection for intravenous use	See standard *Oncology (Injectable) – Mylotarg Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable)	Azedra	iobenguane I 131 intravenous infusion	See standard *Oncology (Injectable) – Azedra Prior Authorization Policy* criteria	See PA duration

Data Class: Confidential

Formulary Exception Criteria

EXPRESS SCRIPTS®

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer (Injectable)	Perjeta	pertuzumab intravenous infusion	See standard *Oncology (Injectable – HER2 Antagonist) – Perjeta Prior Authorization Policy* criteria.	See PA duration
Cancer (Injectable) – Bortezomib Agents	Bortezomib (Hospira)	bortezomib injection 1 mg, 2.5 mg vials	Approve if the patient has tried one of bortezomib injection (Velcade, generics) or Boruzu, if formulary. If neither are formulary, approve.	1 year
Cancer (Injectable) – Bortezomib Agents	Bortezomib for injection	bortezomib for injection 3.5 mg vial	Approve if the patient has tried one of bortezomib injection (Velcade, generics) or Boruzu, if formulary. If neither are formulary, approve.	1 year
Cancer (Injectable) – Bortezomib Agents	Bortezomib injection (MAIA Pharmaceuticals/Fosun)	bortezomib injection	Approve if the patient has tried one of bortezomib injection (Velcade, generics) or Beoruzu, if formulary. If neither are formulary, approve.	1 year
Cancer (Injectable) – Bortezomib Agents	Boruzu	bortezomib injection	Approve if the patient has tried bortezomib injection (Velcade, generics) if formulary. If bortezomib injection (Velcade, generics) are non-formulary, approve.	1 year
Cancer (Injectable) – CAR-T Therapy	Aucatzyl	obecabtagene autoleucel intravenous infusion	Patient meets *Oncology (Injectable – CAR-T) – Aucatzyl Prior Authorization Policy* AND ONE of the following: **1.** Approve if the patient is unable to use Tecartus. **2.** Approve if Tecartus is non-formulary. **3.** Approve if Tecartus is not available at the treatment facility or treatment center in which the patient is enrolled to receive therapy. **4.** Approve if the patient has already been started on therapy with Aucatzyl and has received part of the inital dose.	See PA duration
Cancer (Injectable) – CAR-T Therapy	Kymriah	tisagenlecleucel suspension for intravenous infusion	See standard *Oncology (Injectable – CAR-T) – Kymriah Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable) – CAR-T Therapy	Yescarta	axicabtagene ciloleucel suspension for intravenous infusion	See standard *Oncology (Injectable – CAR-T) – Yescarta Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable) – Leucovorin Agents	Vykoura	leucovorin calcium injection (intramuscular or intravenous)	Approve if the patient has tried and cannot take generic leucovorin for injection. If generic leucovorin for injection is non-formulary, approve.	1 year
Cancer (Injectable) - Metastatic Colorectal Cancer (Epidermal Growth Factor Receptor Antagonists)	Erbitux	cetuximab intravenous infusion	**1**. Colon Cancer; Rectal Cancer. Approve if the patient meets one of the following (A or B): A. Patient has tried Vectibix. If Vectibix is non-formulary, approve; OR B. Patient has already been started on therapy with Erbiutx OR has already been started on therapy with Krazati or Braftovi. **2**. Appendiceal Adenocarcinoma. Approve if the patient meets one of the following (A or B): A. Patient has tried Vectibix. If Vectibix is non-formulary, approve; OR B. Patient has already been started on therapy with Erbiutx. **3**. Head and Neck Cancer; Non-Small Cell Lung Cancer; Penile Cancer - recurrent or metastatic; Cutaneous Squamous Cell Cancer: Approve.	1 year
Cancer (Injectable) - Metastatic Colorectal Cancer (Epidermal Growth Factor Receptor Antagonists)	Vectibix	panitumumab intravenous infusion	**1.** Colon Cancer; Rectal Cancer. Approve if the patient meets one of the following (A, B, or C): A. Patient has tried Erbitux. If Erbitux is non-formulary, approve; OR B. Patient meets ONE of the following (i or ii): i. According to the prescriber, the patient lives in an area with high endemic rates of alpha-gal; OR ii. Patient has known alpha-gal positivity; OR C. Patient has already been started on therapy with Vectibix OR has already been started on therapy with Lumakras. **2.** Appendiceal Adenocarcinoma. Approve if the patient meets one of the following (A, B, or C): A. Patient has tried Erbitux. If Erbitux is non-formulary, approve; OR B. Patient meets ONE of the following (i or ii): i. According to the prescriber, the patient lives in an area with high endemic rates of alpha-gal; OR ii. Patient has known alpha-gal positivity; OR C. Patient has already been started on therapy with Vectibix.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer (Injectable) - Pemetrexed Agents	Pemetrexed intravenous infusion (Brand Agents)	pemetrexed disodium injection	**1.** Approve if the patient has tried one other pemetrexed injectable product. **2.** If generic pemetrexed injectable is not available or formulary, approve.	1 year
Cancer (Injectable) - Pemetrexed Agents	Pemfexy	pemetrexed injection	**1.** Approve if the patient has tried one other pemetrexed injectable product. **2.** If generic pemetrexed injectable is not available or formulary, approve.	1 year
Cancer (Injectable) - Pemetrexed Agents	Axtle	pemetrexed intravenous infusion	**1.** Approve if the patient has tried one other pemetrexed injectable product. **2.** If generic pemetrexed injectable is not available or formulary, approve.	1 year
Cancer (Injectable) - Pemetrexed Agents	Pemrydi RTU	pemetrexed intravenous infusion	**1.** Approve if the patient has tried one other pemetrexed injectable product. **2.** If generic pemetrexed injectable is not available or formulary, approve.	1 year
Cancer (Injectable) – Programmed Death Ligand -1 Blocking Antibody	Unloxcyt	cosibelimab-ipdl intravenous infusion	Cutaneous Squamous Cell Carcinoma in a patient ≥ 18 years of age. **1.** Approve if the patient has tried or is unable to use one of Keytruda or Libtayo. If neither are formulary, approve. **2.** Approve if the patient has already started on therapy with Unloxcyt. Colon and rectal cancer; small bowel adenocarcinoma: Approve if patient is ≥ 18 years of age.	1 year
Cancer (Injectable) – Programmed Death Receptor	Keytruda Qlex	pembrolizumab and berahyaluronidase alpha-pmph subcutaneous injection	**1**. Approve if the patient has tried Keytruda intravenous (IV). If Keytruda IV is non-formulary, approve. **2**. Approve if the patient is unable to obtain IV access.	1 year
Cancer (Injectable) – Programmed Death Receptor	Tevimbra	tislelizumab-jsgr intravenous infusion	Esophageal and Esophagogastric Junction Cancer in a patient ≥ 18 years of age. **1**. Approve if the patient is unable to tolerate one of Keytruda or Opdivo. If neither are formulary, approve. **2.** Patient with a Combined Positive Score (CPS) of less than 10%, approve if the patient is unable to tolerate Opdivo. If Opdivo is non-formulary, approve. **3**. Approve if the patient has already been started on therapy with Tevimbra. Gastric or Gastroesophageal Junction Adenocarcinoma – unresectable, locally advanced, recurrent or metastatic human epidermal growth factor receptor 2 (HER2)-negative disease with tumor expression for PD-L1 with a combined positive score (CPS) ≥ 1% in a patient ≥ 18 years of age: approve. Anal Carcinoma; Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma; Classic Hodgkin Lymphoma; Colon, Rectal, or Appendiceal Cancer; Endometrial Carcinoma; Hepatocellular Carcinoma; Nasopharyngeal Carcinoma; Small Bowel Adenocarcinoma: approve if patient is ≥ 18 years of age.	1 year
Cancer (Injectable) – Programmed Death Receptor	Tecentriq IV	atezolizumab injection for intravenous use	**1.** Approve if the patient has tried Tecentriq Hybreza. If Tecentriq Hybreza is non-formulary, approve. **2.** Approve if the patient has alveolar soft part sarcoma and is < 12 years of age or < 40 kg	1 year
Cancer (Injectable) – Programmed Death Receptor	Keytruda intravenous	pembrolizumab injection for intravenous use	**1.** Approve if the patient has tried Keytruda Qlex. If Keytruda Qlex is non-formulary, approve. **2.** Approve for an FDA-approved indication (that is not shared by Keytruda Qlex): Classic Hodgkin Lymphoma; Primary Mediastinal Large B-Cell Lymphoma; Colon, Rectal, or Appendiceal Cancer. **3.** Approve for one of the requested indications (that is not shared by Keytruda Qlex): Adrenal Gland Tumor; Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma; Extranodal NK/T-Cell Lymphoma, Nasal Type; Kaposi	1 year
Cancer (Injectable) – Programmed Death Receptor	Tecentriq Hybreza	atezolizumab and hyaluronidase-tqjs subcutaneous injection	**1.** Approve if the patient has tried Tecentriq intravenous (IV). If Tecentriq IV is non-formulary, approve. **2.** Approve if the patient is unable to obtain IV access.	1 year
Cancer (Injectable) – Programmed Death Receptor	Zynyz	retifanlimab-dlwr intravenous infusion	See standard *Oncology (Injectable – Programmed Death Receptor-1) – Zynyz Prior Authorization Policy* criteria.	See PA duration
Cancer (Injectable) – Programmed Death Receptor	Imfinzi	durvalumab intravenous infusion	See standard *Oncology (Injectable – Programmed Death-Ligand 1) – Imfinzi Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable) – Programmed Death Receptor	Loqtorzi	toripalimab intravenous infusion	See standard *Oncology (Injectable – Programmed Death Receptor-1) - Loqtorzi Prior Authorization Policy* criteria.	See PA duration
Cancer (Injectable) – Programmed Death Receptor	Bavencio	avelumab intravenous infusion	See standard *Oncology (Injectable – Programmed Death-Ligand 1) – Bavencio Prior Authorization Policy* criteria	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer (Injectable) – Programmed Death Receptor	Libtayo	cemiplimab-rwlc intravenous infusion	See standard *Oncology (Injectable – Programmed Death Receptor-1) – Libtayo Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable) – Programmed Death Receptor – Nivolumab Agents	Opdivo Qvantig	nivolumab and hyaluronidase-nvhy subcutaneous injection	**1.** Approve if the patient has tried Opdivo intravenous (IV). If Opdivo IV is non-formulary, approve. **2.** Approve if the patient is unable to obtain IV access.	1 year
Cancer (Injectable) – Programmed Death Receptor – Nivolumab Agents	Opdivo intravenous	nivolumab injection for IV use	**1**. Approve if the patient has tried Opdivo Qvantig. If Opdivo Qvantig is non-formulary, approve. **2**. Approve if the patient is using or will be using Opdivo intravenous in combination with Yervoy (ipilimumab intravenous infusion). **3**. Approve for an FDA-approved indication (that is not shared by Opdivo Qvantig): Classic Hodgkin lymphoma; Colon, Rectal, or Appendiceal cancer in patients ≥ 12 and < 18 years of age; Melanoma in patients ≥ 12 and < 18 years of age; Mesothelioma; Pediatric Hodgkin lymphoma. **4**. Approve for one of the requested indications (that is not shared by Opdivo Qvantig): Pediatric Diffuse High-Grade Gliomas; Extranodal NK/T-Cell lymphomas; Pancreatic cancer; Primary Mediastinal large B-Cell Lymphoma.	1 year
Cancer (Injectable) - Bispecific Delta-like Ligand 3 (DLL3)-directed CD3 T-cell Engager	Imdelltra	tarlatamab-dlle intravenous infusion	See standard *Oncology (Injectable) – Imdelltra Prior Authorization Policy* criteria.	See PA duration
Cancer (Injectable) CAR-T Therapy	Abecma	idecabtagene vicleucel injection	See standard *Oncology (Injectable – CAR-T) – Abecma Prior Authorization Policy* criteria	See PA duration
Cancer (Injectable) CAR-T Therapy	Carvykti	ciltacabtagene autoleucel intravenous infusion	See standard *Oncology (Injectable – CAR-T) – Carvykti Prior Authorization Policy* criteria.	See PA duration
Cancer (Injectable) - Tumor-Derived Autologous T-Cell Immunotherapy	Amtagvi	lifileucel intravenous infusion	See standard *Oncology (Injectable) – Amtagvi Prior Authorization Policy* criteria	See PA duration
Cancer (Intravesical)	Inlexzo	gemicitabine intravesical system	Bacillus Calmette-Guerin (BCG)-unresponsive non-muscle invasive bladder cancer. **1.** Approve if the patient has tried or is unable to take BOTH of Anktiva and Adstiladrin (or one if only one is formulary). If neither are formulary, approve. **2.** If the patient requires a product not given with Bacillus Calmette-Guerin (BCG), approve if the patient has tried or is unable to take Adstiladrin. If Adstiladrin is non-formulary, approve. **3.** Approve if the patient has already been started on therapy with Inlexzo.	1 year
Cancer (Intravesical)	Adstiladrin	nadofaragene firadenovec-vncg suspension for intravesical use	Bacillus Calmette-Guerin (BCG)-unresponsive non-muscle invasive bladder cancer (NMIBC). **1.** Approve if the patient has tried or is unable to take BOTH of Anktiva and Inlexzo (or one if only one is formulary). If neither are formulary, approve. **2.** If the patient has Ta/T1 papillary tumors without carcinoma in situ AND tried or is unable to take Anktiva, approve. If Anktiva non-formulary, approve. **3.** If the patient requires a product not given with Bacillus Calmette-Guerin (BCG), approve if the patient has tried or is unable to take Inlexzo. If Inlexzo is non-formulary, approve. **4.** Approve if the patient has already been started on therapy with Adstiladrin.	1 year
Cancer (Intravesical)	Anktiva	nogapendekin alfa inbakicept-pmln intravesical solution	Bacillus Calmette-Guerin (BCG)-unresponsive non-muscle invasive bladder cancer. **1.** Approve if the patient has tried or is unable to take BOTH of Adstiladrin and Inlexzo (or one if only one is formulary). If neither are formulary, approve. 2. If the patient has Ta/T1 papillary tumors without carcinoma in situ AND tried or is unable to take Adstiladrin, approve. If Adstiladrin is non-formulary, approve. 3. Approve if the patient has already been started on therapy with Anktiva.	1 year
Cancer (Oral) – FMS-Like Tyrosine Kinase 3 Inhibitors for AML	Vanflyta	quizartinib tablets	FLT3-ITD Mutation-positive Acute Myeloid Leukemia. **1.** Approve if the patient has tried Rydapt **[documentation required]**. If Rydapt is non-formulary, approve. **2.** If, according to the prescriber, the patient has or is at risk for pulmonary toxicity, approve. **3.** Approve if the patient has already been started on Vanflyta therapy. Myeloid/Lymphoid Neoplasms: Approve.	1 year
Cancer (Oral) – FMS-Like Tyrosine Kinase 3 Inhibitors for AML	Xospata	gilteritinib tablets	See standard *Oncology (Oral – FMS-Like Tyrosine Kinase 3 Inhibitor) – Xospata Prior Authorization Policy* criteria.	See PA duration
Cancer (Oral) – FMS-Like Tyrosine Kinase 3 Inhibitors for AML	Rydapt	midostaurin capsules	See standard *Oncology (Oral – FMS-Like Tyrosine Kinase 3 Inhibitor) – Rydapt Prior Authorization criteria.*	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer (Oral) – Histone Deacetylase Inhibitor	Zolinza	vorinostat capsules	See standard *Oncology (Oral – Histone Deacetylase Inhibitor) – Zolinza Prior Authorization Policy* criteria	See PA duration
Cancer (Oral) – Isocitrate Dehydrogenase-1 Inhibitors	Rezlidhia	olutasidenib capsules	Acute myeloid leukemia with isocitrate dehydrogenase-1 (IDH1) mutation positive disease in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Tibsovo. If Tibsovo is non-formulary, approve. **2.** Approve if the patient has QTc prolongation OR is or will be taking medications that can prolong the QTc interval. **3.** Patients with Guillain-Barre, approve. **4.** Approve if the patient has already been started on Rezlidhia therapy.	1 year
Cancer (Oral) – Isocitrate Dehydrogenase-1 Inhibitors	Tibsovo	ivosidenib tablets	See standard *Oncology (Oral – Isocitrate Dehydrogenase 1 Inhibitor) – Tibsovo Prior Authorization Policy* criteria.	See PA duration
Cancer (Oral) - Isocitrate Dehydrogenase-2 (IDH2) Inhibitors	Idhifa	enasidenib tablets	See standard *Oncology – Idhifa Prior Authorization Policy* criteria	See PA duration
Cancer (Oral) - Kinase Inhibitor of Vascular Endothelial Growth Factor Receptor	Fruzaqla	fruquintinib capsules	Appendiceal, Colon, or Rectal Cancer in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Lonsurf. If Lonsurf is non-formulary, approve. **2.** According to the prescriber, the patient has or is at risk of myelosuppression, approve. **3.** Approve if the patient has already been started on therapy with Fruzaqla.	1 year
Cancer (Oral) – Kinase Inhibitors	Balversa	erdafitinib tablets	See standard *Oncology – Balversa Prior Authorization Policy* criteria	See PA duration
Cancer (Oral) – MEK Inhibitors	Mekinist oral solution	trametinib oral solution	Melanoma; Solid Tumors; Non-Small Cell Lung Cancer; Thyroid Carcinoma, Anaplastic; Glioma; Histiocytic Neoplasm; Ovarian, Fallopian Tube, or Primary Peritoneal Cancer; Hairy Cell Leukemia; Uveal Melanoma; Epithelioid Hemangioendothelioma. Note: Examples of solid tumors include: biliary tract cancer, brain metastases due to melanoma, differentiated thyroid carcinoma, gastrointestinal stromal tumors, gastric cancer, esophageal and esophagogastric junction cancers, salivary gland tumors, pancreatic adenocarcinoma, neuroendocrine tumors, occult primary, ampullary adenocarcinoma, small bowel adenocarcinoma. **1.** Approve if the patient has tried Mekinist tablets. If Mekinist tablets are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets. **3.** Approve if the patient's dose cannot be obtained with Mekinist tablets.	1 year
Cancer (Oral) – MEK Inhibitors	Mekinist	trametinib tablets	See standard *Oncology (Oral – MEK Inhibitor) – Mekinist Prior Authorization Policy* criteria. **tablets only**	See PA duration
Cancer (Oral) – Nucleoside Metabolic and Thymidine Phosphorylase Inhibitors	Lonsurf	trifluridine and tipiracil tablets	Appendiceal, Colon, or Rectal Cancer in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Fruzaqla. If Fruzaqla is non-formulary, approve. **2.** If Lonsurf is being given with bevacizumab, approve. **3.** Approve if the patient has already been started on therapy with Lonsurf. Gastric or Gastroesophageal Junction Adenocarcinoma: Approve.	1 year
Cancer (Oral) – Topoisomerase I Inhibitor	Hycamtin	topotecan capsules	See standard *Oncology (Injectable – Topoisomerase inhibitor) – Topotecan Products Prior Authorization Policy* criteria	See PA duration
Cancer (Oral) – Tryptophan Hydroxylase Inhibitor	Xermelo	telotristat ethyl tablets	See standard *Oncology (Oral) – Xermelo Prior Authorization Policy* criteria	See PA duration
Cancer (Oral) – Tyrosine Kinase Inhibitors	Stivarga	regorafenib tablets	See standard *Oncology – Stivarga Prior Authorization Policy* criteria	See PA duration
Cancer (Oral) – Tyrosine Kinase Inhibitors	Nerlynx	neratinib tablets	See standard *Oncology (Oral) – Nerlynx Prior Authorization Policy* criteria	See PA duration
Cancer (Topical)	Valchlor	mechlorethamine 0.016% gel	See standard *Oncology – Valchlor Prior Authorization Policy* criteria	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agent – (Injectable) - MAGE-A4 Directed Genetically Modified Autologous T-Cell Immunotherapy	Tecelra	afamitresgene autoleucel intravenous infusion	See standard *Oncology (Injectable – T-Cell Immunotherapy – MAGE-A4) – Tecelra Prior Authorization Policy* criteria.	See PA duration
Cancer Agent - Bispecific EGFR-directed and MET Receptor-Directed Antibody	Rybrevant intravenous	amivantamab-vmjw injection for intravenous infusion	Approve if the patient has tried Rybrevant Faspro. If Rybrevant Faspro is non-formulary, approve.	1 year
Cancer Agent - Bispecific EGFR-directed and MET Receptor-Directed Antibody	Rybrevant Faspro	amivantamab and hyaluronidase-lpuj subcutaneous injection	See standard *Oncology (Injectable – EGFR- and MET-Directed Antibody) – Rybrevant Faspro Prior Authorization Policy* criteria.	See PA duration
Cancer Agent – Multiple Myeloma Nuclear Export Inhibitor	Xpovio	selinexor tablets	Multiple Myeloma. Approve if the patient meets ONE of the following (A or B): A. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried at least FOUR prior regimens for multiple myeloma; OR ii. Patient meets both of the following (a and b): a) Patient has tried at least TWO prior regimens for multiple myeloma; AND b) The medication will be taken in combination with pomalidomide (Pomalyst, generics); OR iii. Patient meets both of the following (a and b): a) Patient has tried at least ONE prior regimen for multiple myeloma; AND b) The medication will be taken in combination with bortezomib, Darzalex (daratumumb infusion), Darzlaex Faspro (daratumumab and hyaluronidase-fihj injection), or Kyprolis (carfilzomib intravenous infusion); OR Note: Examples of prior regimens include Darzalex (daratumumab intravenous infusion)/bortezomib/lenalidomide/dexamethasone, bortezomib/lenalidomide/dexamethasone, Kyprolis (carfilzomib intravenous infusion)/lenalidomide/dexamethasone, Darzalex (daratumumab intravenous infusion)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody. B. Patient has already been started on therapy with Xpovio. Diffuse Large B-Cell Lymphoma; High-grade B-Cell Lymphoma; HIV-related B-Cell Lymphoma; Post-transplant lymphoproliferative disorders. Note: Diffuse Large B-Cell Lymphoma includes patients with histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma. Approve if the patient meets ONE of the following (A or B): A. Patient has tried at least TWO prior therapies; OR B. Patient has already been started on therapy with Xpovio.	1 year
Cancer Agent (Intravenous)	Bizengri	zenocutuzumab-zbco intravenous infusion	See standard *Oncology (Injectable) – Bizengri Prior Authorization Policy* criteria.	See PA duration
Cancer Agent (Intravenous) - Bispecific Human Epidermal Growth Factor Receptor 2 (HER2)-Directed Antibody	Ziihera	zanidatamab-hrii intravenous infusion	See standard *Oncology (Injectable) – Ziihera Prior Authorization Policy* criteria.	See PA duration
Cancer Agent (intravenous) for Cutaneous T-cell Lymphoma	Lymphir	denileukin diftitox-cxdl intravenous infusion	Cutaneous T-Cell Lymphoma. **1.** Approve if the patient has tried at least one prior systemic therapy. Note: Examples of systemic therapies include oral retinoids (acitretin, bexarotene, isotretinoin), histone deacetylase inhibitors (Zolinza, romidepsin), interferons, Poteligio, Adectris, systemic chemotherapies. **2.** Approve if the patient has already been started on therapy with Lymphir.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agent (Oral)	Vitrakvi	larotrectinib capsules and oral solution	Neurotrophic tyrosine receptor kinase (NTRK) fusion-positive solid tumors. Approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, or 7): **1.** Patient has tried BOTH of Augtyro and Rozlytrek (or one if one is formulary). If neither are formulary, approve: OR **2.** If patient has recurrent or progressive glioma or glioblastoma, approve if the patient has tried Rozlytrek. If Rozlytrek is non-formulary, approve. a. If patient has congestive heart failure or, according to the prescriber, the patient has a risk of QT prolongation, approve; OR **3.** If Rozlytrek is non-formulary, approve if the patient has a NTRK gene fusion tumor that, according to the prescriber, Augtyro treatment is not addressed in clinical guidelines; OR **4.** Patient is < 12 years of age OR the patient is unable to or has difficulty swallowing a solid oral dosage form, patient has tried Rozlytrek. If Rozlytrek is non-formulary, approve; OR a. If patient has congestive heart failure or, according to the prescriber, the patient has a risk of QT prolongation, approve. **5.** Patient has congestive heart failure or, according to the prescriber, the patient has a risk of QT prolongation, patient has tried Augtyro. If Augtyro is non-formulary, approve; OR a. If the patient has a NTRK gene fusion tumor that, according to the prescriber, Augtyro treatment is not addressed in clinical guidelines, approve. **6.** Patient has or is at risk of interstitial lung disease; patient has tried Rozlytrek. If Rozlytrek is non-formulary, approve; OR **7.** Patient has already been started on therapy with Vitrakvi. Pediatric (patient is ≤ 21 years of age) Neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive, diffuse high-grade gliomas: Approve.	1 year
Cancer Agent (Oral)	Zusduri	mitomycin intravesical solution	See standard *Oncology (Intravesical) – Zusduri Prior Authorization Policy* criteria.	See PA duration
Cancer Agent (Oral)	Targretin capsule	bexarotene capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agent (Oral) - Kinase Inhibitor	Lazcluze	lazertinib tablets	See standard *Oncology (Oral – Epidermal Growth Factor Receptor Inhibitor) – Lazcluze Prior Authorization Policy* criteria.	See PA duration
Cancer Agent (Oral) - Protease Activator	Modeyso	dordaviprone capsules	See standard *Oncology (Oral) – Modeyso Prior Authorization Policy* criteria.	See PA duration
Cancer Agent (Oral) - Glucocorticoid Receptor Antagonist	Lifyorli	relacorilant capsules	See standard *Oncology (Oral) – Lifyorli Prior Authorization Policy* criteria.	See PA duration
Cancer Agent (Oral) –Neuroblastoma - Ornithine Decarboxylase Inhibitor	Iwilfin	eflornithine tablets	See standard *Oncology – Iwilfin Prior Authorization Policy* criteria.	See PA duration
Cancer Agent (oral), Kinase Inhibitor, for, is indicated for (NSCLC)	Hyrnuo	sevabertinib tablets	Non-Small Cell Lung Cancer in a patient ≥ 18 years of age whose tumor has human epidermal growth factor receptor 2 (HER2) [ERBB2] activating mutation. **1.** Approve if the patient has tried Hernexeos. If Hernexeos is non-formulary, approve. **2.** Approve if the patient has a cardiovascular risk or ventricular dysfunction. **3.** Approve if the patient has already been started on therapy with Hyrnuo.	1 year
Cancer Agent (oral), Kinase Inhibitor, for, is indicated for (NSCLC)	Hernexeos	zongertinib tablets	See standard *Oncology (Oral – HER2 Inhibitor) – Hernexeos Prior Authorization Policy* criteria.	See PA duration
Cancer Agent Injectable – Antibody-Drug Conjugate – c-Met	Emrelis	telisotuzumab vedotin-tllv intravenous infusion	See standard *Oncology (Injectable – Antibody-Drug Conjugate – c-Met) – Emrelis Prior Authorization Policy* criteria.	See PA duration
Cancer Agent - Tenosynovial Giant Cell Tumor (TGCT)	Romvimza	vimseltinib capsules	See standard *Oncology – Romvimza Prior Authorization Policy* criteria.	See PA duration
Cancer Agent - Tenosynovial Giant Cell Tumor (TGCT)	Turalio	pexidartinib capsules	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis). **1.** Approve if the patient has tried Romvimza. If Romvimza is non-formulary, approve. **2.** Approve if the patient has allergic reactions or sensitivities to FD&C yellow No. 5 (tartrazine) or No 6 (sunset yellow FCF). **3.** Approve if the patient has already been started on therapy with Turalio. Histiocytic Neoplasms. Approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents – Diffuse Large B-cell Lymphoma Agents	Zynlonta	loncastuximab tersirine-lpyl intravenous infusion	B-Cell Lymphomas. Note: This includes classic follicular lymphoma, diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from low grade lymphoma, and high-grade B-cell lymphoma. **1.** Approve if the patient has tried at least two systemic regimens. Note: Examples of systemic therapies containing one or more of the following products include gemcitabine, oxaliplatin, rituximab, Polivy (polatuzumab vedotin intravenous infusion), bendamustine, Monjuvi (tafasitamab-cxix intravenous infusion), or Revlimid (lenalidomide capsules). Autologous stem cell transplant and chimeric antigen receptor (CAR) T-cell therapy also count as a systemic regimen. **2.** Approve if the patient has already been started on Zynlonta. Human Immunodeficiency Virus-Related B-Cell Lymphoma. Note: This includes human immunodeficiency virus-related diffuse large B-cell lymphoma (DLBCL), primary effusion lymphoma, and human herpes virus 8 (HHV8)-positive DLBCL not otherwise specified. Approve. Post-Transplant Lymphoproliferative Disorders, approve.	1 year
Cancer Agents – Diffuse Large B-cell Lymphoma Agents	Polivy	polatuzumab vedoten-piiq injection for intravenous use	See standard *Oncology (Injectable) – Polivy Prior Authorization Policy* criteria.	See PA duration
Cancer Agents – Diffuse Large B-cell Lymphoma Agents	Monjuvi	tafasitamab-cxix for intravenous injection	Diffuse Large B-Cell Lymphoma. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (a and b): a. Patient has tried at least one regimen for diffuse large B-cell lymphoma;AND Note: Examples include rituximab + cyclophosphamide + doxorubicin, vincristine (RCHOP); GemOx (gemcitabine + oxaliplatin) ± rituximab; Polivy. b. Medication will be used in combination with lenalidomide; OR **2**. Patient has already been started on therapy with Monjuvi. B-Cell Lymphoma. Note: Examples include high-grade B-cell lymphoma, HIV-related B-cell lymphoma, post-transplant lymphoproliferative disorders, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (a and b): a. Patient has tried at least one regimen for B-cell lymphoma; AND Note: Examples include: CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) plus rituximab or Gazyva (obinutuzumab intravenous infusion), CVP (cyclophosphamide, vincristine, prednisone) plus rituximab or Gazyva, or lenalidomide plus rituximab. b. Medication will be used in combination with lenalidomide; OR **2.** Patient has already been started on therapy with Monjuvi. Follicular Lymphoma. Approve if the patient meets one of the following (1 or 2): **1**. Patient meets BOTH of the following (a and b): a. Patient has tried at least one systemic regimen for follicular lymphoma AND b. Medication will be used in combination with lenalidomide and rituximab; OR **2**. Patient has already been started on therapy with Monjuvi.	1 year
Cancer Agents - (Injectable)	Elahere	mirvetuximab soravtansine-gynx intravenous infusion	See standard *Oncology (Injectable) – Elahere Prior Authorization Policy* criteria.	See PA duration
Cancer Agents – (Injectable) - Docetaxel intravenous infusion	Beizray	docetaxel intravenous infusion	**1.** Approve if the patient has tried generic docetaxel. If generic docetaxel is non-formulary, approve. **2.** Approve in a patient with hypersensitivities to polysorbate 80.	1 year
Cancer Agents – (Injectable) - Docetaxel intravenous infusion	Docivyx	docetaxel intravenous infusion	**1.** Approve if the patient has tried generic docetaxel. If generic docetaxel is non-formulary, approve. **2.** Approve in patients with hypersensitivities to polysorbate 80.	1 year
Cancer Agents - Acute myeloid leukemia (AML) Agents	Onureg	azacitadine tablets	Acute Myeloid Leukemia: Approve if the patient meets ONE of the following (1 OR 2): 1. Patient is ≥ 18 years of age and using the medication for post-remission maintenance; OR 2. The patient has been started on therapy with Onureg. Peripheral T-Cell Lymphoma: Approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Acute myeloid leukemia (AML) Agents	Daurismo	glasdegib tablets	Acute Myeloid Leukemia (AML). **1.** Approve if the patient has tried one other regimen for AML (e.g., 5-azacytidine, decitabine, cytarabine, Venclexta) OR the patient is using Daurismo concomitantly with at least one other agent. **2.** Approve if the patient has already been started on Daurismo.	1 year
Cancer Agents - ALK Positive NSCLC (Oral)	Ensacove	ensartinib capsules	Non-Small Cell Lung Cancer – anaplastic lymphoma kinase (ALK)-positive. **1.** Approve if the patient has tried or is unable to take one of Alecensa or Alunbrig. If neither are formulary, approve. Note: A trial of Lorbrena would also meet an approval. **2.** Approve if the patient has already been started on therapy with Ensacove.	1 year
Cancer Agents - ALK Positive NSCLC (Oral)	Zykadia	ceritinib capsules and tablets	**1.** Non-Small Cell Lung Cancer – anaplastic lymphoma kinase (*ALK*)-positive. Approve if the patient meets one of the following criteria (A or B): **A.** Patient has tried one of Alecensa or Alunbrig. If neither are formulary, approve; OR **B.** Patient has already been started on therapy with Zykadia. **2.** Inflammatory Myofibroblastic Tumor with anaplastic lymphoma kinase (*ALK*) translocation: Approve if the patient meets one of the following criteria (A or B): **A.** Patient has advanced, recurrent, or metastatic disease; OR **B.** The tumor is inoperable. **3.** Erdheim-Chester Disease – anaplastic lymphoma kinase (*ALK*) rearrangement/fusion-positive: Approve. **4.** Anaplastic Large Cell Lymphoma (ALCL) - anaplastic lymphoma kinase (*ALK*)-positive: Approve.	1 year
Cancer Agents - ALK Positive NSCLC (Oral)	Xalkori capsules	crizotinib capsules	**1.** Non-Small Cell Lung Cancer – anaplastic lymphoma kinase (*ALK*)-positive. Approve if the patient meets one of the following (A or B): **A.** Patient has tried one of Alecensa or Alunbrig. If neither are formulary, approve; OR **B.** Patient has already been started on therapy with Xalkori. **2.** Non-Small Cell Lung Cancer with ROS1 rearrangement-positive: Approve if the patient meets one of the following (A or B): A. Patient has tried one of Augtyro, Ibtrozi, or Rozlytrek. If none are formulary, approve; OR B. Patient has already been started on therapy with Xalkori. **3.** Non-Small Cell Lung Cancer with high level *MET* amplification or *MET* Exon 14 skipping mutation: Approve if the patient meets one of the following (A or B): **A.** Patient has tried one of Tabrecta or Tepmetko. If neither is formulary, approve; OR **B.** Patient has already been started on therapy with Xalkori. **4.** Inflammatory Myofibroblastic Tumor with anaplastic lymphoma kinase (ALK)-positive disease: Approve if the patient meets one of the following criteria (A or B): **A.** Patient has advanced, recurrent, or metastatic disease; OR **B.** The tumor is inoperable. **5.** Anaplastic Large Cell Lymphoma – anaplastic lymphoma kinase (*ALK*)-positive : Approve if the patient meets one of the following criteria (A or B): **A.** The medication is used for palliative-intent therapy; OR **B.** Patient has relapsed or refractory disease. **6.** Histiocytic Neoplasm – anaplastic lymphoma kinase (*ALK*) rearrangement/fusion-positive: Approve if the patient meets one of the following (A, B, or C): **A.** Patient has Erdheim-Chester disease; OR **B.** Patient has Langerhans Cell Histiocytosis; OR **C.** Patient has Rosai-Dorfman Disease. **7.** Melanoma, cutaneous. Approve if the patient meets one of the following criteria (A or B): **A.** Patient has anaplastic lymphoma kinase (ALK)-fusion disease; OR **B.** Patient has ROS1 fusion disease.	1 year
Cancer Agents - ALK Positive NSCLC (Oral)	Lorbrena	lorlatinib tablets	**1.** Non-Small Cell Lung Cancer – anaplastic lymphoma kinase (*ALK*)-positive: Approve if the patient meets one of the following (A, B, or C). **A.** Patient has tried one of Alecensa or Alunbrig. If neither are formulary, approve; OR **B.** Patient had disease progression on at least one other *ALK* inhibitor; OR Note: Examples of other ALK inhibitors are Alecensa, Alunbrig, Ensacove, Xalkori, and Zykadia. **C.** Patient has already been started on therapy with Lorbrena. **2.** Non-Small Cell Lung Cancer with *ROS1* rearrangement-positive disease: Approve if the patient meets one of the following (A or B): **A.** Patient has tried one of Rozlytrek, Xalkori, Augtyro, or Ibtrozi. If none are formulary, approve; OR **B.** Patient has already been started on therapy with Lorbrena. **3.** Erdheim-Chester Disease – anaplastic lymphoma kinase (*ALK*) rearrangement/fusion-positive: Approve. **4.** Inflammatory Myofibroblastic Tumor with *ALK* translocation: Approve if the patient meets one of the following criteria (A or B): **A.** Patient has advanced, recurrent, or metastatic disease; OR **B.** The tumor is inoperable. **5.** Large B-Cell Lymphoma – anaplastic lymphoma kinase (ALK)-positive: approve. **6.** Pediatric Diffuse High-Grade Gliomas – anaplastic lymphoma kinase (ALK)-positive in patients < 18 years of age: approve 7. Anaplastic Large Cell Lymphoma – anaplastic lymphoma kinase (ALK)-positive disease: approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - ALK Positive NSCLC (Oral)	Xalkori oral pellets	crizotinib oral pellets	**1.** Approve if the patient has tried Xalkori capsules. If Xakori capsules are non-formulary, approve. **2.** Approve if the patient is unable to swallow capsules/tablets or has difficulty swallowing capsules/tablets. **3.** Approve if the patient's dose cannot be obtained with Xalkori capsules.	1 year
Cancer Agents - ALK Positive NSCLC (Oral)	Alunbrig	brigatinib tablets	**1.** Non-Small Cell Lung Cancer – anaplastic lymphoma kinase (*ALK*)-positive: Approve if the patient meets one of the following criteria (A or B): **A.** Patient has tried Alecensa. If Alecensa is non-formulary, approve; OR Note: A trial of Lorbrena or Ensacove would also count for an approval. **B.** Patient has already been started on therapy with Alunbrig. **2.** Erdheim-Chester Disease – anaplastic lymphoma kinase (*ALK*) rearrangement/fusion-positive: Approve. **3.** Inflammatory Myofibroblastic Tumor with anaplastic lymphoma kinase (*ALK*) translocation: Approve if the patient meets one of the following criteria (A or B): **A.** Patient has advanced, recurrent, or metastatic disease; OR **B.** The tumor is inoperable. **4.** Anaplastic Large Cell Lymphoma (ALCL) - anaplastic lymphoma kinase (*ALK*)-positive: Approve.	1 year
Cancer Agents - ALK Positive NSCLC (Oral)	Alecensa	alectinib capsules	**1.** Non-Small Cell Lung Cancer – anaplastic lymphoma kinase (*ALK*)-positive: Approve if the patient meets ONE of the following (A, B, or C): **A.** Patient has tried Alunbrig. If Alunbrig is non-formulary, approve. Note: A trial of Lorbrena or Ensacove would also count for an approval. **B.** The medication is used as adjuvant treatment following tumor resection. Note: For tumors ≥ 4 cm or node positive. **C.** Patient has already been started on therapy with Alecensa. **2.** Anaplastic Large Cell Lymphoma – anaplastic lymphoma kinase (*ALK*)-positive: Approve if the patient meets ONE of the following (A or B): **A.** Medication is being used for palliative-intent therapy; OR **B.** Patient has relapsed or refractory disease. **3.** Erdheim-Chester Disease – anaplastic lymphoma kinase (*ALK*) rearrangement/fusion-positive: Approve. **4.** Inflammatory Myofibroblastic Tumor – anaplastic lymphoma kinase (ALK)-positive: Approve if the patient meets ONE of the following (A or B): **A.** Patient has advanced, recurrent, or metastatic disease; OR **B.** The tumor is inoperable. **5.** Large B-Cell Lymphoma – anaplastic lymphoma kinase (ALK)-positive: Approve. **6.** Pediatric Diffuse High-Grade Glioma – anaplastic lymphoma kinase (ALK)-positive in a patient ≤ 21 years of age, approve.	1 year
Cancer Agents - Basal Cell Carcinoma Hedgehog Pathway Inhibitors (Oral)	Erivedge	vismodegib capsules	Basal Cell Carcinoma. Note: This includes diffuse basal cell carcinoma formation, such as basal cell nevus syndrome (Gorlin syndrome) or other genetic forms of multiple basal cell carcinoma. **1.** Approve if the patient has tried Odomzo. If Odomzo is non-formulary, approve. **2.** Patient has METASTATIC basal cell carcinoma, approve. Note: This includes primary or recurrent nodal metastases AND distant metastatic disease. **3.** Approve if the requested medication will be used as neoadjuvant therapy before surgery. **4.** Approve if the requested medication will be used in combination with radiation therapy. **5.** Patient has already been started on therapy with Erivege, approve. Central nervous system cancer, approve.	1 year
Cancer Agents - Basal Cell Carcinoma Hedgehog Pathway Inhibitors (Oral)	Odomzo	sonidegib capsules	Basal Cell Carcinoma. Note: This includes diffuse basal cell carcinoma formation, such as basal cell nevus syndrome (Gorlin syndrome) or other genetic forms of multiple basal cell carcinoma. **1.** Approve if the patient has tried Erivedge. If Erivedge is non-formulary, approve. **2.** Patient has already been started on therapy with Odomzo, approve.	1 year
Cancer Agents – B-cell Lymphoma (Oral)	Imbruvica oral suspension	ibrutinib oral suspension	Approve if the patient is unable to swallow or has difficulty swallowing Imbruvica or other Bruton's Tyrosine Kinsase inhibitors (i.e, Calquence, Brukinsa, Jayprica) in an oral dosage form (tablets or capsules).	1 year
Cancer Agents – B-cell Lymphoma (Oral)	Zydelig	idelalisib tablets	Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma: **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried one of Brukinsa or Calquence; AND Note: If neither are formulary, patient would still need to try Venclexta. Note: If the patient has tried Jaypirca or Imbruvica, this would satisfy criterion A. B. Patient has tried Venclexta. Note: If Venclexta is non-formulary, patient would still need to meet criterion A. If none are formulary in criterion A and B, approve. **2.** Patient has already been started on therapy with Zydelig: Approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents – B-cell Lymphoma (Oral)	Imbruvica capsules and tablets	ibrutinib capsules and tablets	Chronic Lymphocytic Leukemia; Small Lymphocytic Lymphoma. Note: CLL includes histologic transformation (Richter). **1.** Approve if the patient has tried one of Brukinsa or Calquence. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Imbruvica. B-Cell Lymphoma-Mantle Cell Lymphoma. **1.** Approve if the patient has tried one of Brukinsa or Calquence. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Imbruvica. Waldenström Macroglobulinemia. **1.** Approve if the patient has tried Brukinsa. If Brukinsa is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Imbruvica. Brain Metastases; Graft-Versus-Host Disease; B-Cell Lymphoma - Marginal Zone Lymphoma; Primary Central Nervous System Lymphoma; Hairy Cell Leukemia; B-Cell Lymphoma - Other: Approve. Note: Examples of other B-cell lymphomas include: diffuse large B-cell lymphomas, Human immunodeficiency virus (HIV)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, and high-grade B-cell lymphoma.	1 year
Cancer Agents – B-cell Lymphoma (Oral)	Copiktra	duvelisib capsules	Chronic Lymphocytic Leukemia; Small Lymphocytic Lymphoma: **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ONE of Brukinsa or Calquence; AND Note: If neither are formulary, patient would still need to try Venclexta. Note: If the patient has tried Jaypirca or Imbruvica, this would also satisfy criterion A. B. Patient has tried Venclexta. Note: If Venclexta is non-formulary, patient would still need to meet criterion A. If none are formulary in criterion A and B, approve. **2.** Patient has already been started on therapy with Copiktra: Approve. Mycosis Fungoides/Sezary Syndrome; T-Cell Lymphoma: Approve.	1 year
Cancer Agents – B-cell Lymphoma (Oral)	Calquence	acalabrutinib tablets	Chronic Lymphocytic Leukemia (CLL), Small Lymphocytic Lymphoma: Note: CLL includes histologic transformation (Richter). **1.** Approve if the patient has tried Brukinsa. If Brukinsa is non-formulary, approve. **2.** Approve if the patient is using Calquence in combination with Venclexta. **3.** If the patient is using or is planning to use the requested agent in combination with Gazyva (obinutuzumab), approve. **4.** Patient has already started on therapy with Calquence: approve. Mantle Cell Lymphoma. **1.** Approve if the patient has tried Brukinsa. If Brukinsa is non-formulary, approve. **2.** Approve if Calquence will be used in combination with bendamustine and rituximab for the treatment of previously untreated mantle cell lymphoma patients who are ineligible for autologous hematopoietic stem cell transplantation. **3.** Approve if the patient has already been started on Calquence. Marginal Zone Lymphoma: Approve. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma: **1.** Approve if the patient has tried Brukinsa. If Brukinsa is non-formulary, approve. **2.** Patient has already started on therapy with Calquence: approve.	1 year
Cancer Agents – Bendamustine Agents	Vivimusta	bendamustine hydrochloride intravenous infusion	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of bendamustine vial (Treanda, generics), Bendeka, bendamustine hydrochloride injection, or Belrapzo. If none are formulary, approve. **NOTE**: A trial of the requested agent would NOT count toward this requirement.	1 year
Cancer Agents – Bendamustine Agents	Belrapzo	bendamustine injection ready to dilute solution	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of bendamustine hydrochloride injection, Bendeka, bendamustine vial (Treanda, generics), or Vivimusta. If none are formulary, approve. **NOTE**: A trial of the requested agent would NOT count toward this requirement.	1 year
Cancer Agents – Bendamustine Agents	bendamustine hydrochloride injection (brand)	bendamustine injection ready to dilute solution	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Belrapzo, bendamustine vial (Treanda, generics), Bendeka, or Vivimusta. If none are formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents – Bendamustine Agents	Bendeka	bendamustine injection (low-volume/short-time infusion)	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of bendamustine vial (Treanda, generics), bendamustine hydrochloride injection, Belrapzo, or Vivimusta. If none are formulary, approve. **NOTE**: A trial of the requested agent would NOT count toward this requirement.	1 year
Cancer Agents - Bevacizumab-containing Agents	Alymsys	bevacizumab-maly injection for intravenous infusion	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried at least three of the following: Avastin, Jobevne, Mvasi, Vegzelma, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Bevacizumab-containing Agents	Avastin	bevacizumab injection for intravenous use	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried at least three of the following: Alymsys, Jobevne, Mvasi, Vegzelma, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Bevacizumab-containing Agents	Jobevne	bevacizumab-nwgd for intravenous use	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried at least three of the following: Alymsys, Avastin, Mvasi, Vegzelma, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Bevacizumab-containing Agents	Mvasi	bevacizumab-awwb injection for intravenous use	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried at least three of the following: Alymsys, Avastin, Jobevne, Vegzelma, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Bevacizumab-containing Agents	Vegzelma	bevacizumab-adcd intravenous infusion	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried at least three of the following: Alymsys, Avastin, Jobevne, Mvasi, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Bevacizumab-containing Agents	Zirabev	bevacizumab-bvzr injection for intravenous use	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried at least three of the following: Alymsys, Avastin, Jobevne, Mvasi, or Vegzelma, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents – Bispecific Antibodies for B-Cell Lymphomas	Lunsumio Velo	mosunetuzumab-axgb subcutaneous injection	Follicular Lymphoma. **1.** Approve if the patient has tried Epkinly. If Epikinly is non-formulary, approve. Note: If the patient has already tried Lunsumio intravenous, this would also count as an approval. **2.** Approve if the patient has already been started on Lunsumio Velo or Lunsumio intravenous. Mantle Cell Lymphoma: Approve.	1 year
Cancer Agents – Bispecific Antibodies for B-Cell Lymphomas	Epkinly	epcoritamab-bysp subcutaneous injection	Diffuse Large B-Cell Lymphoma. Note: Examples of diffuse large B-cell lymphoma (DLBCL) include DLBCL not otherwise specified, DLBCL arising from indolent lymphoma, and high-grade B-cell lymphoma. Approve if the patient meets ONE of the following: (1, 2, 3, or 4): **1.** Patient has tried Columvi. If Columvi is non-formulary, approve; OR **2.** Patient is not a candidate for Gazyva (obinutuzumab); OR **3.** Patient is unable to obtain and/or maintain intravenous access; OR **4.** Patient has already been started on therapy with Epkinly. Follicular Lymphoma: Approve. Human Immunodeficiency Virus (HIV)-Related B-Cell Lymphomas Note: HIV-related B-cell lymphomas includes HIV-related diffuse large B-cell lymphoma (DLBCL), primary effusion lymphoma, and human herpes virus-8 (HHV8) positive DLBCL. ;Post-Transplant Lymphoproliferative Disorders; Chronic lymphocytic leukemia; Small Lymphocytic Lymphoma: Approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents – Bispecific Antibodies for B-Cell Lymphomas	Lunsumio intravenous	mosunetuzumab-axgb intravenous infusion	Follicular Lymphoma. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient has tried Epkinly. If Epkinly is non-formulary, approve; OR Note: If the patient has already tried Lunsumio Velo, this would also count as an approval. **2.** Patient has already been started on therapy with Lunsumio intravenous or Lunsumio Velo. B-Cell Lymphoma. Approve. Note: Examples of B-cell lymphomas include diffuse large B-cell lymphoma, high-grade B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphomas, and post-transplant lymphoproliferative disorders.	1 year
Cancer Agents – Bispecific Antibodies for B-Cell Lymphomas	Columvi	glofitamab intravenous infusion	Diffuse Large B-Cell Lymphoma. Note: Examples of diffuse large B-cell lymphoma (DLBCL) include DLBCL not otherwise specified, high-grade B-cell lymphoma, and DLBCL arising from indolent lymphoma. Approve if the patient meets ONE of the following (1, 2, or 3): **1.** Patient has tried Epkinly. If Epkinly is non-formulary, approve; OR **2.** Approve if Columvi is being used in combination with Polivy (polatuzumab intravenous infusion). **3.** Patient has already been started on therapy with Columvi. Burkitt Lymphoma; Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma; Human Immunodeficiency Virus (HIV)-Related B-Cell Lymphomas Note: HIV-related B-cell lymphomas includes HIV-related diffuse large B-cell lymphoma (DLBCL), primary effusion lymphoma, and human herpes virus-8 (HHV8) positive DLBCL. Mantle Cell Lymphoma; Post-Transplant Lymphoproliferative Disorders: Approve.	1 year
Cancer Agents – BRAF Inhibitors	Tafinlar oral suspension	dabrafenib tablets for oral suspension	Melanoma; Solid Tumors; Non-Small Cell Lung Cancer; Thyroid Carcinoma, Anaplastic; Thyroid Carcinoma, Differentiated; Glioma; Histiocytic Neoplasm; Hairy Cell Leukemia. Note: Examples of solid tumors include: biliary tract cancer, brain metastases due to melanoma, differentiated thyroid carcinoma, gastrointestinal stromal tumors, gastric cancer, esophageal and esophagogastric junction cancers,	1 year
Cancer Agents – BRAF Inhibitors	Braftovi	encorafenib capsules	BRAF V600 mutation-positive melanoma. **1.** Approve if the patient has tried one of Tafinlar or Zelboraf. If neither are formulary, approve. **2.** Patients already started on therapy with Braftovi: approve. BRAF V600E mutation-positive Non-small cell lung cancer. **1.** Approve if the patient has tried Tafinlar. If Tafinlar is non-formulary, approve.	1 year
Cancer Agents – BRAF Inhibitors	Zelboraf	vemurafenib tablets	BRAF V600 mutation-positive melanoma. **1.** Approve if the patient has tried one of Tafinlar or Braftovi. If neither are formulary, approve. **2.** Approve if the patient is unable to take Tafinlar/Mekinist or Braftovi/Mektovi due to a concomitant condition, according to the prescribing physician. **3.** Patient has already started on therapy with Zelboraf: approve. Hairy cell leukemia; BRAF V600 mutation-positive Erdheim-Chester disease; BRAF V600 mutation-positive disease central nervous system cancer; BRAF V600 mutation-positive histiocytic neoplasm; BRAF V600E mutation-positive non-small cell lung cancer; BRAF mutation-positive differentiated thyroid carcinoma: approve.	1 year
Cancer Agents – BRAF Inhibitors	Tafinlar capsules	dabrafenib capsules	See standard *Oncology (Oral – BRAF Inhibitor) – Tafinlar Prior Authorization Policy* criteria	See PA duration
Cancer Agents - Bruton Tyrosine Kinase Inhibitors	Brukinsa	zanubrutinib tablets and capsules	See standard *Oncology (Oral – Bruton's Tyrosine Kinase Inhibitor) – Brukinsa Prior Authorization Policy* criteria.	See PA duration
Cancer Agents - Bruton Tyrosine Kinase Inhibitors	Jaypirca	pirtobrutinib tablets	Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma. 1. Approve if the patient has tried one of Brukinsa or Calquence. If neither are formulary, approve. Note: If the patient has tried Imbruvica, this would also satisfy criterion 1. 2. Patient has already been started on Jaypirca therapy, approve. Mantle cell lymphoma. 1. Approve if the patient has tried one of Brukinsa or Calquence. If neither are formulary, approve. 2. Patient has already been started on Jaypirca therapy, approve. Histologic Transformation (Richter); Marginal Zone Lymphoma; Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma: Approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - CD19-directed Genetically Modified Autologous T-cell Immunotherapy	Breyanzi	lisocabtagene maraleucel suspension for intravenous infusion	See standard *Oncology (Injectable – CAR-T) – Breyanzi Prior Authorization Policy* criteria	See PA duration
Cancer Agents - Cyclin-Dependent Kinase 4/6 Inhibitors	Verzenio	abemaciclib tablets	Breast Cancer: **1.** Approve if the patient has tried one product from the following list: Kisqali or Ibrance. If neither are formulary, approve. **2.** For the diagnosis of breast cancer: advanced or metastatic, HER2 negative, hormone receptor-positive disease, approve if the patient is using Verzenio as monotherapy OR in combination with Inluriyo. 3. For use as adjuvant therapy in early breast cancer (i.e., not advanced or metastatic), approve if the patient meets one of the following (A or B): A. Patient has tried Kisqali. If Kisqali is non-formulary, approve; OR B. Verzenio is being used in combination with tamoxifen. 4. Patient with HER2-positive breast cancer in the metastatic or recurrent setting, approve if the patient is using Verzenio in combination with fulvestrant and trastuzumab. 5. Patient has already been started on therapy with Verzenio, approve. Endometrial Cancer; Liposarcoma: Approve.	1 year
Cancer Agents - Cyclin-Dependent Kinase 4/6 Inhibitors	Ibrance	palbociclib capsules and tablets	Breast Cancer: **1.** Approve if the patient has tried one product from the following list: Kisqali or Verzenio. If neither are formulary, approve. **2.** Approve if patient has human epidermal growth factor receptor 2 (HER2)-positive breast cancer. **3.** If patient will be using Ibrance in combination with Itovebi, approve. **4.** Patient has already been started on therapy with Ibrance, approve. Endometrial Cancer; Liposarcoma; Uterine Sarcoma: Approve.	1 year
Cancer Agents - Etoposide Intravenous Infusion Products	Avopef	etoposide intravenous infusion	Approve if the patient tried and cannot take at least ONE of the following: generic etoposide intravenous infusion or Etopophos. If neither are formulary, approve.	1 year
Cancer Agents - Etoposide Intravenous Infusion Products	Etopophos	etoposide phosphate IV infusion	Approve if the patient tried and cannot take at least ONE of the following: generic etoposide intravenous infusion or Avopef. If neither are formulary, approve.	1 year
Cancer Agents - Fluorouracil Intravenous Products	Favlyxa	fluorouracil intravenous	Approve if the patient has tried and cannot take generic fluorouracil intravenous. If generic fluorouracil intravenous is non-formulary, approve.	1 year
Cancer Agents - Kinase inhibitor	Piqray	alpelisib tablets	**1.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the patient has a known PIK3CA mutation, Piqray is used in combination with fulvestrant, and the patient has tried one of the following agents: a Cyclin-Dependent Kinase 4/6 Inhibitor (e.g., Ibrance [palbociclib], Kisqali [ribociclib], Kisqali Co-Pack [ribociclib, letrozole], Verzenio [abemaciclib]), an aromatase inhibitor (e.g., letrozole, anastrozole,exemestane), tamoxifen, or fulvestrant. **2.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the patient has a known PIK3CA mutation and the patient has already been started on Piqray.	1 year
Cancer Agents - Kinase inhibitor	Truqap	capivasertib tablets	Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer in a patient with a known phosphatidylinositol 3-kinase (PIK3CA mutation) or serine/threonine protein kinase (AKT1) or phosphatase and tensin homolog (PTEN)-alteration or inactivating mutations and genomic changes. **1.** Approve if the patient has tried BOTH of the following: A. Cyclin-Dependent Kinase 4/6 Inhibitor (e.g., Ibrance [palbociclib], Kisqali [ribociclib], Kisqali Co-Pack [ribociclib, letrozole], Verzenio [abemaciclib]); AND B. Endocrine Therapy (e.g., anastrozole, exemestane, fulvestrant, letrozole, tamoxifen). **2.** Approve if the patient has recurrence on or within 12 months of completing adjuvant endocrine therapy. **3.** Approve if the patient has already been started on therapy with Truqap. Metastatic androgen pathway modulation-naïve or sensitive phosphatase and tensin homolog (PTEN)-deficient Prostate Cancer: Approve.	1 year
Cancer Agents - Kinase inhibitor (phosphatidylinositol 3-kinase [PI3K])	Itovebi	inavolisib tablets	See *Oncology – Itovebi Prior Authorization Policy* criteria.	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Kinase inhibitor (RET fusion or RET mutant)	Gavreto	pralsetinib capsules	**1.** Rearranged during transfection (RET) fusion-positive non-small cell lung cancer: Approve if the patient meets ONE of the following (A, B, C, or D): A. Patient has tried Retevmo; OR B. Retevmo is non-formulary; OR C. Patient has a concurrent or history of a cardiac co-morbidity or predisposition (e.g., QT prolongation) as confirmed by the prescriber; OR D. Patient has already been started on therapy with Gavreto. **2.** Rearranged during transfection (RET)-mutant or fusion positive Differentiated Thyroid Cancer; RET-mutant or fusion positive Anaplastic Thyroid Cancer; RET-mutant or fusion positive Medullary Thyroid Cancer: Approve if the patient meets ONE of the following (A, B, C, or D): A. Patient has tried Retevmo; OR B. Retevmo is non-formulary; OR C. Patient has a concurrent or history of a cardiac co-morbidity or predisposition (e.g., QT prolongation) as confirmed by the prescriber; OR D. Patient has already been started on therapy with Gavreto.	1 year
Cancer Agents - Kinase inhibitor (RET fusion or RET mutant)	Retevmo	selpercatinib capsules and tablets	See standard *Oncology (Oral – Rearranged During Transfection-Targeting Agent) – Retevmo Prior Authorization Policy* criteria.	See PA duration
Cancer Agents - Kinase Inhibitors	Vizimpro	dacomitinib tablets	Non-Small Cell Lung Cancer: **1.** Approve if the patient has tried one of erlotinib (Tarceva, generics), gefitinib (Iressa, generics), Gilotrif or Tagrisso. If none are formulary, approve. **2.** Approve if the patient has already been started on Vizimpro.	1 year
Cancer Agents – Kinase Inhibitors	Ojemda	tovorafenib tablets and oral suspension	See standard *Oncology – Ojemda Prior Authorization Policy* criteria.	See PA duration
Cancer Agents - Kirsten rat sarcoma (KRAS) inhibitor	Krazati	adagrasib tablets	Non-Small Cell Lung Cancer - KRAS G12C-mutated. **1.** Approve if the patient has tried Lumakras. If Lumakras is non-formulary, approve. **2.** Patient with brain metastases, approve. **3.** Approve if the patient has already been started on therapy with Krazati. Colon, Rectal, or Appendiceal Cancer - KRAS G12C-mutated. **1.** Approve if the patient has tried Lumakras. If Lumakras is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Krazati OR has already been started on therapy with Erbitux. Ampullary Adenocarcinoma - KRAS G12C-mutated; Biliary Tract Cancer - KRAS G12C-mutated; Pancreatic Adenocarcinoma - KRAS G12C-mutated; Small Bowel Adenocarcinoma - KRAS G12C-mutated: Approve.	1 year
Cancer Agents - Kirsten rat sarcoma (KRAS) inhibitor	Lumakras	sotorasib tablets	Non-Small Cell Lung Cancer - KRAS G12C-mutated. **1.** Approve if the patient has tried Krazati. If Krazati is non-formulary, approve. **2.** Approve if the patient is unable to swallow or has difficulty swallowing Krazati tablets. **3.** Approve if, according to the prescriber, the patient is unable to take Krazati due to gastrointestinal issues, such as a previous gastrointestinal bleed. **4.** Approve if the patient has QTc prolongation OR patient is taking a medication that can prolong the QTc interval. **5.** Approve if the patient has already been started on therapy with Lumakras. Colon, Rectal, or Appendiceal Cancer - KRAS G12C-mutated. **1.** Approve if the patient has tried Krazati. If Krazati is non-formulary, approve. **2.** Approve if the patient is unable to swallow or has difficulty swallowing Krazati tablets. **3.** Approve if, according to the prescriber, the patient is unable to take Krazati due to gastrointestinal issues, such as a previous gastrointestinal bleed. **4.** Approve if the patient has QTc prolongation OR patient is taking a medication that can prolong the QTc interval. **5.** Approve if the patient has already been started on therapy with Lumakras OR has already been started on therapy with Vectibix. Ampullary Adenocarcinoma - KRAS G12C-mutated; Pancreatic Adenocarcinoma- KRAS G12C-mutated; Small Bowel Adenocarcinoma - KRAS G12C-mutated: Approve.	1 year
Cancer Agents - Kirsten RAt Sarcoma (KRAS)-Mutated Ovarian Cancer Agents	Avmapki Fakzynja Co-Pack	avutometinib capsules; defactinib tablets co-package	See standard *Oncology (Oral) – Avmapki Fakzynja Co-Pack Prior Authorization Policy* criteria.	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents – MEK Inhibitors	Mektovi	binimetinib tablets	BRAF V600 mutation-positive melanoma. **1.** Approve if the patient has tried one of Mekinist or Cotellic. If neither are formulary, approve. **2.** Patients already started on therapy with Mektovi: approve. BRAF V600E mutation-positive non-small cell lung cancer. **1.** Approve if the patient has tried Mekinist. If Mekinist is non-formulary, approve. 2. Patients already started on therapy with Mektovi: approve. Histiocytic Neoplasm, approve.	1 year
Cancer Agents – MEK Inhibitors	Cotellic	cobimetinib tablets	BRAF V600 mutation-positive melanoma. **1.** Approve if the patient has tried one of Mekinist or Mektovi. If neither are formulary, approve. **2.** Approve if the patient is unable to take Mekinist/Tafinlar or Braftovi/Mektovi due to a concomitant condition, according to the prescribing physician. **3.** Patient has already started on therapy with Cotellic: approve. Histiocytic neoplasm; BRAF V600 mutation-positive central nervous system cancer: approve.	1 year
Cancer Agents – Metastatic Small Cell Lung Cancer (SCLC) Agents	Zepzelca	lurbinectedin injection for intravenous use	See standard *Oncology (Injectable - Alkylating Agent) – Zepselca Prior Authorization Poli*cy criteria.	See PA duration
Cancer Agents – Methyltransferase EZHZ inhibitor	Tazverik	tazemetostat tablets	See standard *Oncology – Tazverik Prior Authorization Policy* criteria	See PA duration
Cancer Agents - Multiple Myeloma Agent	Blenrep	belantamab mafodotin-blmf for intravenous infusion	Multiple Myeloma. **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried at least two systemic regimens; AND B. Among the previous regimens tried, the patient has received at least one drug from each of the following classes (i and ii): i. Proteasome inhibitor; AND Note: Examples include bortezomib, Kyprolis (carfilzomib intravenous infusion), and Ninlaro (ixazomib capsules). ii. Immunomodulatory drug. Note: Examples include lenalidomide, Pomalyst (pomalidomide capsules), and Thalomid (thalidomide capsules). **2.** Approve if the patient has already been started on therapy with Blenrep.	1 year
Cancer Agents - Multiple Myeloma CD38-directed Monoclonal Antibody Injectable	Darzalex Faspro	daratumumab and hyaluronidase-fihj for subcutaneous injection	See standard *Oncology (Injectable – CD38 - Directed Cytolytic Antibody) – Darzalex Faspro Prior Authorization Policy* criteria	See PA duration
Cancer Agents - Multiple Myeloma CD38-directed Monoclonal Antibody Injectable	Darzalex intravenous (IV)	daratumumab injection	Systemic light chain amyloidosis; Multiple myeloma: **1.** Approve if the patient has tried Darzalex Faspro. If Darzalex Faspro is non-formulary, approve. **2.** If the patient has already been started on therapy with Darzalex intravenous, approve. Acute lymphoblastic leukemia: Approve.	1 year
Cancer Agents - Multiple Myeloma CD38-directed Monoclonal Antibody Injectable	Sarclisa Escena	isatuximab-irfc subcutaneous injection	Multiple Myeloma. **1.** Approve if the patient has tried Darzalex Faspro. If Darzalex Faspro is non-formulary, approve. Note: If the patient has tried Darzalex intravenous, this would also count as an approval. **2.** In the primary treatment setting, for non-transplant candidates, approve if the patient is also being treated with bortezomib (Velcade, generics). **3.** Approve if the patient has already been started on therapy with Sarclisa Escena or Sarclisa intravenous.	1 year
Cancer Agents - Multiple Myeloma CD38-directed Monoclonal Antibody Injectable	Sarclisa IV	isatuximab-irfc injection for intravenous use	Multiple Myeloma: **1.** Approve if the patient has tried one of Darzalex intravenous or Darzalex Faspro. If neither are formulary, approve. **2.** In the primary treatment setting, for non-transplant candidates, approve if the patient is also being treated with bortezomib (Velcade, generics). **3.** Approve if the patient has already been started on therapy with Sarclisa intravenous or Sarclisa Escena.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Multiple Myeloma Histone Deacetylase (HDAC) Inhibitor (Oral)	Farydak	panobinostat capsules	Multiple Myeloma: Patients started on therapy with Farydak: approve.	1 year
Cancer Agents - Multiple Myeloma Immunomodulatory Drug (Oral)	Revlimid	lenalidomide capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agents - Multiple Myeloma Proteosome Inhibitor Drug (Oral)	Ninlaro	ixazomib capsules	**1.** Multiple Myeloma: Approve if the patient meets one of the following (A or B): A. Patient has tried one of the following: lenalidomide, Kyprolis or bortezomib (Velcade, generics); OR Note: If none are formulary, approve. B. Patient has already been started on Ninlaro, approve. **2.** Approve for Systemic Light Chain Amyloidosis or Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma.	1 year
Cancer Agents - Multiple Myeloma SLAMF7-directed Immunostimulatory Antibody (Injectable)	Empliciti	elotuzumab for IV injection	Multiple Myeloma: **1.** Approve if the patient has tried at least one other regimen for multiple myeloma. Note: Examples of agents used in other regimens include Velcade (bortezumab injection), Revlimid (lenalidomide capsules), cyclophosphamide, Darzalex (daratumumab injection). **2.** Patients started on therapy with Empliciti: approve.	1 year
Cancer Agents - Multi-Tyrosine Kinase Inhibitor (Oral)	Cabometyx	cabozantinib tablets	See standard *Oncology (Oral) – Cabometyx Prior Authorization Policy* criteria.	See PA duration
Cancer Agents - NSCLC (Oral) - MET receptor tyrosine kinase inhibitor	Tabrecta	capmatinib tablets	Non-Small Cell Lung Cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations or high-level MET amplification: **1.** Approve if the patient has tried Tepmetko. If Tepmetko is non-formulary, approve. **2.** Approve if the patient has already been started on Tabrecta.	1 year
Cancer Agents - NSCLC (Oral) -MET receptor tyrosine kinase inhibitor	Tepmetko	tepotinib tablets	Non-Small Cell Lung Cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations or high-level MET amplification: **1.** Approve if the patient has tried Tabrecta. If Tabrecta is non-formulary, approve. **2.** Approve if the patient has already been started on Tepmetko.	1 year
Cancer Agents – Oral – Menin Inhibitor	Komzifti	ziftomenib capsules	Relapsed or refractory acute myeloid leukemia with a susceptible nucleophosmin 1 (NPM1) mutation in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Revuforj. If Revuforj is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Komzifti.	1 year
Cancer Agents – Oral – Menin Inhibitor	Revuforj	revumenib tablets	Relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation. **1.** Approve if the patient has tried Komzifti. If Komzifti is non-formulary, approve. **2.** Approve if the patient is < 18 years of age. **3.** Approve if the patient is on a proton-pump inhibitor. Note: Examples of proton-pump inhibitors include dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole. **4.** Approve if the patient has already been started on therapy with Revuforj. Relapsed or refractory acute myeloid leukemia (AML) AND the disease is positive for a lysine methyltransferase 2A (KMT2A) gene translocation or rearrangement, approve. Relapsed or refractory acute lymphoblastic leukemia (ALL) AND the disease is positive for a lysine methytransferase 2A (KMT2A) gene translocation or rearrangement, approve.	1 year
Cancer Agents - PARP inhibitor/Prostate Cancer Agent	Akeega	niraparib and abiraterone acetate tablets	BRCA-mutated Prostate Cancer. **1.** Approve if the patient has BRCA2-mutated metastatic castration-sensitive prostate cancer. **2.** Approve if the patient has tried or is unable to use Lynparza +/- abiraterone. If Lynparza is non-formulary, approve. Note: If the patient has already tried any of the following: Rubraca, Talzeena, or Zejula, this would satisfy the requirement for an approval. **3.** Approve if the patient has already been started on therapy with Akeega.	1 year

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - PARP Inhibitors (oral)	Rubraca	rucaparib tablets	**1.** Ovarian, Fallopian Tube, or Primary Peritoneal Cancer in the Maintenance setting (after complete or partial response to chemotherapy): Approve if the patient meets one of the following criteria (A or B): A) Patient has tried or is unable to use one of Zejula or Lynparza. If neither are formulary, approve; OR B) Patient has already been started on therapy with Rubraca. **2.** Prostate cancer: Approve if the patient meets one of the following criteria (A or B): A) Patient has tried or is unable to use Lynparza. If Lynparza is non-formulary, approve; OR Note: If the patient has already tried Akeega or Talzenna, this would satisfy the requirement for an approval. B) Patient has already been started on therapy with Rubraca. **3.** Uterine Leiomyosarcoma: Approve if the patient meets one of the following (A or B): A) Patient has tried or is unable to take one of Zejula or Lynparza. If neither is formulary, approve; OR B) Patient has already been started on therapy with Rubraca. **4.** Pancreatic Adenocarcinoma: approve.	1 year
Cancer Agents - PARP Inhibitors (oral)	Talzenna	talazoparib capsules and softgels	BRCA-mutated-positive, recurrent or metastatic breast cancer. **1.** Approve if the patient has tried or is unable to use Lynparza. If Lynparza is non-formulary, approve. **2.** Approve if the patient has already been started on Talzenna. Prostate cancer. **1.** BRCA-mutated prostate cancer, approve if the patient tried or is unable to use Lynparza. If Lynparza is non-formulary, approve. Note: If the patient has already tried any of the following: Akeega, Rubraca or Zejula, this would satisfy the requirement for an approval. **2.** Patient has a homologous recombination repair (HHR) mutation OTHER THAN a BRCA-mutation (i.e., patient does not have a BRCA mutation), approve. **3.** Approve if the patient has already been started on therapy with Talzenna	1 year
Cancer Agents - PARP Inhibitors (oral)	Zejula	niraparib capsules and tablets	**1.** Ovarian, Fallopian Tube, or Primary Peritoneal Cancer in the Maintenance setting (after complete or partial response to chemotherapy): Approve if the patient meets one of the following (A, B, or C): A) Patient has tried **[documentation required]** or is unable to use Lynparza. If Lynparza is non-formulary, approve; OR B) Patient meets ALL of the following (i, ii, and iii): i. Patient has had a complete or partial response to first-line platinum-based chemotherapy; AND ii. Patient does not have a BRCA mutation **[documentation required]**; AND iii. Patient has a homologous recombination deficiency (HRD)-positive tumor; OR C) Patient has already been started on therapy with Zejula. **2.** Prostate cancer: Approve if the patient meets one of the following criteria (A, B, or C): A) Patient has metastatic castration-sensitive prostate cancer AND patient is using Zejula in combination with abiraterone; OR B) Patient has tried **[documentation required]** or is unable to use Lynparza. If Lynparza is non-formulary, approve; OR Note: If the patient has already tried Akeega, Talzenna, or Rubraca, this would satisfy the requirement for an approval. C) Patient has already been started on therapy with Zejula. **3.** Uterine Leiomyosarcoma: Approve if the patient meets one of the following (A or B): A) Patient has tried **[documentation required]** or is unable to use Rubraca or Lynparza. If neither is formulary, approve; OR B) Patient has already been started on therapy with Zejula.	1 year

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Programmed Death Receptor-1 Blocking Antibodies	Jemperli	dostarlimab intravenous infusion	Endometrial Cancer. Approve if the patient meets ALL of the following criteria (A, B, C, and D): A) Patient is ≥ 18 years of age; AND B) Patient has recurrent, advanced, or metastatic disease; AND C) The medication is prescribed by or in consultation with an oncologist; AND D) Patient meets the following (1, 2, or 3): 1. Patient has tried Keytruda. If Keytruda is non-formulary, approve; OR 2. Patient has endometrial carcinosarcoma; OR 3. Patient has already been started on therapy with Jemperli. Mismatch Repair Deficient (dMMR) or Microsatellite Instability-High (MSI-H) Solid Tumors. Approve if the patient meets ALL of the following criteria (A, B and C): A) Patient is ≥ 18 years of age; AND B) The medication is prescribed by or in consultation with an oncologist; AND C) Patient meets the following (1 or 2): 1. Patient has tried Keytruda. If Keytruda is non-formulary, approve; OR 2. Patient has already been started on therapy with Jemperli. Small Bowel Adenocarcinoma; Anal Carcinoma; Colon, Rectal, or Appendiceal Cancer: Approve.	1 year
Cancer Agents - Prostate Cancer (Oral)	Nubeqa	darolutamide tablets	Prostate Cancer – Non-Metastatic, Castration-Resistant. Approve if the patient meets one of the following (1 or 2): 1. Approve if the patient has tried one of Erleada or Xtandi. If neither are formulary, approve; OR 2. Approve if the patient has been started on therapy with Nubeqa. Prostate Cancer – Metastatic, Castration-Sensitive. Approve if the patient meets one of the following (1, 2, or 3): 1. Patient has tried one of abiraterone (Zytiga, generics), Erleada, or Xtandi. If none are formulary, approve; OR 2. If abiraterone (Zytiga, generics) are the only formulary alternative AND patient has a contraindication or severe intolerance (e.g., difficulty achieving blood glucose control in patients with diabetes, psychiatric reactions) to low-dose systemic corticosteroids (e.g., prednisone) according to the prescriber; OR 3. Approve if the patient has been started on therapy with Nubeqa.	1 year
Cancer Agents - Prostate Cancer (Oral)	Xtandi	enzalutamide capsules and tablets	Prostate Cancer –Castration-Resistant (CRPC) [Metastatic]. Approve if the patients meets one of the following (1, 2, or 3): 1. Patient has tried abiraterone (Zytiga [generics], Yonsa). If abiraterone (Zytiga, generics) are non-formulary, approve; OR 2. Patient with a contraindication or severe intolerance (e.g., difficulty achieving blood glucose control in patients with diabetes, psychiatric reactions) to low-dose systemic corticosteroids (e.g., prednisone) according to the prescriber; OR 3. Patient has already been started on therapy with Xtandi. Prostate Cancer –Castration-Resistant (CRPC) [Non-Metastatic]. Approve if the patient meets one of the following (1 or 2): 1. Patient has tried Erleada or Nubeqa. If neither are formulary, approve; OR 2. Patient has already been started on therapy with Xtandi. Prostate Cancer – Metastatic, Castration-Sensitive. Approve if the patient meets one of the following (1, 2, or 3): 1. Patient has tried abiraterone (Zytiga, generics), Nubeqa, or Erleada. If none are formulary, approve; OR 2. If abiraterone (Zytiga, generics) are the only formulary alternative AND patient has a contraindication or severe intolerance (e.g., difficulty achieving blood glucose control in patients with diabetes, psychiatric reactions) to low-dose systemic corticosteroids (e.g., prednisone) according to the prescriber; OR 3. Approve if the patient has already been started on therapy with Xtandi. Prostate Cancer – Non-Metastatic, Castration-Sensitive. Approve.	1 year

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Prostate Cancer (Oral)	Erleada	apalutamide tablets	Prostate Cancer – Non-Metastatic, Castration-Resistant. Approve if the patient meets one of the following (1 or 2): 1. Patient has tried at least one of Xtandi or Nubeqa. If neither are formulary approve; OR 2. Patient has already been started on therapy with Erleada. Prostate Cancer – Metastatic, Castration-Sensitive. Approve if the patient meets one of the following (1, 2, or 3): 1. Patient has tried at least one of abiraterone (Zytiga, generics), Nubeqa, or Xtandi. If none are formulary, approve; OR 2. If abiraterone (Zytiga, generics) are the only formulary alternative AND patient has a contraindication or severe intolerance (e.g., difficulty achieving blood glucose control in patients with diabetes, psychiatric reactions) to low-dose systemic corticosteroids (e.g., prednisone) according to the prescriber; OR 3. Patient has already been started on therapy with Erleada. Prostate Cancer – Non-Metastatic, Castration-Sensitive. Approve if the patient meets one of the following (1 or 2): 1. Patient has tried Xtandi. If Xtandi is non-formulary, approve; OR 2. Patient has already been started on therapy with Erleada.	1 year
Cancer Agents - Prostate Cancer (Oral)	Yonsa	abiraterone tablet (125 mg)	Prostate Cancer – Metastatic, Castration-Resistant; Prostate Cancer – Metastatic, Castration Sensitive; Prostate Cancer – Post Radical Prostatectomy or Radiation Therapy; Prostate Cancer – Regional Risk Group; Prostate Cancer – Very-High Risk Group. **1.** Approve if the patient has tried abiraterone (Zytiga, generics). If abiraterone (Zytiga, generics) are non-formulary approve. **2.** Approve if the patient has been started on therapy with Yonsa.	1 year
Cancer Agents - Prostate Cancer (Oral)	Zytiga	abiraterone acetate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agents - Renal Cell Carcinoma (Oral)	Fotivda	tivozanib capsules	Renal Cell Carcinoma. Approve if the patient meets one of the following (1, 2, or 3): **1.** Patient has tried one of Inlyta, Lenvima, or Cabometyx. If none are formulary, approve; OR **2.** If there are toxicity concerns with a trial of Lenvima (and other concomitantly given medications), according to the prescriber, approve if the patient has tried Inlyta or Cabometyx. If neither are formulary, approve; OR **3.** Patient has already been started on therapy with Fotivda.	1 year
Cancer Agents - Renal Cell Carcinoma (Oral)	Lenvima	lenvatinib capsules	See standard *Oncology (Oral) – Lenvima Prior Authorization Policy* criteria.	See PA duration
Cancer Agents - Renal Cell Carcinoma (Oral)	Inlyta	axitinib tablets	Renal Cell Cancer. Approve if the patient meets one of the following (1, 2, or 3): **1.** Patient has tried one of Lenvima or Cabometyx. If neither are formulary, approve: OR **2.** If there are toxicity concerns with a trial of Lenvima (and other concomitantly given medications), according to the prescriber, approve if the patient has tried Cabometyx. If Cabometyx is non-formulary, approve; OR **3.** Patient has already been started on therapy with Inlyta. Thyroid Carcinoma, Differentiated. Approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried Lenvima. If Lenvima is non-formulary, approve; OR **2.** Patient has already been started on therapy with Inlyta. Endometrial Carcinoma; Salivary Gland Tumor; Soft Tissue Sarcoma; Thymic Carcinoma: Approve.	1 year
Cancer Agents - Renal Cell Carcinoma (Oral)	Afinitor Disperz	everolimus tablets for oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agents - Renal Cell Carcinoma (Oral)	Afinitor tablet	everolimus tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agents - Tissue Factor-Directed Antibody and Microtubule Inhibitor Conjugate	Tivdak	tisotumab vedotin-tftv intravenous infusion	See standard *Oncology (Injectable) – Tivdak Prior Authorization Policy* criteria.	See PA duration

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Trastuzumab-containing Agents	Herceptin	trastuzumab for intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Hercessi, Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Trastuzumab-containing Agents	Herceptin Hylecta	trastuzumab and hyaluronidase-oysk for subcutaneous use	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Herceptin intravenous, Hercessi, Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma. If none are formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** If the patient has already been started on therapy with Herceptin Hylecta, approve.	1 year
Cancer Agents - Trastuzumab-containing Agents	Hercessi	trastuzumab-strf for intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Herceptin intravenous, Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Trastuzumab-containing Agents	Herzuma	trastuzumab-pkrb for intravenous injection	Approve if patient meets BOTH of the following (A and B): A. Patient has tried four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Herceptin intravenous, Hercessi, Kanjinti, Ogivri, Ontruzant, or Trazimera; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Trastuzumab-containing Agents	Kanjinti	transtuzumab-anns for intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Hercessi, Herceptin intravenous, Trazimera, Ogivri, Ontruzant, or Herzuma; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Trastuzumab-containing Agents	Ogivri	trastuzumab- dkst intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Hercessi, Herceptin intravenous, Trazimera, Kanjinti, Ontruzant, or Herzuma; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Trastuzumab-containing Agents	Ontruzant	trastuzumab-dttb for intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Hercessi, Kanjinti, Trazimera, Ogivri, Herzuma, or Herceptin intravenous; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Trastuzumab-containing Agents	Trazimera	trastuzumab- qyyp for intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Hercessi, Herceptin intravenous, Kanjinti, Ogivri, Ontruzant, or Herzuma; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Gilotrif	afatinib tablets	Non-Small Cell Lung Cancer: **1.** Approve if the patient has tried one of the following: gefitinib (Iressa, generics), erlotinib (Tarceva, generics), Tagrisso, or Vizimpro. If none are formulary, approve. **2.** Patients with non-small cell lung cancer that is squamous cell carcinoma: approve. **3.** Patients with non-small cell lung cancer whose tumors have epidermal growth factor receptor (EGFR) mutations OTHER THAN exon 19 deletions OR exon 21 substitution mutations, approve if the patient has tried Tagrisso. If Tagrisso is non-formulary, approve. 4. Approve if the patient has been started on Gilotrif. Head and Neck Cancer, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Tyrosine Kinase Inhibitors	Sprycel	dasatinib tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Tykerb	lapatinib tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Caprelsa	vandetanib tablets	**1.** Approve if the patient has tried Cometriq. If Cometriq is non-formulary approve. **2.** Approve if the patient is unable to take Cometriq according to the prescribing physician (e.g., due to safety concerns, drug interactions, etc.). **3.** Approve if the patient has been started on Caprelsa.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Bosulif	bosutinib tablets and capsules	Chronic Myeloid Leukemia (Philadelphia chromosome-positive or *BCR::ABL1* -positive). **1**. Approve if the patient has tried at least one other tyrosine kinase inhibitor. Note: Examples of other tyrosine kinase inhibitors include: an imatinib product [Gleevec, generics, Imkeldi (imatinib oral solution)], dasatinib tablets (Sprycel, Phyrago, generics), a nilotinib product (nilotinib capsules [Tasigna, generics], Danziten, or nilotinib tartrate capsules [brand]), Iclusig. Scemblix. **2.** Approve if the patient has already been started on Bosulif. Acute Lymphoblastic Leukemia (Philadelphia chromosome-positive). **1**. Approve if the patient has tried one product from the following list: 1) an imatinib product [Gleevec, generics, Imkeldi (imatinib oral solution)], or 2) dasatinib tablets (Sprycel, Phyrago, generics). If none are formulary, approve. **2**. Approve if the patient has already been started on Bosulif. Myeloid/Lymphoid Neoplasms with Eosinophilia. **A**. Approve if the tumor has an ABL1 rearrangement.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Scemblix	asciminib tablets	Chronic Myeloid Leukemia (Philadelphia chromosome-positive or *BCR::ABL1* -positive). **1**. Approve if the patient has tried at least one other tyrosine kinase inhibitor. Note: Examples of other tyrosine kinase inhibitors include: an imatinib product (Gleevec, generics, Imkeldi [imatinib oral solution]), dasatinib tablets (Sprycel, Phyrago, generics), a nilotinib product (nilotinib capsules [Tasigna, generics], Danziten, or nilotinib tartrate capsules [brand]), Bosulif, Iclusig. **2**. Patient has newly diagnosed disease, approve if the patient tried one of 1) dasatinib tablets (Sprycel, Phyrago, generics) or 2) a nilotinib product (nilotinib capsules [Tasigna, generics], Danziten, or nilotinib tartrate capsules [brand]). If neither are formulary, approve. **3**. Approve if the patient is T315I-positive. **4**. Approve if the patient has already been started on therapy with Scemblix. Acute Lymphoblastic Leukemia (Philadelphia chromosome-positive). **1.** Approve if the patient has tried at least one other tyrosine kinase inhibitor. Note: Examples of other tyrosine kinase inhibitors include: an imatinib product (Gleevec, generics, Imkeldi [imatinib oral solution[), dasatinib tablets (Sprycel, Phyrago, generics), Iclusig, a nilotinib product (nilotinib capsules [Tasigna, generics], Danziten,or nilotinib tartrate capsules [brand]), Bosulif. **2.** Approve if the patient has already been started on therapy with Scemblix. Myeloid/Lymphoid Neoplasms with Eosinophilia. **A**. Approve if the tumor has an ABL1 rearrangement.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Phyrago	dasatinib tablets	**1**. Approve if the patient has tried dasatinib tablets (Sprycel, generics). If dasatinib tablets (Sprycel, generics) are non-formulary, approve. **2**. Approve if according to the prescriber, patient requires co-administration with a histamine-2 antagonist or proton pump inhibitor.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Tasigna	nilotinib capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Imkeldi oral solution	imatinib oral solution 80 mg/mL	**1.** Approve if the patient tried and cannot take imatinib tablets (Gleevec, generics). If imatinib tablets (Gleevec, generics) are non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Tyrosine Kinase Inhibitors	Iclusig	ponatinib tablets	Chronic Myeloid Leukemia (Philadelphia chromosome-positive or *BCR::ABL1*-positive): 1. Approve if the patient is T315I-positive. 2. Approve if the patient has tried at least one other tyrosine kinase inhibitors (TKIs). Note: Examples of other TKIs include: an imatinib product [Gleevec, generics, Imkeldi (imatinib oral solution)], dasatinib tablets (Sprycel, Phyrago, generics), a nilotinib product (nilotinib capsules [Tasigna, generics], Danziten, or nilotinib tartrate capsules [brand]), Bosulif, Scemblix. 3. Approve if the patient has accelerated-phase CML or blast-phase CML and no other tyrosine kinase inhibitor is indicated. 4. Approve if the patient has been started on Iclusig. Acute Lymphoblastic Leukemia (Philadelphia chromosome-positive or *ABL*-class translocation). 1. Approve if the patient is T315I-positive. 2. Approve if the patient has tried ONE product from the following list: 1) an imatinib product [Gleevec, generics, Imkeldi (imatinib oral solution)] or 2) a dasatinib product (Sprycel, Phyrago, generics). If none are formulary approve. 3. Approve if patient is ≥ 18 years of age, newly diagnosed and is taking requested medication in a combination regimen with chemotherapy. 4. Approve if the patient has been started on Iclusig. Myeloid/Lymphoid Neoplasms with Eosinophilia: approve if the patient meets the following (A or B): A. The tumor has an ABL1 rearrangement; OR B. The tumor has an FGFR1 rearrangement. Gastrointestinal Stromal Tumor: Approve if the patient has tried each of the following (A, B, C, and D): A. imatinib, if formulary; AND B. sunitinib, if formulary; AND C. Stivarga, if formulary; AND D. Qinlock, if formulary. Note: If the patient has tried a brand version of a generic product, this would satisfy the trial of the product. Note: If there are no formulary products in criterion A, B. C, or D, then those criterion do not need to be met.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Tagrisso	osimertinib tablets	See standard *Oncology (Oral – Epidermal Growth Factor Receptor Inhibitor) – Tagrisso Prior Authorization Policy* criteria.	See PA duration
Cancer Agents - Tyrosine Kinase Inhibitors	Qinlock	ripretinib tablets	Gastrointestinal stromal tumor. **1.** Approve if the patient has been previously treated with at least two other kinase inhibitors. Note: Examples of kinase inhibitors are an imatinib product (Gleevec, generics, Imkeldi), sunitinib (Sutent), Stivarga, sorafenib (Nexavar), pazopanib (Votrient), nilotinib (Tasigna). **2.** Approve if the patient has already been started on therapy with Qinlock. Melanoma, Cutaneous. **1.** Approve if the patient meets all of the following (A, B and C): A. Patient has metastatic or unresectable disease; AND B. Patient has an activating KIT mutation; AND C. Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules) + Mekinist (trametinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets). **2.** Approve if the patient has already been started on therapy with Qinlock.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Ayvakit	avapritinib tablets	See standard *Oncology (Oral) – Ayvakit Prior Authorization Policy* criteria.	See PA duration
Cancer Agents - Tyrosine Kinase Inhibitors	Cometriq	cabozantinib capsules	**1.** Approve if the patient has tried Caprelsa. If Caprelsa is non-formulary, approve. **2.** Approve if the patient is unable to take Caprelsa according to the prescribing physician (e.g., due to safety concerns, drug interactions, etc.). **3.** If the patient has differentiated thyroid carcinoma, approve if the patient is < 18 years of age; OR the patient has tried Lenvima (lenvatinib capsules) or sorafenib tablets. **4.** Approve if the patient has been started on Cometriq. **5.** Approve if the patient has Non-Small Cell Lung Cancer.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors	Gleevec	imatinib tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents - Tyrosine Kinase Inhibitors – Nilotinib Products	Cavhanza	nilotinib orally disintegrating tablets	**1.** Approve if the patient tried and cannot take at least ONE of 1) nilotinib capsules (Tasigna, generics), 2) nilotinib tartrate capsules (brand), or 3) Danziten. If none are formulary, approve. **2.** Approve if the patient has difficulty swallowing solid oral dosage forms or cannot swallow solid oral dosage forms.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors – Nilotinib Products	Danziten	nilotinib tablets	Approve if the patient tried and cannot take at least ONE of 1) nilotinib capsules (Tasigna, generics), 2) nilotinib tartrate capsules (brand), or 3) Cavhanza. If none are formulary, approve.	1 year
Cancer Agents - Tyrosine Kinase Inhibitors – Nilotinib Products	Nilotinib tartrate capsules (brand) Cipla	nilotinib tartrate capsules	Approve if the patient tried and cannot take at least ONE of 1) nilotinib capsules (Tasigna, generics), 2) Danziten, or 3) Cavhanza. If none are formulary, approve.	1 year
Cancer Agents - Uveal Melanoma	Kimmtrak	tebentafusp-tebn intravenous infusion	See standard *Oncology (Injectable) – Kimmtrak Prior Authorization Policy* criteria	See PA duration
Cancer Agents (Injectable)	Beleodaq	belinostat injeciton for intravenous use	T-Cell Lymphoma: **1.** Approve if the patient has tried one of Folotyn (pralatrexate) or Istodax (romidepsin). If neither are formulary, approve. **2.** Patients started on therapy with Beleodaq: approve.	1 year
Cancer Agents (Injectable)	Xofigo	radium Ra 223 dichloride injection, for intravenous use	Prostate Cancer: Approve.	1 year
Cancer Agents (Injectable)	Romidepsin injection for intravenous use	romidepsin injection (10 mg/2 mL and 27.5 mg/5.5 mL single-dose vials)	Approve if the patient has tried Istodax, if formulary. If Istodax is non-formulary, approve.	1 year
Cancer Agents (Injectable)	Abraxane	paclitaxel albumin-bound suspension, intravenous infusion	Approve if the patient has tried paclitaxel protein-bound intravenous infusion (authorized generic for Abraxane), if formulary. If paclitaxel protein-bound intravenous infusion (authorized generic for Abraxane) is non-formulary, approve.	1 year
Cancer Agents (Injectable)	Paclitaxel albumin-bound suspension, intravenous infusion (authorized generic to Abraxane)	paclitaxel albumin-bound suspension, intravenous infusion	Approve if the patient has tried brand Abraxane, if formulary. If brand Abraxane is non-formulary, approve.	1 year
Cancer Agents (Injectable)	Istodax	romidepsin for injection	Approve if the patient has tried Romidepsin injection, if formulary. If Romidepsin injection is non-formulary, approve. Note: A trial of Istodax would NOT count toward this requirement.	1 year
Cancer Agents (injectable)	Padcev	enfortumab vedotin-ejfv injection for intravenous use	See standard *Oncology (Injectable) – Padcev Prior Authorization Policy* criteria	See PA duration
Cancer Agents (Injectable)	Proleukin	aldesleukin intravenous infusion	See standard *Oncology (Injectable) – Proleukin Prior Authorization Policy* criteria.	See PA duration
Cancer Agents (injectable)	Imjudo	tremelimumab-actl intravenous infusion	See standard *Oncology (Injectable – CTLA-4 Antibody) – Imjudo Prior Authorization Policy* criteria.	See PA duration

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer Agents (Injectable)	Lutathera	lutetium Lu 177 dotatate intravenous infusion	**1.** Neuroendocrine Tumors (NETs) of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas. Approve if the patient meets the following criteria (A, B, C, D, and E): A) Patient is ≥ 12 years of age; AND B) Patient has locally advanced or metastatic disease; AND C) Patient has somatostatin receptor-positive tumor as detected by somatostatin receptor-based imaging; AND Note: Examples of somatostatin receptor-based imaging include Gallium-68 dotatate imaging (positron emission tomography [PET]/computed tomography or PET/magnetic resonance imaging) or somatostatin receptor scintigraphy. D) Patient meets ONE of the following (i or ii) i. Patient has progressed on an octreotide acetate injection product (e.g., Bynfezia Pen, Sandostatin [generic], Sandostatin LAR Depot) or Somatuline Depot (lanreotide injection); OR ii. Patients meets ALL of the following (a, b, and c) a. Medication is being used as first-line therapy; AND b. Patient has Ki-67 index ≥ 10%; AND c. Patient has a clinically significant tumor burden; AND Note: Examples of clinically significant tumor burden include inoperable tumor, large tumor size, location of tumor, or presence of symptoms; AND E) Lutathera is prescribed by or in consultation with an oncologist, radiologist, or endocrinologist. **2.** Pheochromocytoma and Paraganglioma. Approve if the patient meets the following criteria (A, B, C, and D): A) Patient is ≥ 18 years of age; AND B) Patient has locally unresectable disease or distant metastases; AND C) Patient has somatostatin receptor-positive tumor as detected by somatostatin receptor-based imaging; AND Note: Examples of somatostatin receptor-based imaging include Gallium-68 dotatate imaging (positron emission tomography [PET]/computed tomography or PET/magnetic resonance imaging) or somatostatin receptor scintigraphy. D) Lutathera is prescribed by or in consultation with an oncologist or radiologist.	1 year
Cancer Agents (Injectable)	Folotyn and pralatrexate	pralatrexate injection	See standard *Oncology (Injectable) – Pralatrexate Prior Authorization Policy* criteria	See PA duration
Cancer Agents (Injectable) – melphalan	Evomela	melphalan injection (Captisol technology)	Approve if the patient has tried and cannot use either of the following: 1) melphalan injection (Alkeran, generics) OR 2) Ivra injection. If neither are formulary, approve.	1 year
Cancer Agents (Injectable) – melphalan	Ivra	melphalan injection	Approve if the patient has tried and cannot use melphalan injection (Alkeran, generics). If melphalan injection (Alkeran, generics) is non-formulary, approve.	1 year
Cancer Agents (Injectable) - Microtubule Inhibitors	Jevtana	cabazitaxel intravenous infusion	See *Oncology (Injectable – Microtubule Inhibitor) – Jevtana Prior Authorization Policy* criteria.	See PA duration
Cancer Agents (Oral)	Gleostine	lomustine capsules	Hodgkin Lymphoma; Hodgkin Disease; Non-Hodgkin's Lymphoma; Melanoma; Brain Tumors or Intracranial Tumors, including but not limited to glioblastoma, gliomas, medulloblastomas; Central Nervous System Cancer, including but not limited to intracranial and spinal ependymoma; Acute Myelogenous Leukemia; Carcinoma of breast; Colorectal Cancer; Lung Cancer; Malignant tumor of thymus: Approve.	1 year
Cancer Agents (Oral)	Leukeran	chlorambucil tablets	Chronic Lymphatic (Lymphocytic) Leukemia or Small Lymphocytic Lymphoma; Lymphomas including but not limited to lymphosarcoma, giant follicular lymphoma, and Hodgkin's disease; Hodgkin Lymphoma; Non-Hodgkin's Lymphoma; Macroglobulinemia; Nephrotic Syndrome; Dermatomyositis, Pneumonitis, Lupus Nephritis, or Polymyositis related to Systemic Lupus Erythematosus; Rheumatoid Arthritis; Systemic Vasculitis Syndromes, including Behcet's syndrome, Churg-Strauss syndrome, Polyarteritis Nodosa, Uveitis, or Granulomatosis with Polyangiitis; Immune Thrombocytopenic Purpura; B-Cell Lymphoma, including nongastric mucosa-associated lymphoid tissue (MALT), gastric MALT, Follicular lymphoma, Marginal zone lymphoma; Cutaneous Lymphoma; Mycosis fungoides; Sezary syndrome; Gestational Trophoblastic Neoplasia; Histiocytosis X Syndrome; Waldenstrom Macroglobulinemia: Approve.	1 year
Cancer Agents (Oral)	Lysodren	mitotane tablets	Adrenocortical Cancer, including but not limited to neuroendocrine and adrenal tumors; Cushing's Syndrome: Approve.	1 year
Cancer Agents (Oral)	Matulane	procarbazine capsules	Hodgkin Disease; Hodgkin Lymphoma; Non-Hodgkin's Lymphoma; Stem Cell Transplant Preparation; Central Nervous System Cancers, including but not limited to malignant glioma, medulloblastoma; Intracranial Tumors; Primary CNS lymphoma; Non-Small Cell Lung Cancer; Multiple Myeloma; B-Cell Lymphoma, including but not limited to diffuse large B-Cell lymphoma, post-transplant lymphoproliferative disorders: Approve.	1 year
Cancer Agents (Oral)	Myleran	busulfan tablets	Chronic Myelogenous Leukemia; Hemopoietic Stem Cell Transplant; Bone Marrow Transplant; Stem Cell Transplant Preparation, including patients with Chronic Myelogenous Leukemia, Acute Myelogenous Leukemia, Non-Hodgkin Lymphoma, Neuroblastoma, or Multiple Myeloma; CNS cancers; Ovarian Cancer; Breast Cancer: Approve.	1 year
Cancer Agents (Oral)	Tabloid	thioguanine tablets	**1.** Approve if the patient has tried one other therapy for the requested indication. **2.** Approve if the patient has already been started on Tabloid.	1 year
Cancer Agents (Oral) - Isocitrate Dehydrogenase-1 (IDH1) and IDH2 Inhibitor	Voranigo	vorasidenib tablets	See standard *Oncology (Oral – IDH1 and IDH2 Inhibitor) – Voranigo Prior Authorization Policy* criteria.	See PA duration
Cancer Alkylating Agent	Jelmyto	mitomycin for pyelocalyceal solution	See standard *Oncology (Other) – Jelmyto Prior Authorization Policy* criteria	See PA duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cancer –ROS1 Inhibitors	Rozlytrek	entrectinib capsules and pellet packet	ROS1-positive non-small cell lung cancer. Note: If the patient has non-small cell lung cancer with neurotrophic receptor tyrosine kinase (NTRK) gene fusion, see Solid Tumors indication. Approve if the patient meets ONE of the following (1, 2, or 3): **1.** Patient has tried one of Augtyro or Ibtrozi. If neither are formulary, approve; OR **2.** Patient has or is at risk of interstitial lung disease; OR **3.** Patient has already been started on therapy with Rozlytrek. Neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors. Approve if the patient meets ONE of the following (1, 2, 3, 4, 5, 6, or 7): **1.** Patient has tried BOTH of Augtyro and Vitrakvi (if one is formulary). If neither are formulary, approve; OR **2.** If patient has recurrent or progressive glioma or glioblastoma, approve if the patient has tried Vitrakvi. If Vitrakvi is non-formulary, approve; OR **3.** If Vitrakvi is non-formulary, approve if the patient has a NTRK gene fusion tumor that, according to the prescriber, Augtyro treatment is not addressed in clinical guidelines; OR **4.** Patient is < 12 years of age OR the patient is unable to or has difficulty swallowing a solid oral dosage form, patient has tried Vitrakavi. If Viktrakvi is non-formulary, approve; OR **5.** Patient is < 4 months of age; OR **6.** Patient has or is at risk of interstitial lung disease; patient has tried Vitrakavi. If Viktrakvi is non-formulary, approve; OR **7.** Patient has already been started on therapy with Rozlytrek. Pediatric (patient is < 18 years of age) Neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive, diffuse high-grade gliomas: Approve.	1 year
Cancer –ROS1 Inhibitors	Augtyro	repotrectinib capsules	ROS1-positive non-small cell lung cancer. Note: If the patient has non-small cell lung cancer with neurotrophic receptor tyrosine kinase (NTRK) gene fusion, see Solid Tumors indication. Approve if the patient meets ONE of the following (1, 2, 3, 4, 5, or 6): **1.** Patient has tried one of Ibtrozi or Rozlytrek. If neither are formulary, approve; OR **2.** If Augtyro has not been tried previously, approve if the patient has progression on Rozlytrek (entrectinib capsules and pellet packet), Xalkori (crizotinib capsules), or Ibtrozi (taletrectinib capsules); OR **3.** If the patient has a ROS1 G2032R resistance mutation, approve if the patient has tried Ibtrozi. If Ibtrozi is non-formulary, approve. 4. Patient has congestive heart failure, approve if the patient has tried Ibtrozi. If Ibtrozi is non-formulary, approve; OR **5.** According to the prescriber, the patient has a risk of QT prolongation; OR **6.** Patient has already been started on therapy with Augtyro. Neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors. Approve if the patient meets ONE of the following (1, 2, 3, or 4): **1.** Patient has tried BOTH of Rozlytrek and Vitrakvi (or one if one is formulary). If neither are formulary, approve; OR **2.** Patient has locally advanced disease; OR **3.** Patient has congestive heart failure or, according to the prescriber, the patient has a risk of QT prolongation, patient has tried Vitrakvi. If Vitrakvi is non-formulary, approve; OR **4.** Patient has already been started on therapy with Augtyro. Neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive diffuse high-grade glioma in a pediatric patient < 18 years of age: approve.	1 year
Carbamazepines	Equetro	carbamazepine extended-release capsules	Approve if the patient has tried one carbamazepine product from the following list (if one is formulary): immediate-release carbamazepine (e.g., Tegretol, generics) or extended-release carbamazepine (e.g., Carbatrol or Tegretol XR, generics). If none are formulary, approve.	1 year
Carbonic Anhydrase Inhibitors	Keveyis and generics (including dichlorphenamide tablets, Ormalvi)	dichlorphenamide tablets	Approve if the patient has tried one of dichlorphenamide tablets or Ormalvi, if formulary. If BOTH dichlorphenamide tablets and Ormalvi are non-formulary, or generic dichlorphenamide or Ormalvi is being requested, approve if the patient meets one of the following (1 or 2): **1.** For the treatment of primary hyperkalemic periodic paralysis (HyperPP), primary hypokalemic periodic paralysis (HypoPP), and related variants: approve if the patient has tried one of acetazolamide tablets (generics) or acetazolamide ER capsules, if one is formulary. If neither are formulary, approve. **2.** For the treatment of primary hyperkalemic periodic paralysis (HyperPP), primary hypokalemic periodic paralysis (HypoPP), and related variants: approve if the patient has been started on therapy with Keveyis, Ormalvi or dichlorphenamide.	1 year
Carboplatin Cancer Agents (Injectable)	Kyxata	carboplatin intravenous infusion	Approve if the patient has tried and cannot take carboplatin intravenous infusion. If carboplatin intravenous infusion is non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cardiovascular Medications - Other	Corlanor	ivabradine tablets and solution	If requesting brand Corlanor tablets or Corlanor solution, approve if the patient meets ONE of the following (1 or 2): **1.** Patient has tried and cannot take generic ivabradine tablets; OR **2.** Patient cannot swallow or has difficulty swallowing tablets, approve Corlanor solution. If requesting generic ivabradine tablets or generic ivabradine tablets are non-formulary, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Patient has tried, or is currently receiving a beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) OR the patient has a contraindication to beta-blockers; OR **2.** Heart failure due to dilated cardiomyopathy, approve if the patient is < 18 years of age; OR **3.** Patient has already been started on Corlanor or ivabradine.	1 year
Cardiovascular Medications - Other	Aspruzyo Sprinkle	ranolazine extended-release granules	**1.** Approve if the patient meets one of the following (A or B): A. Patient is unable to or has difficulty swallowing ranolazine extended-release tablets (Ranexa, generics); OR B. Patient requires administration by nasogastric or gastrostomy/gastric tube. **2.** If ranolazine extended-release tablets (Ranexa, generics) are non-formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried two of the following: beta blockers, calcium-channel blockers, or nitrates; OR Note: Two products in the same class would satisfy this criterion. B. Patient has difficulty swallowing oral dosage forms and is unable to try a beta-blocker, calcium-channel blocker, or a nitrate; OR C. Patient has already been started on a ranolazine product (e.g., Ranexa, Aspruzyo Sprinkle).	1 year
Cardiovascular Medications - Other	Multaq	dronedarone tablets	Approve for ONE of the following (1, 2, 3, or 4): **1.** Approve if the patient has tried one of the following: dofetilide capsules (Tikosyn, generics), flecainide (generics), or propafenone ER (generics). If none are formulary, approve. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. **2.** According to the prescriber, if the patient is not a candidate for dofetilide capsules (Tikosyn, generics), flecainide (generics), or propafenone ER (generics), approve. **3.** Approve if the patient has tried sotalol or amiodarone. **4.** Patient has already been started on Multaq: approve.	1 year
Cardiovascular Medications - Other	BiDil	isosorbide dinitrate and hydralazine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cardiovascular Medications - Other	Tikosyn	dofetilide capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
CD19-directed genetically modified autologous T-cell immunotherapy	Tecartus	brexucabtagene autoleucel suspension for intravenous infusion	See standard *Oncology (Injectable – CAR-T) – Tecartus Prior Authorization Policy* criteria	See PA duration
CD19-directed monoclonal antibody	Uplizna	inebilizumab-cdon injection for intravenous infusion	Anti-aquaporin (AQ4P) antibody-positive Neuromyelitis Optica Spectrum Disorder in a patient ≥ 18 years of age. **1.** Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with Enspryng, if formulary. If Enspryng is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Uplizna. Immunoglobulin G4-Related Disease in a patient ≥ 18 years of age: Approve. Generalized Myasthenia Gravis, anti-acetylcholine receptor antibody-positive OR anti-muscle-specific tyrosine kinase antibody-positive, in a patient ≥18 years of age. **1.** Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with TWO of 1) Imaavy, 2) an efgartigimod product (Vyvgart Intravenous or Vyvgart Hytrulo) or, 3) Rystiggo, if formulary (or one if one is formulary). If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Uplizna.	1 year
Central Nervous System Non-Stimulants	Atoncy, atomoxetine oral solution	atomoxetine oral solution	**1.** Approve if the patient has tried and cannot take atomoxetine capsule, if formulary. **2.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Qelbree, if formulary. **3.** If neither atomoxetine capsules nor Qelbree is formulary, approve. **4.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Qelbree, if formulary. If Qelbree is non-formulary, approve. **5.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve. **6.** Approve if the patient has already been started on therapy with Atoncy.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Central Nervous System Non-Stimulants	Onyda XR	clonidine hydrochloride extended-release oral suspension	**1.** Approve if the patient has tried and cannot take clonidine ER tablets (generic of Kapvay), if formulary. If clonidine ER tablets (generic of Kapvay) is non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets. **3.** Approve if the patient has already been started on therapy with Onyda XR.	1 year
Central Nervous System Non-Stimulants	Qelbree	viloxazine extended-release capsules	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with at least ONE of atomoxetine capsule or Atoncy, if formulary. If neither are formulary, approve. **2.** If the patient is unable to swallow or has difficulty swallowing solid oral dosage forms, approve if the patient has tried Atoncy, if formulary. If Atoncy is non-formulary, approve. **3.** Approve if the patient has already been started on therapy with Qelbree.	1 year
Central Nervous System Non-Stimulants	Intuniv	guanfacine HCl tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Non-Stimulants	Strattera	atomoxetine HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Amphetamine Products	Dyanavel XR tablets	amphetamine extended-release tablets	**1.** Approve if the patient has tried Dyanavel XR oral suspension, if formulary. **2.** If Dyanavel XR oral suspension is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), or 2) amphetamine ER ODT tablets (Adzenys XR ODT tablets, generics), or 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics). If none are formulary, approve. Note: Lisdexamfetamine capsules (Vyvanse capsule,generics) and lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) would count as one alternative. Note: A product and its generic count as one alternative.	1 year
Central Nervous System Stimulants – Amphetamine Products	Arynta	lisdexamfetamine dimesylate oral solution	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two formulary products (or one if one is formulary) from the following list: 1) a lisdexamfetamine capsule or chewable tablets (Vyvanse capsules or chewable tablets, generics) 2) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 3) amphetamine ER ODT (Adzenys XR-ODT tablets, generics), or 4) Dyanavel XR oral suspension or Dyanavel XR tablets. If none are formulary, approve. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products, if formulary: 1) amphetamine ER ODT tablets (Adzenys XR ODT tablets, generics) or 2) Dyanavel XR suspension. If neither are formulary, approve. Note: A product and its generic count as one alternative. Note: Dyanavel XR oral suspension and Dyanavel XR tablets count as one alternative **3.** Patients with binge eating disorder: approve if the patient has tried one other medication for this diagnosis. Note: Examples of medication therapy for binge eating disorder includes citalopram (Celexa, generics), escitalopram (Lexapro, generics), fluoxetine (Prozac, generics), paroxetine (Paxil, generics), sertraline (Zoloft, generics), imipramine (Tofranil, generics), topiramate (Topamax, generics), zonisamide (Zonegran, generics).	1 year
Central Nervous System Stimulants – Amphetamine Products	Dyanavel XR suspension	amphetamine extended-release oral suspension	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), or 2) amphetamine ER ODT tablets (Adzenys XR ODT tablets, generics), or 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics). If none are formulary, approve. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following, if formulary: 1) amphetamine ER ODT tablets (Adzenys XR ODT tablets, generics) or 2) Arynta solution. If neither are formulary, approve. Note: Lisdexamfetamine capsules (Vyvanse capsule,generics) and lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) would count as one alternative. Note: A product and its generic count as one alternative.	1 year
Central Nervous System Stimulants – Amphetamine Products	Mydayis and generics	mixed salts of a single-entity amphetamine product extended-release capsules	If requesting brand Mydayis ER capsule: Approve if the patient has tried and cannot take generic dextroamphetamine-amphetamine ER capsule (generic for Mydayis ER capsule) due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic dextroamphetamine-amphetamine ER capsule (generic for Mydayis ER capsule) or generic dextroamphetamine-amphetamine ER capsule (generic for Mydayis ER capsule) is non-formulary: Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products (or two if two are formulary, or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 2) amphetamine ER ODT (Adzenys XR-ODT tablets, generics), 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) or 4) Dyanavel XR oral suspension or Dyanavel XR tablets. If none are formulary, approve. Note: Lisdexamfetamine capsules (Vyvanse capsule, generics) and lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) would count as one alternative. Note: Dyanavel XR oral suspension and Dyanavel XR tablets would count as one alternative. Note: A product and its generic count as one alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Central Nervous System Stimulants – Amphetamine Products	Vyvanse capsules and lisdexamfetamine capsules	lisdexamfetamine capsules	If requesting brand Vyvanse capsules: Approve if the patient has tried and cannot take generic lisdexamfetamine capsules due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic lisdexamfetamine capsule or generic lisdexamfetamine capsules are non-formulary: **1.** Approve if the patient has tried one of generic lisdexamfetamine chewable tablets or brand Vyvanse chewable tablets, if formulary. **2.** If both lisdexamfetamine chewable tablets and brand Vyvanse chewable tablets are non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 2) amphetamine ER ODT (Adzenys XR-ODT tablets, generics), or 3) Dyanavel XR oral suspension or Dyanavel XR tablets. If none are formulary, approve. **3.** Patients with binge eating disorder: approve if the patient has tried one other medication for this diagnosis. Note: Examples of medication therapy for binge eating disorder includes citalopram (Celexa, generics), escitalopram (Lexapro, generics), fluoxetine (Prozac, generics), paroxetine (Paxil, generics), sertraline (Zoloft, generics), imipramine (Tofranil, generics), topiramate (Topamax, generics), zonisamide (Zonegran, generics).	1 year
Central Nervous System Stimulants – Amphetamine Products	Vyvanse chewable tablets and lisdexamfetamine chewable tablets	lisdexamfetamine chewable tablets	If requesting brand Vyvanse chewable tablets: Approve if the patient has tried and cannot take generic lisdexamfetamine chewable tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic lisdexamfetamine chewable tablets or generic lisdexamfetamine chewable tablets are non-formulary: **1.** Approve if the patient has tried one of generic lisdexamfetamine capsules or brand Vyvanse caspules, if formulary. **2.** If both generic lisdexamfetamine capsules and brand Vyvanse capsules are non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 2) amphetamine ER ODT (Adzenys XR-ODT tablets, generics), or 3) Dyanavel XR oral suspension or Dyanavel XR tablets. If none are formulary, approve. Note: Dyanavel XR oral suspension and Dyanavel XR tablets count as one alternative. Note: A product and its generic count as one alternative. **3.** Patients with binge eating disorder: approve if the patient has tried one other medication for this diagnosis. Note: Examples of medications for binge eating disorder includes citalopram (Celexa, generics), escitalopram (Lexapro, generics), fluoxetine (Prozac, generics), paroxetine (Paxil, generics), sertraline (Zoloft, generics), imipramine (Tofranil, generics), topiramate (Topamax, generics), zonisamide (Zonegran, generics).	1 year
Central Nervous System Stimulants – Amphetamine Products	Adderall	dextroamphetamine/amphetamine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Amphetamine Products	Adderall XR	dextroamphetamine/amphetamine extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Amphetamine Products	Evekeo	amphetamine sulfate tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Azstarys	serdexmethylphenidate and dexmethylphenidate capsules	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, or 4) QuilliChew ER tablets or Quillivant XR suspension. Note: QuilliChew ER tablets and Quillivant XR suspension count as one alternative.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Jornay PM	methylphenidate hydrochloride ER capsule	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Azstarys, 4) QuilliChew ER tablets or Quillivant XR suspension. Note: QuilliChew ER tablets and Quillivant XR suspension count as one alternative.	1 year
Central Nervous System Stimulants – Methylphenidate Products	QuilliChew ER	methylphenidate HCl extended-release chewable tablets	Approve if the patient has tried Quillivant XR suspension, if formulary. If Quillivant XR suspension is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, 4) Azstarys.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Central Nervous System Stimulants – Methylphenidate Products	Relexxii and authorized generic	methylphenidate ER tablet	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five products (or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, or 4) Azstarys or 5) QuilliChew ER tablets or Quillivant XR suspension. Note: QuilliChew ER tablets and Quillivant XR suspension count as one alternative.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Quillivant XR	methylphenidate hydrochloride for extended-release oral suspension	**1.** Approve if the patient has tried QuilliChew ER tablets, if formulary. If QuilliChew ER tablets are non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, 4) Azstarys. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Cotempla XR-ODT	methylphenidate extended-release orally disintegrating tablets	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five products (or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, , 4) Azstarys, or 5) QuilliChew ER tablets or Quillivant XR suspension. Note: A product and its generic count as one alternative. Note: QuilliChew ER tablets and Quillivant XR suspension count as one alternative. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Quillivant XR susupension, if formulary. If Quillivant XR suspension is non-formulary, approve.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Aptensio XR	methylphenidate hydrochloride XR capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Concerta	methylphenidate hcl extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Focalin and Focalin XR	dexmethylphenidate tablets and extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Ritalin	methylphenidate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants – Methylphenidate Products	Ritalin LA	methylphenidate long-acting capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System Stimulants –Amphetamine Products	Adzenys XR – ODT and generics	amphetamine extended-release orally disintegrating tablets	If requesting brand Adzenys XR ODT: Approve if the patient has tried and cannot take generic amphetamine ER ODT due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic amphetamine ER ODT or generic amphetamine ER ODT is non-formulary: **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 2) lisdexamfetamine capsules (Vyvanse capsules, generics) or lisdexamfetamine chewable tablets (Vyanse chewable tablets, generics) or 3) Dyanavel XR oral suspension or Dyanavel XR tablet. If none are formulary, approve. Note: Lisdexamfetamine capsules (Vyvanse capsule, generics) and lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) would count as one alternative. Note: Dyanavel XR oral suspension and Dyanavel XR tablets would count as one alternative. Note: A product and its generic count as one alternative. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products, if formulary: 1) Dyanavel XR suspension, or 2) Arynta solution. If neither are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Central Nervous System Stimulants –Amphetamine Products	Xelstrym	dextroamphetamine transdermal system	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products, if formulary (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 2) amphetamine ER ODT (Adzenys XR-ODT tablets, generics), 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics), or 4) Dyanavel XR oral suspension or Dyanavel XR tablets. If none are formulary, approve. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products, if formulary: 1) amphetamine ER ODT tablets (Adzenys XR ODT tablets, generics), 2) Dyanavel XR suspension, or 3) Arynta solution. If none are formulary, approve. Note: Lisdexamfetamine capsules (Vyvanse capsule, generics) and lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) would count as one alternative. Note: Dyanavel XR oral suspension and Dyanavel XR tablets would count as one alternative. Note: A product and its generic count as one alternative.	1 year
Central Nervous System/Autonomic Drugs	Zurnai	nalmefene intramuscular or subcutaneous injection	Approve if the patient has tried one naloxone-containing product. Note: Examples of naloxone-containing products are naloxone syringes (either given via nasal or injection), naloxone nasal spray (Narcan nasal spray, generics), Zimhi, Kloxxado.	1 year
Central Nervous System/Autonomic Drugs	Opvee	nalmefene nasal spray	Approve if the patient has tried one naloxone-containing product. Note: Examples of naloxone-containing products are: naloxone syringes (either given via nasal or injection), naloxone nasal spray (Narcan nasal spray, generics), Zimhi, Kloxxado.	1 year
Central Nervous System/Autonomic Drugs	Northera and generic droxidopa capsules	droxydopa capsules	Neurogenic Orthostatic Hypotension. Approve if the patient has tried two of the following products: 1) midodrine tablets, 2) fludrocortisone tablets, 3) dihydroergotamine injection/nasal spray, 4) indomethacin capsules/injection, 5) pyridostigmine tablets, or 6) atomoxetine.	1 year
Central Nervous System/Autonomic Drugs	Lumryz	sodium oxybate extended-release oral suspension	Cataplexy Treatment in a Patient with Narcolepsy; Excessive Daytime Sleepiness in Patients with Narcolepsy (both diagnoses in a patient ≥ 7 years of age). **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with at least ONE of sodium oxybate (Xyrem, generics), Xywav, or Wakix, if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Lumryz.	1 year
Central Nervous System/Autonomic Drugs	Xywav	calcium, magnesium, potassium, and sodium oxybates oral solution	Cataplexy Treatment in Patients with Narcolepsy; Excessive Daytime Sleepiness in Patients with Narcolepsy (both diagnoses in a patient ≥ 7 years of age). **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with at least ONE of Lumryz, sodium oxybate (Xyrem, generics), or Wakix, if formulary. If none are formulary, approve. **2.** If according to the prescriber, the patient has a concomitant diagnosis of heart failure, hypertension, or renal impairment: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Wakix, if formulary. If Wakix is non-formulary, approve. **3.** Approve if the patient has already been started on therapy with Xywav. Idiopathic hypersomnia in a patient ≥ 18 years of age. **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with at least ONE of modafinil or armodafinil, if formulary; AND Note: If neither are formulary, would still need to try a methylphenidate-containing product. B. Patient has tried a methylphenidate-containing product. **2.** Approve if the patient has already been started on therapy with Xywav.	1 year
Central Nervous System/Autonomic Drugs	Xyrem	sodium oxybate oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Central Nervous System/Autonomic Drugs – Naloxone nasal sprays	Kloxxado	naloxone hydrochloride 8 mg nasal spray	**1.** Approve if the patient has tried one product from the following list (if one is formulary): naloxone syringes (without a needle concentrated at 1 mg/mL or greater) used with a nasal/mucusal atomizer, naloxone nasal spray (Narcan nasal spray, generics), or Rextovy nasal spray, if formulary. If none are formulary, approve. Note: If the patient tried a prescription or over-the-counter (OTC) naloxone nasal spray (e.g., naloxone nasal spray, Narcan, or ReVive), this would count toward an approval of the requested agent. **2.** If a nasal/mucosal atomization device is not available from the pharmacy OR the patient or caregiver is unable to use a naloxone syringe (either as an injection or nasally with an atomizer), approve if the patient has tried naloxone nasal spray (Narcan nasal spray, generics) or Rextovy nasal spray, if formulary. If neither are formulary, approve. Note: If the patient tried a prescription or over-the-counter (OTC) naloxone nasal spray (e.g., naloxone nasal spray, Narcan, or ReVive), this would count toward an approval of the requested agent.	1 year
Central Nervous System/Autonomic Drugs – Naloxone nasal sprays	Rextovy	naloxone hydrochloride 4 mg nasal spray	**1.** Approve if the patient has tried one product from the following list (if one is formulary): naloxone syringes (without a needle concentrated at 1 mg/mL or greater) used with a nasal/mucusal atomizer, naloxone nasal spray (Narcan nasal spray, generics), or Kloxxado nasal spray, if formulary. If none are formulary, approve. Note: If the patient tried a prescription or over-the-counter (OTC) naloxone nasal spray (e.g., naloxone nasal spray, Narcan, or ReVive), this would count toward an approval of the requested agent. **2.** If a nasal/mucosal atomization device is not available from the pharmacy OR the patient or caregiver is unable to use a naloxone syringe (either as an injection or nasally with an atomizer), approve if the patient has tried one of naloxone nasal spray (Narcan nasal spray, generics), or Kloxxado nasal spray, if formulary. If neither are formulary, approve. Note: If the patient tried a prescription or over-the-counter (OTC) naloxone nasal spray (e.g., naloxone nasal spray, Narcan, or ReVive), this would count toward an approval of the requested agent.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cerebral Adrenoleukodystrophy Agent	Skysona	elivaldogene autotemcel intravenous infusion	See standard *Neurology – Gene Therapy – Skysona Prior Authorization Policy* criteria.	See PA duration
Cerebrotendinous Xanthomatosis Agent	Ctexli	chenodiol tablets	See standard *Chenodiol Products Prior Authorization Policy* criteria	See PA duration
Chagas Disease Agents	Lampit	nifurtimox tablets	**1.** Approve if the patient has tried benznidazole, if formulary. If benznidazole is non-formulary, approve. **2.** Approve if the patient is less than 2 years of age. **3.** Approve if the patient has already started on therapy with Lampit.	1 year
Chelating Agents	Ferriprox oral solution	deferiprone oral solution	**1.** Approve if the patient has tried deferiprone tablets (Ferriprox tablets, generics), if formulary. If deferiprone tablets (Ferriprox tablets, generics) are non-formulary, approve. **2.** The dose prescribed cannot be attained with deferiprone tablets: approve. **3.** Patients who cannot swallow or have difficulty swallowing tablets: approve.	1 year
Chelating Agents	Ferriprox tablets two times per day blister pack	deferiprone tablets	**1.** Approve if the patient has tried deferiprone tablets (Ferriprox tablets, generics), if formulary. If deferiprone tablets (Ferriprox tablets, generics) are non-formulary, approve. **2.** The dose prescribed cannot be attained with deferiprone tablets: approve.	1 year
Chelating Agents	Chemet	succimer capsules	See standard *Chelating Agents – Chemet Prior Authorization* criteria	See PA duration
Chelating Agents	Exjade	deferasirox tablets for oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Chelating Agents	Jadenu	deferasirox tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Chelating Agents	Jadenu Sprinkles	deferasirox oral granules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Chelating Agents - Wilson's Disease	Cuprimine	penicillamine capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Chelating Agents - Wilson's Disease	trientine 500 mg capsules	trientine 500 mg capsules	Approve if the patient has tried generic trientine 250 mg capsules, if formulary. If generic trientine 250 mg capsules are non-formulary, approve if the patient meets one of the following: **1.** Approve if the patient has tried one penicillamine product: penicillamine (Cuprimine, generics) or penicillamine (Depen, generics), if one is formulary. If neither are formulary, approve. **2.** Approve if per the prescriber, the patient is intolerant to penicillamine or the patient has clinical features indicating the potential for intolerance to penicillamine (i.e., history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency). **3.** Approve if, per the prescriber, the patient has a contraindication to penicillamine. **4.** Approve if the patient has neurological manifestations of Wilson's Disease. **5.** Approve if the patient is pregnant. **6.** Approve if the patient has been started on therapy with a trientine product.	1 year
Chelating Agets - Wilson's Disease	Cuvrior	trientine tetrahydrochloride 300 mg tablets	Approve if the patient has tried trientine capsules (Syprine, generics), if formulary. If trientine capsules (Syprine, generics) are non-formulary, approve if the patient meets one of the following: **1.** Approve if the patient has tried one penicillamine product: penicillamine (Cuprimine, generics) or penicillamine (Depen, generics), if one is formulary. If neither are formulary, approve. **2.** Approve if per the prescriber, the patient is intolerant to penicillamine or the patient has clinical features indicating the potential for intolerance to penicillamine (i.e., history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency). **3.** Approve if, per the prescriber, the patient has a contraindication to penicillamine. **4.** Approve if the patient has neurological manifestations of Wilson's Disease. **5.** Approve if the patient is pregnant. **6.** Approve if the patient has been started on therapy with a trientine product or Cuvrior.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Chemo- protective Agents	Pedmark	sodium thiosulfate intravenous infusion	Ototoxicity Risk Reduction. Approve if the patient meets ALL of the following (1, 2, 3, 4, 5, and 6): **1**. Patient is ≥ 1 month of age; AND **2**. Patient is receiving cisplatin chemotherapy; AND **3**. Patient has a solid tumor; AND Note: Examples of solid tumors include medulloblastoma, osteosarcoma, germ cell tumor, neuroblastoma, hepatoblastoma, and anaplastic astrocytoma. **4**. Patient has localized, non-metastatic disease; AND **5**. Patient has a baseline serum sodium level ≤ 145 mmol/L; AND **6**. The medication is prescribed by or in consultation with an oncologist.	1 year
Citric acid and Sodium citrate Agents	Oracit	citric acid and sodium citrate solution	Approve if the patient has tried sodium citrate-citric acid solution.	1 year
Colchicine Agents	Lodoco	colchicine 0.5 mg tablets	Atherosclerotic Disease. Approve if the patient meets ALL of the following (1, 2, 3, and 4): **1.** Patient is ≥ 18 years of age; AND **2.** Lodoco is being added onto a background regimen(s) of other atherosclerotic disease medication(s) **[documentation required]**; AND Note: Examples of medications recommended in guideline-directed therapy for patients with atherosclerotic disease can include aspirin, antiplatelet agents (e.g., clopidogrel, ticagrelor), anticoagulants, lipid-lowering agents (e.g., statins such as atorvastatin and rosuvastatin), beta blockers, angiotensin-converting enzyme inhibitors, and/or angiotensin receptor blockers. **3**. Patient has tried colchicine 0.6 mg tablets or capsules **[documentation required]**.	1 year
Colony Stimulating Factor-1 Receptor-Blocking Antibody	Niktimvo	axatilimab-csfr intravenous infusion	Chronic Graft-Versus-Host Disease. **1.** Approve if the patient has tried at least TWO systemic medications for chronic graft-versus-host disease. Note: Examples of systemic therapy may include Jakafi (ruxolitinib tablets), Rezurock (belumosudil tablets), Imbruvica (ibrutinib tablets, capsules, and oral suspension), imatinib, hydroxychloroquine, methotrexate, rituximab, pentostatin, interleukin-2 (e.g., Proleukin [aldesleukin intravenous infusion]), methylprednisolone, cyclosporine, tacrolimus, sirolimus, etanercept products, and mycophenolate mofetil. **2.** Approve if the patient has already been started on therapy with Niktimvo.	1 year
Colony Stimulating Factors	Rolvedon	eflapegrastim-xnst subcutaneous injection	Cancer in a Patient ≥ 18 Years of Age Receiving Myelosuppressive Chemotherapy. Approve if the patient meets BOTH of the following (A and B): A. Patient has tried Ryzneuta, if formulary; AND B. Patient has tried one pegfilgrastim product **[documentation required]**. Note: Pegfilgrastim products include Neulasta, Fulphila, Fylnetra, Nyvepria, Udenyca, Stimufend, and Ziextenzo. Note: If neither Ryzneuta nor any pegfilgrastim products are formulary, approve. Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]) in a Patient ≥ 18 Years of Age: Approve.	1 year
Colony Stimulating Factors	Ryzneuta	efbemalenograstim alfa-vuxw subcutaneous injection	Cancer in a Patient ≥ 18 Years of Age Receiving Myelosuppressive Chemotherapy. Approve if the patient meets BOTH of the following (A and B): A. Patient has tried Rolvedon, if formulary; AND B. Patient has tried one pegfilgrastim product. Note: Pegfilgrastim products include Neulasta, Fulphila, Fylnetra, Nyvepria, Udenyca, Stimufend, and Ziextenzo. Note: If neither Rolvedon nor any pegfilgrastim products are formulary, approve. Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]) in a Patient ≥ 18 Years of Age: Approve.	1 year
Colony Stimulating Factors	Leukine	sargramostim injection (GM-CSF)	**1**. Approve if the patients has tried one of Neulasta, Fulphila, Flynetra, Nyvepria, Stimufend, Udenyca, Ziextenzo, Neupogen, Nivestym, Nypozi, Releuko, Zarxio, Filkri, or Granix, if formulary. If none are formulary, approve. **2.** Patients with neuroblastoma using Leukine in combination with a regimen that recommends administration in combination with a granulocyte-macrophage colony stimulating factor (GM-CSF), approve. Note: Examples of medications that are administered in combination with a GM-CSF include Unituxin (dinutuximab intravenous infusion), Danyelza (naxitamab intravenous injection). **3.** Patients who have been started on a course of therapy with Leukine: approve to complete the current course of therapy. **4.** Patients who require administration by intravenous (IV) infusion: approve if the patient has tried one of Neupogen, Nivestym, Nypozi, Releuko, Filkri, or Zarxio, if formulary. If none are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Colony Stimulating Factors - Filgrastim	Filkri	filgrastim-laha intravenous or subcutaneous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Nivestym, Neupogen, Granix, Releuko, or Zarxio; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets BOTH of the following (A and B): A. Patient has tried one of Nypozi, Nivestym, Neupogen, Releuko, or Zarxio, if formulary; AND Note: If none are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Filgrastim	Granix	tbo-filgrastim subcutaneous injection	**1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Releuko, Neupogen, Nivestym, Filkri, or Zarxio **[documentation required]**; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients requiring a dose < 180 mcg: approve if the patient meets the following (A and B): A. Patient has tried one of Neupogen or Nivestym **[documentation required]**, if formulary; AND Note: If neither are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Filgrastim	Neupogen	filgrastim intravenous or subcutaneous injection	**1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Releuko, Zarxio, Nivestym, Filkri, or Granix **[documentation required]**; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets the following (A and B): A. Patient has tried one of Nypozi, Releuko, Zarxio, Filkri, or Nivestym **[documentation required]**, if formulary; AND Note: If none are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If Nivestym is non-formulary and the patient requires a dose of < 180 mcg, approve. **3.** Patients requiring a dose < 180 mcg: approve if the patient meets the following (A and B): A. Patient has tried one of Nivestym or Granix **[documentation required]**; AND Note: If neither are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If the only formulary alternative is Granix and the patient requires intravenous administration, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Colony Stimulating Factors - Filgrastim	Nivestym	filgrastim-aafi subcutaneous or intravenous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four of the following products, if formulary (or three if three are formulary, two if two are formulary, or one if one is formulary): Nypozi, Releuko, Neupogen, Granix, Filkri, or Zarxio; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets BOTH of the following (A and B): A. Patient has tried one of Nypozi, Releuko, Neupogen, Filkri, or Zarxio, if formulary; AND Note: If none are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If Neupogen is non-formulary and the patient requires a dose of < 180 mcg, approve. **3.** Patients requiring a dose of < 180 mcg: approve if the patient has meets the following (A and B): A. Patient has tried one of Neupogen or Granix, if formulary; AND Note: If neither are formulary, approve. B. Patient continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If the only formulary alternative is Granix and the patient requires intravenous administration, approve.	1 year
Colony Stimulating Factors - Filgrastim	Nypozi	filgrastim-txid subcutaneous or intravenous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (A and B): a. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Neupogen, Releuko, Zarxio, Nivestym, Filkri, or Granix **[documentation required]**; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets the following (A and B): A. Patient has tried one of Neupogen, Releuko, Zarxio, Filkri, or Nivestym **[documentation required]**, if formulary; AND Note: If none are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Filgrastim	Releuko	filgrastim-ayow subcutaneous or intravenous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Nivestym, Neupogen, Granix, Filkri, or Zarxio **[documentation required]**; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets BOTH of the following (A and B): A. Patient has tried one of Nypozi, Nivestym, Neupogen, Filkri, or Zarxio **[documentation required]**, if formulary; AND Note: If none are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Colony Stimulating Factors - Filgrastim	Zarxio	filgrastim-sndz subcutaneous or intravenous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (A and B): A. The patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Releuko, Neupogen, Nivestym, Filkri, or Granix **[documentation required]**; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient has meets the following (A and B): A. Patient has tried one of Nypozi, Releuko, Neupogen, Filkri, or Nivestym **[documentation required]**, if formulary; AND Note: If none are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Pegfilgrastim	Fulphila	pegfilgrastim-jmdb subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Udenyca, Ziextenzo, Nyvepria, Fylnetra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Pegfilgrastim	Fylnetra	pegfilgrastim-pbbk subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if there are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Udenyca, Ziextenzo, Nyvepria, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Pegfilgrastim	Neulasta	pegfilgrastim subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Fulphila, Udenyca, Ziextenzo, Nyvepria, Fylnetra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Pegfilgrastim	Nyvepria	pegfilgrastim-apgf subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Udenyca, Ziextenzo, Fylnetra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Pegfilgrastim	Stimufend	pegfilgrastim-fpgk	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Nyvepria, Fulphila, Udenyca, Ziextenzo, or Fylnetra **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Pegfilgrastim	Udenyca	pegfilgrastim-cbqv subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Ziextenzo, Nyvepria, Fylnetra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Colony Stimulating Factors - Pegfilgrastim	Ziextenzo	pegfilgrastim- bmez subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Udenyca, Fulphila, Neulasta, Nyvepria, Fyletra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Complement Factor D inhibitor	Voydeya	danicopan tablets	Paroxysmal nocturnal hemoglobinuria in a patient ≥ 18 years of age. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Empaveli or Fabhalta, if formulary. If neither are formulary, criterion A is considered as met; AND B. Patient will be receiving Voydeya in combination with an eculizumab product (Soliris, Bkemv, Epysqli) or Ultomiris; OR **2.** Patient meets BOTH of the following (A and B): A. Patient has already started on therapy with Voydeya; AND B. Patient is receiving Voydeya in combination with an eculizumab product (Soliris, Bkemv, Epysqli) or Ultomiris.	1 year
Complement Inhibitor – CHAPLE disease	Veopoz	pozelimab-bbfg intravenous infusion and subcutaneous injection	See standard *Complement Inhibitors - Veopoz Prior Authorization Policy* criteria.	See PA duration
Complement Inhibitors	Enjaymo	sutimlimab-jome intravenous infusion	See standard *Hematology – Enjaymo Prior Authorization Policy* criteria	See PA duration
Complement Inhibitors	Ultomiris	ravulizumab-cwvz injection for intravenous use	**1.** Paroxysmal nocturnal hemoglobinuria: Approve if the patient meets one of the following (A, B, C, or D): A. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of 1) an eculizumab product (Soliris, Bkemv, Epysqli) or 2) PiaSky, if formulary. If neither are formulary, approve; OR Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli). B. Patient is < 18 years of age and meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with PiaSky, if formulary. If PiaSky is non-formulary, approve; OR ii. Patient weighs < 40 kg; OR C. Patient is < 13 years of age; OR D. Patient has already been started on therapy with Ultomiris. **2.** Atypical hemolytic uremic syndrome: approve. **3.** Anti-acetylcholine receptor antibody positive generalized myasthenia gravis in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. Patient meets BOTH of the following (i and ii): i. Patient has tried, and according to the prescriber, experienced an inadequate efficacy or significant intolerance with ONE of 1) an eculizumab product (Soliris, Bkemv, Epysqli) or 2) Zilbrysq, if formulary; AND Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli). Note: If neither are formulary, would still need to meet criterion ii. ii. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of the following: Imaavy, Vyvgart intravenous, Vyvgart Hytrulo, Rystiggo, or Uplizna, if formulary. Note: If none are formulary, would still need to meet criterion i. Note: If there are no formulary alternatives from criterion i or ii, approve. B. Patient has already been started on therapy with Ultomiris. **4.** Anti-aquaporin (AQ4P) antibody-positive Neuromyelitis optica spectrum disorder in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. The patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance to BOTH Uplizna and Enspryng, if formulary. If one is formulary, would need to try one or if neither are formulary, approve; OR B. The patient has already been started on therapy with Ultomiris.	1 year
Complement Inhibitors	PiaSky	crovalimab-akkz intravenous infusion and subcutaneous injection	Paroxysmal nocturnal hemoglobinuria in a patient ≥ 13 years of age. **1.** Approve if the patient has tried ONE of 1) an eculizumab product (Soliris, Bkemv, Epysqli) or 2) Ultomiris, if formulary. If neither are formulary, approve. Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli). **2.** Patient < 18 years of age, approve if the patient has tried Ultomiris, if formulary. If Ultomiris is non-formulary, approve. **3.** Patient is unable to maintain intravenous access, approve. 4. Patient has already been started on therapy with PiaSky, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Complement Inhibitors	Empaveli	pegcetacoplan subcutaneous infusion	Paroxysmal nocturnal hemoglobinuria in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Fabhalta, if formulary. If Fabhalta is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Empaveli. Complement 3 Glomerulopathy in a patient ≥ 12 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Fabhalta, if formulary. If Fabhalta is non-formulary, approve. **2.** Patient is ≥ 12 years of age and < 18 years of age, approve. **3.** Patient has had a transplant, approve. **4.** If, according to the prescriber the patient has severe nephrotic-range proteinuria OR a rapidly declining estimated glomerular filtration rate, approve. **5.** Approve if the patient has already been started on therapy with Empaveli. Primary Immune-Complex Membranoproliferative Glomerulonephritis in a patient ≥ 12 years of age, approve.	1 year
Complement Inhibitors	Fabhalta	Iptacopan capsules	Paroxysmal nocturnal hemoglobinuria in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Empaveli, if formulary. If Empaveli is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Fabhalta. Primary Immunoglobulin A Nephropathy in a patient ≥ 18 years of age. **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Filspari, if formulary; OR Note: If Filspari is non-formulary, criterion A is met. ii. Patient is pregnant or planning to become pregnant; OR iii. Patient has hepatic impairment OR, according to the prescriber, is at risk of hepatic impairment; AND B. Patient meets ONE of the following (i or ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of Vanrafia or Voyxact, if formulary; OR Note: If neither are formulary, criterion B is met. ii. Patient is pregnant or planning to become pregnant, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Voyxact, if formulary; OR Note: If Voyxact is non-formulary, criterion B is met. **2.** Approve if the patient has already been started on therapy with Fabhalta. Complement 3 Glomerulopathy in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Empaveli, if formulary. If Empaveli is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Fabhalta.	1 year
Complement Inhibitors - Complement C5 inhibitor	Zilbrysq	zilucoplan subcutaneous injection	Anti-acetylcholine receptor antibody positive generalized myasthenia gravis in a patient ≥ 18 years of age. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with ONE of 1) an eculizumab product (Soliris, Bkemv, Epysqli) or 2) Ultomiris, if formulary; OR Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli). ii. Patient is unable to obtain intravenous access; AND Note: If neither are formulary, would still need to meet criterion B. B. Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of Imaavy, Vyvgart intravenous, Vyvgart Hytrulo, Rystiggo, or Uplizna, if formulary; OR a. Patient is unable to obtain intravenous access, patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of Vyvgart Hytrulo or Rystiggo, if formulary; OR Note: If none are formulary, would still need to meet criterion A. Note: If there are no formulary alternatives from criterion A or B, approve. **2.** Approve if the patient has already been started on therapy with Zilbrysq.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Complement Inhibitors – Eculizumab Products	Bkemv	eculizumab-aeeb intravenous infusion	If either Soliris or Epysqli are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried both of Soliris and Epysqli, if formulary; AND B. Patient cannot continue to use all the formulary eculizumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If neither Soliris nor Epysqli are formulary: Approve if the patient meets ONE of the following (1, 2, 3, or 4): **1.** Atypical hemolytic uremic syndrome: Approve. **2.** Anti-acetylcholine receptor antibody positive generalized myasthenia gravis in a patient ≥ 6 years of age. Approve if the patient meets one of the following (A, B, or C): A. Patient meets ONE of the following (i or ii): i. Patient is ≥ 12 years of age and < 18 years of age, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Imaavy, if formulary. If Imaavy is non-formulary, approve; OR ii. Patient is ≥ 6 years of age and < 12 years of age; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Ultomiris or Zilbrysq, if formulary; AND Note: If neither are formulary, would still need to meet criterion ii. ii. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Imaavy, Vyvgart intravenous, Vyvgart Hytrulo, Rystiggo, or Uplizna, if formulary; OR Note: If none are formulary, would still need to meet criterion i. Note: If there are no formulary alternatives from criterion i or ii, approve. C. Patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli). **3.** Paroxysmal nocturnal hemoglobinuria in a patient ≥ 18 years of age: Approve if the patient meets one of the following (A or B): A. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Ultomiris IV or PiaSky, if formulary. If neither are formulary, approve; OR B. Patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli). **4.** Anti-aquaporin (AQ4P) antibody-positive Neuromyelitis optica spectrum disorder in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. The patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance to BOTH Uplizna and Enspryng, if formulary (or one if one is formulary). If neither are formulary, approve; OR B. The patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli).	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Complement Inhibitors – Eculizumab Products	Epysqli	eculizumab-aagh intravenous infusion	If either Soliris or Bkemv are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried both of Soliris and Bkemv, if formulary; AND B. Patient cannot continue to use all the formulary eculizumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If neither Soliris nor Bkemv are formulary: Approve if the patient meets ONE of the following (1, 2, 3, or 4): **1.** Atypical hemolytic uremic syndrome: Approve. **2.** Anti-acetylcholine receptor antibody positive generalized myasthenia gravis in a patient ≥ 6 years of age. Approve if the patient meets one of the following (A, B, or C): A. Patient meets ONE of the following (i or ii): i. Patient is ≥ 12 years of age and < 18 years of age, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Imaavy, if formulary. If Imaavy is non-formulary, approve; OR ii. Patient is ≥ 6 years of age and < 12 years of age; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Ultomiris or Zilbrysq, if formulary; AND Note: If neither are formulary, would still need to meet criterion ii. ii. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Imaavy, Vyvgart intravenous, Vyvgart Hytrulo, Rystiggo, or Uplizna, if formulary; OR Note: If none are formulary, would still need to meet criterion i. Note: If there are no formulary alternatives from criterion i or ii, approve. C. Patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli). **3.** Paroxysmal nocturnal hemoglobinuria in a patient ≥ 18 years of age: Approve if the patient meets one of the following (A or B): A. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Ultomiris IV or PiaSky, if formulary. If neither are formulary, approve; OR B. Patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli). **4.** Anti-aquaporin (AQ4P) antibody-positive Neuromyelitis optica spectrum disorder in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. The patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance to BOTH Uplizna and Enspryng, if formulary (or one if one is formulary). If neither are formulary, approve; OR B. The patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli).	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Complement Inhibitors – Eculizumab Products	Soliris	eculizumab concentrated solution for intravenous infusion	If either Bkemv or Epysqli are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried both of Bkemv and Epysqli, if formulary; AND B. Patient cannot continue to use all the formulary eculizumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If neither Bkemv nor Epysqli are formulary: Approve if the patient meets ONE of the following (1, 2, 3, or 4): **1.** Atypical hemolytic uremic syndrome: Approve. **2.** Anti-acetylcholine receptor antibody positive generalized myasthenia gravis in a patient ≥ 6 years of age. Approve if the patient meets one of the following (A, B, or C): A. Patient meets ONE of the following (i or ii): i. Patient is ≥ 12 years of age and < 18 years of age, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Imaavy, if formulary. If Imaavy is non-formulary, approve; OR ii. Patient is ≥ 6 years of age and < 12 years of age; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Ultomiris or Zilbrysq, if formulary; AND Note: If neither are formulary, would still need to meet criterion ii. ii. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Imaavy, Vyvgart intravenous, Vyvgart Hytrulo, Rystiggo, or Uplizna, if formulary; OR Note: If none are formulary, would still need to meet criterion i. Note: If there are no formulary alternatives from criterion i or ii, approve. C. Patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli). **3.** Paroxysmal nocturnal hemoglobinuria in a patient ≥ 18 years of age: Approve if the patient meets one of the following (A or B): A. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Ultomiris IV or PiaSky, if formulary. If neither are formulary, approve; OR B. Patient has already been started on therapy with an eculizumab product (Soliris, Bkemv, Epysqli). **4.** Anti-aquaporin (AQ4P) antibody-positive Neuromyelitis optica spectrum disorder in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. The patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance to BOTH Uplizna and Enspryng, if formulary (or one if one is formulary). If neither are formulary, approve; OR B. The patient has already been started on therapy with an eclulizumab product (Soliris, Bkemv, Epysqli).	1 year
Constipation Agents	Movantik	naloxegol tablets	Approve if the patient has tried two products from the following list: Amitiza (lubiprostone), Symproic, or Relistor tablets, if two are formulary or one if one is formulary. If none are formulary, approve if the patient has tried two laxative agents (e.g., bisacodyl-containing products, senna-containing products, milk of magnesia, lactulose).	1 year
Constipation Agents	Relistor	methylnaltrexone bromide tablets	Approve if the patient has tried two products from the following list **[documentation required]**: Movantik, Symproic, or Amitiza (lubiprostone), if two are formulary or one if one is formulary. If none are formulary, approve if the patient has tried two laxative agents (e.g., bisacodyl-containing products, senna-containing products, milk of magnesia, lactulose).	1 year
Constipation Agents	Relistor injection (SC)	methylnaltrexone bromide inj	**1.** Approve if the patient has tried two products from the following list: Movantik, Symproic, Amitiza (lubiprostone), or Relistor tablets, if two are formulary or one if one is formulary. If none are formulary, approve if patient has tried two laxative agents (e.g., bisacodyl-containing products, senna-containing products, milk of magnesia, lactulose). **2.** Opioid-induced constipation in patients with advanced illness: Approve if the patient has tried two laxative agents (e.g., bisacodyl-containing products, senna-containing products, milk of magnesia, lactulose).	1 year
Constipation Agents	Symproic	naldemedine tablets	Approve if the patient has tried two products from the following list: Relistor tablets, Movantik, or Amitiza (lubiprostone), if two are formulary or one if one is formulary. If none are formulary, approve if the patient has tried two laxative agents (e.g., bisacodyl-containing products, senna-containing products, milk of magnesia, lactulose).	1 year
Constipation Agents – Chronic Idiopathic Constipation Agents	Motegrity and prucalopride tablets	prucalopride tablets	If requesting brand Motegrity in a patient ≥ 18 years of age. Approve if the patient has tried and cannot take generic prucalopride tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic prucalopride tablets or generic prucalopride tablets are non-formulary in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least one of Linzess or Trulance **[documentation required]**, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with prucalopride or Motegrity.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Constipation Agents – Chronic Idiopathic Constipation Agents/Irritable Bowel Syndrome	Linzess	linaclotide capsules	Patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least one of Trulance or prucalopride (Motegrity, generics), if formulary. If neither are formulary, approve. **2.** Patient with pre-existing depression or a history of suicidal ideation, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Trulance, if formulary. If Trulance is non-formulary, approve. **3.** If, according to the prescriber, the patient has severe renal impairment, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Trulance, if formulary. If Trulance is non-formulary, approve. **4.** Approve if the patient has already been started on therapy with Linzess. Patient ≥ 2 years of age and < 18 years of age with functional constipation, approve. Irritable Bowel Syndrome with Constipation. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Trulance, if formulary. If Trulance is non-formulary, approve. **2.** Patient ≥ 7 years of age and < 18 years of age, approve. **3.** Approve if the patient has already been started on therapy with Linzess.	1 year
Constipation Agents – Chronic Idiopathic Constipation Agents/Irritable Bowel Syndrome	Trulance	plecanatide tablets	Patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least one of Linzess or prucalopride (Motegrity, generics), if formulary. If neither are formulary, approve. **2.** Patient with pre-existing depression or a history of suicidal ideation, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Linzess, if formulary. If Linzess is non-formulary, approve. **3.** If, according to the prescriber, the patient has severe renal impairment, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Linzess, if formulary. If Linzess is non-formulary, approve. **4.** Approve if the patient has already been started on therapy with Trulance. Irritable Bowel Syndrome with Constipation in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Linzess, if formulary. If Linzess is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Trulance.	1 year
Constipation Agents – Chronic Idiopathic Constipation Agents/Irritable Bowel Syndrome	Amitiza	lubiprostone capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Constipation Agents – Irritable Bowel Syndrome	Ibsrela	tenapanor tablets	Patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least one of Linzess or Trulance, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Ibsrela.	1 year
Contraceptive - Progestin Drugs	Depo-SubQ Provera 104	medroxyprogesterone acetate injectable suspension 104 mg	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried medroxyprogesterone acetate 150 mg injectable suspension (Depo-Provera, generic), if formulary. If non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The patient has tried medroxyprogesterone acetate 150 mg injectable suspension (Depo-Provera, generic), if formulary. If non-formulary, approve; OR ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, the alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives	Contraceptives (without drug specific criteria)	Any Contraceptive (without drug specific criteria)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, other formulary contraceptives would not be as medically appropriate for the patient as the requested non-formulary drug. Note: This criteria is only applicable when compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Contraceptives	ella	ulipristal acetate tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried one over-the-counter (OTC) emergency contraceptive: product (e.g., Plan B One Step, Econtra EZ, Econtra One Step, Levonorgestrel Emergency Contraceptive, My Choice, My Way, New Day, Take Action, Aftera, Option 2, Opcicon One-Step, After Pill); OR ii. Patient requests emergency contraception > 72 hours since unprotected intercourse. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i, ii, or iii): i. Patient has tried one over-the-counter (OTC) emergency contraceptive: product (e.g., Plan B One Step, Econtra EZ, Econtra One Step, Levonorgestrel Emergency Contraceptive, My Choice, My Way, New Day, Take Action, Aftera, Option 2, Opcicon One-Step, After Pill); OR ii. Patient requests emergency contraception > 72 hours since unprotected intercourse; OR iii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other over-the-counter (OTC) emergency contraceptive products would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives	NuvaRing	etonogestrel/ethinyl estradiol vaginal ring	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN for the prevention of pregnancy or for the improvement of birth outcomes AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Contraceptives	Annovera	segesterone acetate and ethinyl estradiol vaginal system	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried three other contraceptive agents (e.g., oral contraceptives tablets, Twirla [contraceptive patch], Xulane [contraceptive patch], Eluryng [contraceptive vaginal ring], etonogestrel-ethinyl estradiol ring [contracetive vaginal ring], NuvaRing [contraceptive vaginal ring]). Note: Examples include, but may not be limited to, drospirenone-ethinyl estradiol, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Junel Fe, Sprintec, Tri-Sprintec, Xulane. Note: A trial of the three different oral contraceptive agents would meet the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried three other contraceptive agents (e.g., oral contraceptives tablets, Twirla [contraceptive patch], Xulane [contraceptive patch], Eluryng [contraceptive vaginal ring], etonogestrel-ethinyl estradiol ring [contracetive vaginal ring], NuvaRing [contraceptive vaginal ring]); OR Note: Examples include, but may not be limited to, drospirenone-ethinyl estradiol, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Junel Fe, Sprintec, Tri-Sprintec, Xulane. Note: A trial of the three different oral contraceptive agents would meet the requirement. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Contraceptives	Phexx	L-lactic acid, citric acid, and potassium bitartrate vaginal gel	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried or is unable to tolerate THREE other barrier methods of contraception, such as diaphragms, condoms, spermicides (over-the-counter), or sponges. Note: Examples include, but may not be limited to, Caya contoured diaphragm, condom, FC2 Female Condom, FemCap, Gynol II contraceptive gel, VCF contraceptive gel. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following (i or ii): i. Patient has tried or is unable to tolerate THREE other barrier methods of contraception, such as diaphragms, condoms, spermicides (over-the-counter), or sponges; OR Note: Examples include, but may not be limited to, Caya contoured diaphragm, condom, FC2 Female Condom, FemCap, Gynol II contraceptive gel, VCF contraceptive gel. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other barrier methods of contraception would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives	Twirla	levonorgestrel and ethinyl estradiol transdermal system	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried five other contraceptive agents (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]). Note: Examples include, but may not be limited to, Blisovi Fe, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Hailey Fe, Junel Fe, Larin Fe, Xulane. Note: A trial of five different oral contraceptive agents would meet the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following (i or ii): i. The patient has tried five other contraceptive agents (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]); OR Note: Examples include, but may not be limited to, Blisovi Fe, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Hailey Fe, Junel Fe, Larin Fe, Xulane. Note: A trial of five different oral contraceptive agents would meet the requirement. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Intrauterine devices (IUDs) - Copper	Miudella	copper intrauterine system	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried Paragard, if formulary. If Paragard is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Approve if the patient has tried Paragard, if formulary. If Paragard is non-formulary, approve; OR ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, these alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Oral	Averi	desogestrel 0.15 mg; ethinyl estradiol 0.03 mg; ferrous bis-glycinate chelate tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Apri, Cyred eq, Enskyce, Isibloom, Juleber, Kalliga, Reclipsen. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Apri, Cyred eq, Enskyce, Isibloom, Juleber, Kalliga, Reclipsen. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Contraceptives – Oral	Balcoltra	ethinyl estradiol 0.02 mg; levonorgestrel 0.1 mg; ferrous bisglycinate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN for the prevention of pregnancy or for the improvement of birth outcomes AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Contraceptives – Oral	Loestrin and Loestrin FE	ethinyl estradiol/norethindrone and ferrous fumarate tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN for the prevention of pregnancy or for the improvement of birth outcomes AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Contraceptives – Oral	Safyral	drospirenone/ethinyl estradiol-levomefolate tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN for the prevention of pregnancy or for the improvement of birth outcomes AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Contraceptives – Oral	Taytulla	norethindrone and ethinyl estradiol and ferrous fumarate capsules	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN for the prevention of pregnancy or for the improvement of birth outcomes AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Contraceptives – Oral	Yasmin	ethinyl estradiol/ drospirenone tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN for the prevention of pregnancy or for the improvement of birth outcomes AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Contraceptives – Oral	Femlyv	norethindrone acetate and ethinyl estradiol orally disintegrating tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Charlotte 24 Fe, Finzala, Kaitlib Fe, Layolis Fe, Mibelas 24 Fe, norethindrone-ethinyl estradiol, Wymzya Fe. **2.** If the patient is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried one oral chewable birth control product (e.g., Finzala, Mibelas, Charlotte, Wymzya, Kaitlib, Layolis). OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Charlotte 24 Fe, Finzala, Kaitlib Fe, Layolis Fe, Mibelas 24 Fe, norethindrone-ethinyl estradiol, Wymzya Fe. **2.** If the patient is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried one oral chewable birth control product (e.g., Finzala, Mibelas, Charlotte, Wymzya, Kaitlib, Layolis). **3.** The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Oral	Lo Loestrin FE	ethinyl estradiol 0.01 mg; norethindrone acetate 1 mg; ferrous fumarate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried two other oral contraceptive agents. Note: Examples include, but may not be limited to, Hailey Fe, Junel Fe, Larin Fe, Mibelas 24 Fe, Microgestin Fe, norethindrone-ethinyl estradiol-iron. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried two other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Hailey Fe, Junel Fe, Larin Fe, Mibelas 24 Fe, Microgestin Fe, norethindrone-ethinyl estradiol-iron. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Contraceptives – Oral	Natazia	dienogest; estradiol valerate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Oral	Nextstellis	estetrol and drospirenone tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Oral	Oral Contraceptives (without drug specific criteria)	Any Oral Contraceptive (without drug specific criteria)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples of combination oral contraceptives include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. Note: Examples of progestin-only oral contraceptives include, but may not be limited to, Camila, Deblitane, Errin, Heather, norethindrone acetate, Norlyda, Sharobel. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND the patient meets one of the following (a or b): a. Patient has tried four other oral contraceptive agents; OR Note: Examples of combination oral contraceptives include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. Note: Examples of progestin-only oral contraceptives include, but may not be limited to, Camila, Deblitane, Errin, Heather, norethindrone acetate, Norlyda, Sharobel. b. According to the prescriber, these alternatives would not be as medically appropriate for the patient as the requested non-formulary drug; OR ii. The requested non-formulary drug is being prescribed for a use OTHER THAN for the prevention of pregnancy or for the improvement of birth outcomes AND the patient has tried four other oral contraceptive agents. Note: Examples of combination oral contraceptives include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. Note: Examples of progestin-only oral contraceptives include, but may not be limited to, Camila, Deblitane, Errin, Heather, norethindrone acetate, Norlyda, Sharobel.	1 year
Contraceptives – Oral	Tyblume	levonorgestrel 0.1 mg and ethinyl estradiol 0.02 mg tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Altavera, Aviane, Falmina, Lessina, levonorgestrel-ethinyl estradiol, Portia, Vienva. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Altavera, Aviane, Falmina, Lessina, levonorgestrel-ethinyl estradiol, Portia, Vienva. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Contraceptives – Oral	Slynd	drospirenone tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried one progesterone-only contraceptive containing norethindrone. Note: Examples of progesterone-only contraceptives containing norethindrone include Camila, Deblitane, Emzahh, Errin, Nora-BE, norethindrone, Heather, Jencycla, Lyza, Sharobel, Tulana, Lyleq, Incassia. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried one progesterone-only contraceptive containing norethindrone; OR Note: Examples of progesterone-only contraceptives containing norethindrone include Camila, Deblitane, Emzahh, Errin, Nora-BE, norethindrone, Heather, Jencycla, Lyza, Sharobel, Tulana, Lyleq, Incassia. ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND other progesterone-only contraceptives containing norethindrone would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Progestin Drugs (intrauterine devices [IUDs])	Kyleena	levonorgestrel-releasing intrauterine system 19.5 mg	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient meets one of the following criteria (i or ii): i. Approve if the patient has tried one of Liletta, Mirena, or Skyla, if one is formulary. If none are formulary, approve; OR ii. If the prescriber indicates that at least a 5-year duration of therapy is needed: approve if the patient has tried one of Mirena or Liletta, if formulary. If neither are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i, ii or iii): i. Approve if the patient has tried Liletta, Mirena, or Skyla, if one is formulary. If none are formulary, approve; OR ii. If the prescriber indicates that at least a 5-year duration of therapy is needed: approve if the patient has tried Mirena or Liletta, if formulary. If neither are formulary, approve; OR iii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, these alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Progestin Drugs (intrauterine devices [IUDs])	Liletta	levonorgestrel-releasing intrauterine system 52 mg	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried Mirena, if formulary. If Mirena is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Approve if the patient has tried Mirena, if formulary. If Mirena is non-formulary, approve; OR ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, these alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Progestin Drugs (intrauterine devices [IUDs])	Mirena	levonorgestrel-releasing intrauterine system 52 mg	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried Liletta, if formulary. If Liletta is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Approve if the patient has tried Liletta, if formulary. If Liletta is non-formulary, approve; OR ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, these alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Contraceptives – Progestin Drugs (intrauterine devices [IUDs])	Skyla	levonorgestrel-releasing intrauterine system 13.5 mg	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried one of Kyleena, Liletta, or Mirena if one is formulary. If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Approve if the patient has tried one of Kyleena, Liletta, or Mirena if one is formulary. If none are formulary, approve; OR ii. The requested non-formulary drug is being prescribed for the prevention of pregnancy or for the improvement of birth outcomes AND, according to the prescriber, these alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Coronavirus Disease	Lagevrio (molnupiravir)	molnupiravir capsules	**1.** Approve if the patient has tried Paxlovid, if formulary. If Paxlovid is non-formulary, approve. **2.** Approve if there are any availability issues obtaining Paxlovid. **3.** If the prescriber has determined that Paxlovid is not clinically appropriate for the patient (e.g., due to drug-drug interaction with ritonavir), approve. **4.** Approve if alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate. **5.** Patient who has already started on therapy with molnupiravir, approve to complete the course of therapy.	1 month
Coronavirus Disease	Veklury	remdesivir intravenous infusion	See standard *Coronavirus Disease - Veklury Prior Authorization Policy* criteria.	See PA duration
Coronavirus Disease	Evusheld	tixagevimab intramuscular injection and cilgavimab intramuscular injection	See standard *Coronavirus Disease – Evusheld Prior Authorization Policy* criteria.	See PA duration
Coronavirus Disease	Xocova	ensitrelvir tablets	For post-exposure prophylaxis of coronavirus disease 2019 (COVID 19): Approve.	1 month
Corticosteroid (oral) - Eosinophilic Esophagitis Agent	Eohilia	budesonide oral suspension	Patient meets *Gastroenterology – Eohilia Prior Authorization Policy* AND Patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). **2.** Approve if the patient has already been started on a 12-week course of therapy with Eohilia (to allow for completion of up to a 12-week course of therapy).	12 weeks
Corticosteroids (Intra-articular)	Zilretta	triamcinolone acetonide extended-release injectable suspension, for intra-articular use	Approve if the patient has tried triamcinolone immediate-release injection, if formulary. If triamcinolone immediate-release injection is non-formulary, approve.	1 year
Corticosteroids (Oral)	Alkindi Sprinkle	hydrocortisone oral granules	**1.** Approve if the patient has tried and cannot take hydrocortisone tablets. **2.** Approve if the patient cannot swallow or has difficulty swallowing hydrocortisone tablets. **3.** Approve if the prescribed dose cannot be obtained using whole hydrocortisone tablets.	1 year
Corticosteroids (Oral)	Khindivi	hydrocortisone oral solution	**1.** Approve if the patient has tried and cannot take one of the following: hydrocortisone tablets or Alkindi Sprinkle. If neither are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing hydrocortisone tablets, approve if the patient has tried Alkindi Sprinkle, if formulary. If Alkindi Sprinkle is non-formulary, approve. **3.** If the patient has a nasogastric or gastric tube, approve. **4.** Approve if the prescribed dose cannot be obtained using whole hydrocortisone tablets.	1 year
Corticosteroids (Oral)	Hemady	dexamethasone 20 mg tablets	Approve if the patient has tried generic dexamethasone tablets, if formulary. If dexamethasone tablets are non-formulary, approve.	1 year
Corticosteroids (Oral)	Dexabliss 11- Day Dose Pack	dexamethasone 1.5 mg tablets (11-day dose pack)	**1.** Direct to the dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs).	14 days
Corticosteroids (Oral)	Taperdex	dexamethasone 1.5 mg tablets (6 day and 12 day dose packs)	**1.** Direct tothe dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs).	14 days
Corticosteroids (Oral)	Zcort	dexamethasone 1.5 mg tablets (7-day pack)	**1.** Direct to the dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs).	14 days
Corticosteroids (Oral)	DexPak 6 day/10 day/13 day and generics	dexamethasone 1.5 mg tablets (6 day, 10 day, and 13 day dose pack)	**1.** Direct to the dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs).	14 days
Corticosteroids (Oral)	Zodex 6 day/12 day and generics	dexamethasone 1.5 mg tablets (6 day and 12 day dose pack)	**1.** Direct to the dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs).	14 days
Corticosteroids (Oral)	Dexlyt	dexamethasone 0.25 mg tablets	Approve if the patient has tried generic dexamethasone tablets, if formulary. If dexamethasone tablets are non-formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Corticosteroids (Rectal Formulations)	Micort HC 2.5 % rectal cream	hydrocortisone 2.5 % rectal cream	Approve if the patient is unable to use generic hydrocortisone 2.5% rectal cream.	1 year
Corticosteroids (Rectal Formulations)	Anusol-HC suppository	hydrocortisone acetate suppository	Approve if the patient has tried hydrocortisone acetate suppositories. If hydrocortisone acetate suppositories are non-formulary, approve.	1 year
Corticosteroids (Rectal Formulations)	Hydrocortisone-pramoxine suppository	hydrocortisone-pramoxine suppository 25-18 mg	Approve if the patient has tried one of 1) hydrocortisone acetate suppositories or 2) a rectal topical product containing hydrocortisone and pramoxine (e.g., topical foam, topical cream).	1 year
Corticosteroids (Rectal Formulations)	Proctofoam-HC	pramoxine hydrochloride hydrocortisone acetate aerosol, foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with pramoxine-hydrocortisone cream.	1 year
Corticosteroids (Rectal Formulations)	Cortifoam	hydrocortisone acetate aerosol foam	**1.** Approve if the patient has tried budesonide foam (Uceris foam, generics), if formulary. If budesonide foam (Uceris foam, generics) are non-formulary, approve if the patient has tried one corticosteroid enema from the following list (if one is formulary): Cortenema or hydrocortisone enema. If neither are formulary, approve. **2.** Patients who are unable to retain a corticosteroid enema: approve if the patient has tried budesonide foam (Uceris foam, generics), if formulary. If budesonide foam (Uceris foam, generics) are non-formulary, approve.	1 year
Corticosteroids (Topical)	Impoyz (and authorized generic)	clobetasol propionate cream, 0.025%	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide, diflorasone. NOTE: The products must be chemically unique.	1 year
Corticosteroids (Topical)	Sernivo spray	betamethasone dipropionate spray 0.05%	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide. NOTE: The five products must be chemically unique.	1 year
Corticosteroids (Topical)	Verdeso	desonide foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desonide, alclometasone dipropionate, betamethasone valerate, fluocinolone acetonide, triamcinolone, flurandrenolide, hydrocortisone butyrate. **NOTE**: The five products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).	1 year
Corticosteroids (Topical)	clocortolone 0.1% cream pump; clocortolone pivalate 0.1% cream	clocortolone pivalate 0.1% cream	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: betamethasone, fluocinolone acetonide, hydrocortisone valerate, mometasone, triamcinolone acetonide.	1 year
Corticosteroids (Topical)	diflorasone 0.05% ointment and 0.05% cream; Apexicon E 0.05% cream	diflorasone 0.05% ointment and 0.05% cream	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: betamethasone, triamcinolone, fluocinolone, clobetasol, fluocinonide, amcinonide, mometasone furoate, fluticasone.	1 year
Corticosteroids (Topical)	flurandrenolide 0.05% cream; flurandrenolide 0.05% ointment; flurandrenolide 0.05% lotion	flurandrenolide 0.05% cream; flurandrenolide 0.05% ointment; flurandrenolide 0.05% lotion	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: betamethasone, desoximetasone, triamcinolone, fluocinolone, mometasone, fluticasone.	1 year
Corticosteroids (Topical)	halcinonide 0.1% cream; halcinonide 0.1% solution	halcinonide 0.1% cream; halcinonide 0.1% solution	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: betamethasone, clobetasol, fluocinonide, amcinonide, desoximetasone, mometasone furoate.	1 year
Corticosteroids (Topical)	Anusol-HC cream	hydrocortisone acetate cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Corticosteroids (Topical)	Topicort spray	desoximetasone spray	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Corticosteroids (Topical)	Vanos	fluocinonide 0.1% cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Corticotropin-Releasing Factor (CRF) Type 1 Receptor Antagonist	Crenessity	crinecerfont capsules and oral solution	See standard *Adrenal Hyperplasia – Crenessity Prior Authorization Policy* criteria.	See PA duration
Cushing's - Cortisol Synthesis Inhibitor	Isturisa	osilodrostat tablets	Cushing's Disease in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. Patient has tried, or is currently taking, one of Signifor or Signifor LAR. If neither are formulary, approve; OR B. Patient has already been started on Isturisa. Endogenous Cushing's Syndrome in a patient ≥ 18 years of age. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. Approve if the patient meets one of the following (A or B): A. Patient has tried, or is currently taking, ONE of oral ketoconazole, Metopirone (metyrapone capsules), or Recorlev. If oral ketoconazole is non-formulary, approve; OR B. Patient has already been started on Isturisa. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product.	1 year
Cushing's - Cortisol Synthesis Inhibitor	Recorlev	levoketoconazole tablets	Endogenous Cushing's Syndrome in a patient ≥ 18 years of age. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. 1. Approve if the patient meets BOTH the following (A and B): A. Patient has tried oral ketoconazole; AND B. Patient has tried, or is currently taking, Isturisa, if formulary. Note: If Isturisa is non-formulary, would still need to try oral ketoconazole. 2. If the patient has already been started on Recorlev, approve if the patient has tried oral ketoconazole.	1 year
Cushing's -Cortisol Receptor Blocker	Korlym	mifepristone 300 mg tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Cyclin dependent kinase (CDK) 4 and 6 inhibitor	Cosela	trilaciclib injection for intravenous use	See standard *Oncology (Injectable) – Cosela Prior Authorization Policy* criteria.	See PA duration
Cystic Fibrosis Mucolytic Agents	Bronchitol	mannitol powder for oral inhalation	Cystic Fibrosis in adult patients (≥ 18 years of age): Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with hypertonic saline.	1 year
Cystic Fibrosis Transmembrane Conductance Regulators	Kalydeco	ivacaftor tablets and oral granules	Cystic Fibrosis in a patient ≥ 1 month of age. **1.** Approve if the patient has tried, and according to the prescriber experienced inadequate efficacy OR a significant intolerance with one of 1) Alyftrek or 2) Trikafta tablets or oral granules, if formulary. If none are formulary, approve. Note: If Trikafta tablets are the only formulary product and the patient has tried Trikafta oral granules, approve. Note: If Trikafta oral granules are non-formulary and the patient has difficulty swallowing tablets or is unable to swallow tablets, approve if requesting Kalydeco oral granules. **2.** Patient is ≥ 6 years of age, approve if the patient has at least one mutation in the cystic fibrosis transmembrane regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Alyftrek, if ONLY Alyftrek is formulary, and is not covered by Trikafta, if ONLY Trikafta (tablets or oral granules) is formulary. If neither Trikafta nor Alyftrek is formulary, approve. Note: If Trikafta tablets are the only formulary product and the patient has tried Trikafta oral granules, approve. Note: If Trikafta oral granules are non-formulary and the patient has difficulty swallowing tablets or is unable to swallow tablets, approve if requesting Kalydeco oral granules. **3.** Patient is ≥ 2 years of age and < 6 years of age, approve if the patient meets ONE of the following (A or B): A. Patient has tried, and according to the prescriber experienced inadequate efficacy OR a significant intolerance with one of Trikafta tablets or oral granules, if formulary. If neither are formulary, approve; OR B. Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Trikafta, if formulary. If Trikafta is not formulary, approve. Note: If Trikafta tablets are the only formulary product and the patient has tried Trikafta oral granules, approve. Note: If Trikafta oral granules are non-formulary and the patient has difficulty swallowing tablets or is unable to swallow tablets, approve if requesting Kalydeco oral granules. **3.** Patient is < 2 years of age, approve. **4.** If the patient has already been started on therapy with Kalydeco, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Cystic Fibrosis Transmembrane Conductance Regulators	Orkambi	lumacaftor/ ivacaftor tablets and oral granules	Cystic Fibrosis in a patient ≥ 1 year of age. **1.** Approve if the patient has tried, and according to the prescriber experienced inadequate efficacy OR a significant intolerance with one of 1) Alyftrek or 2) Trikafta tablets or oral granules, if formulary. If none are formulary, approve. Note: If Trikafta tablets are the only formulary product and the patient has tried Trikafta oral granules, approve. Note: If Trikafta oral granules are non-formulary and the patient has difficulty swallowing tablets or is unable to swallow tablets, approve if requesting Orkambi oral granules. **2.** Patient is ≥ 2 years of age and < 6 years of age, approve if the patient has tried, and according to the prescriber experienced inadequate efficacy OR a significant intolerance with one of Trikafta tablets or oral granules, if formulary. If neither are formulary, approve. Note: If Trikafta tablets are the only formulary product and the patient has tried Trikafta oral granules, approve. Note: If Trikafta oral granules are non-formulary and the patient has difficulty swallowing tablets or is unable to swallow tablets, approve if requesting Orkambi oral granules. **3.** Patient is < 2 years of age, approve. **4.** If the patient has already been started on therapy with Orkambi, approve.	1 year
Cystic Fibrosis Transmembrane Conductance Regulators	Symdeko	tezacaftor/ ivacaftor and ivacaftor tablets	Cystic Fibrosis in a patient ≥ 6 years of age. **1.** Approve if the patient has tried, and according to the prescriber experienced inadequate efficacy OR a significant intolerance with one of Alyftrek or Trikafta tablets, if formulary. If neither are formulary, approve. Note: If Trikafta tablets are the only formulary product and the patient has tried Trikafta oral granules, approve. **2.** Approve if the patient has at least one mutation in the cystic fibrosis transmembrane regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Alyftrek, if ONLY Alyftrek is formulary, and is not covered by Trikafta, if ONLY Trikafta (tablets or oral granules) is formulary. If neither Trikafta nor Alyftrek is formulary, approve. Note: If Trikafta tablets are the only formulary product and the patient has tried Trikafta oral granules, approve. **3.** If the patient has already been started on therapy with Symdeko, approve.	1 year
Cystic Fibrosis Transmembrane Conductance Regulators	Alyftrek	vanzacaftor, tezacaftor, deutivacaftor tablets	Cystic Fibrosis in a patient ≥ 6 years of age. **1.** Approve if the patient has tried, and according to the prescriber experienced inadequate efficacy OR a significant intolerance with Trikafta tablets, if formulary. If Trikafta tablets are non-formulary, approve. Note: If the patient has tried Trikafta oral granules, this would count as an approval. **2.** Approve if, according to the prescriber, the patient has a variant in the cystic fibrosis transmembrane conductance regulator gene that is not covered by Trikafta. **3.** If the patient has already been started on therapy with Alyftrek, approve.	1 year
Cystic Fibrosis Transmembrane Conductance Regulators	Trikafta oral granules	elexacaftor, tezacaftor, and ivacaftor oral granules; ivacaftor oral granules	See standard *Cystic Fibrosis Transmembrane Conductance Regulator – Trikafta Prior Authorization Policy* criteria.	See PA duration
Cystic Fibrosis Transmembrane Conductance Regulators	Trikafta tablets	elexacaftor, tezacaftor, ivacaftor oral tablet, ivacaftor oral tablet	Cystic Fibrosis in a patient ≥ 2 years of age. **1.** Approve if the patient has tried, and according to the prescriber experienced inadequate efficacy OR a significant intolerance with Alyftrek, if formulary. If Alyftrek is non-formulary, approve. **2.** Patient is < 6 years of age, approve. **3.** If the patient has already been started on therapy with Trikafta (tablets or oral granules), approve.	1 year
Cystinuria Agents	Thiola EC and tiopronin delayed-release tablets, including Venxxiiva DR tablets	tiopronin delayed-release tablets	If requesting brand Thiola EC tablets: Approve if the patient has tried and cannot take one of generic tiopronin delayted-release tablets or Venxxiva CR tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic tiopronin delayed-release tablets or Venxxiva CR tablets or if neither generic product is formulary: Approve if the patient has tried tiopronin tablets (Thiola tablets, generic [not EC]), if formulary. If tiopronin tablets (Thiola tablets, generics [not EC]) are non-formulary, approve.	1 year
Cystinuria Agents	Thiola	tiopronin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Dermatology – Epidermolysis Bullosa Medications	Filsuvez	birch triterpenes topical gel	Patient meets the following: *Dermatology – Filsuvez Prior Authorization Policy* criteria AND Approve if the patient meets ONE of the following (1, 2, or 3): **1.** Approve if the patient has tried Vyjuvek, if formulary. If Vyjuvek is non-formulary, approve. **2.** Approve if the diagnosis has NOT been confirmed by genetic testing showing a pathogenic mutation in the collagen type VII alpha 1 chain (COL7A1) gene. **3.** Patient is currently receiving Filsuvez on previously treated wounds.	See PA duration
Dermatology – Epidermolysis Bullosa Medications	Vyjuvek	beremagene geperpavec-svdt biological suspension	See standard *Dermatology – Gene Therapy – Vyjuvek Prior Authorization Policy* criteria.	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Dermatology – Epidermolysis Bullosa Medications	Zevaskyn	prademagene zamikeracel gene-modified cellular sheets	Dystrophic Epidermolysis Bullosa; Recessive. Approve if the patient meets ALL of the following (A, B, and C): A. The diagnosis is confirmed by genetic testing showing a pathogenic variant in both alleles in the collagen type VII alpha 1 chain (COL7A1) gene; AND B. Patient meets ALL of the following (i, ii, and iii): i. Patient has at least one clinical feature of recessive dystrophic epidermolysis bullosa; AND Note: Examples of clinical features of recessive dystrophic epidermolysis bullosa include but are not limited to blistering, wounds, and scarring. ii. Patient has one or more open wound(s) that will be treated (i.e., "target wound[s]); AND iii. Target wound(s) meets ALL of the following, according to the prescriber (a, b, c and d): a. Target wound(s) is clean in appearance and does not appear to be infected; AND b. Target wound(s) has adequate granulation tissue and vascularization; AND c. Target wound(s) is chronic wound(s) (present ≥ 6 months); AND d. The prescriber attests that there is no evidence or clinical suspicion of squamous cell carcinoma identified at the target wound(s); AND e. The prescriber attests that the medication has NOT been previously applied to the target wound(s); AND C. The medication is prescribed by or in consultation with a dermatologist or wound care specialist.	6 months
Diabetes - Oral Sulfonylurea	Glimepiride 3 mg (brand)	glimepiride 3 mg	Approve if the patient cannot use one of the following: generic glimepiride 1mg, 2mg, or 4 mg. If generic glimepiride is non-formulary, approve.	1 year
Diabetes Agents - CD3-Directed Antibody Agent	Tzield	teplizumab-mzwv intravenous infusion	See standard *Diabetes – Tzield Prior Authorization Policy* criteria.	See PA duration
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor and Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Product	Glyxambi	empagliflozin and linagliptin tablets	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Steglujan, if formulary. If Steglujan is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary). **2.** Patient with a history of heart failure or renal impairment: Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of 1) a dapagliflozin product (Farxiga or dapagliflozin) or 2) Jardiance, if formulary, AND one of 1) Tradjenta or 2) a sitagliptin product (Januvia, Zituvio, or sitagliptin), if formulary. If 1) a dapagliflozin product (Farxiga or dapagliflozin) and 2) Jardiance are both non-formulary, approve. If 1) Tradjenta and 2) a sitagliptin product (Januvia, Zituvio, or sitagliptin) are both non-formulary, approve. Note: If the patient has an estimated glomerular filtration rate < 45 mL/min/1.73 m2 and Jardiance is non-formulary, approve Glyxambi. Note: SGLT-2 inhibitors: Brenzavvy, Farxiga or dapagliflozin, Invokana, Jardiance, Steglatro. Farxiga and dapagliflozin would count as one alternative. DPP-4 inhibitors: Januvia or sitagliptin or Zituvio, Nesina or alogliptin, saxagliptin, Tradjenta. Sitagliptin products would count as one alternative: Januvia, sitagliptin, or Zituvio. Nesina or alogliptin would count as one alternative. Note: If the patient has tried a combination product containing a DPP-4 inhibitor or an SGLT-2 inhibitor, this would count as a trial of the respective product.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor and Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Product	Trijardy XR	empagliflozin/ linagliptin/ metformin extended-release	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Glyxambi, if formulary plus metformin. If Glyxambi is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Steglujan, if formulary AND metformin. If Steglujan is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary) AND metformin. **2.** Patient with a history of heart failure or renal impairment: Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of 1) Farxigna or dapagliflozin or 2) Jardiance, if formulary, AND one of 1) Tradjenta or 2) a sitagliptin product (Januvia, Zituvio, or sitagliptin), if formulary, AND metformin. If 1) Farxiga or dapagliflozin and 2) Jardiance are both non-formulary, approve. If 1) Tradjenta and 2) a sitagliptin product (Januvia, Zituvio, or sitagliptin) are both non-formulary, approve. Note: SGLT-2 inhibitors: Brenzavvy, Farxiga or dapagliflozin, Invokana, Jardiance, Steglatro. Farxiga and dapagliflozin would count as one alternative. DPP-4 inhibitors: Januvia or sitagliptin or Zituvio, Nesina or alogliptin, saxagliptin, Tradjenta. Sitagliptin products would count as one alternative: Januvia, sitagliptin, or Zituvio. Nesina or alogliptin would count as one alternative. Note: If the patient has tried a combination product containing a DPP-4 inhibitor or an SGLT-2 inhibitor, this would count as a trial of the respective product.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Janumet XR	sitagliptin and metformin extended-release tablets	Approve if the patient has tried Zituvimet XR, if formulary. If Janumet XR is non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Janumet (NOT XR), alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), Januvia, Tradjenta, or alogliptin tablets (Nesina, authorized generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried Janumet (NOT XR). If Janumet (NOT XR) is non-formulary, approve if the patient has tried metformin (Glucopage, Glucophage ER, generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Zituvimet XR and authorized generic	sitagliptin and metformin hydrochloride extended-release tablets	Approve if the patient has tried Janumet XR, if formulary. If Janumet XR is non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Janumet (NOT XR), alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), Januvia, Tradjenta, or alogliptin tablets (Nesina, authorized generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried Janumet (NOT XR). If Janumet (NOT XR) is non-formulary, approve if the patient has tried metformin (Glucopage, Glucophage ER, generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Janumet	sitagliptin plus metformin tablets 50-1000; 50-500	Approve if the patient has tried one of sitagliptin-metformin hydrochloride tablets or Zituvimet, if formulary. If both sitagliptin-metformin hydrochloride tablets and Zituvimet, are non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two or formulary or one if one is formulary): alogliptin and metformin tablets, Janumet XR, Jentadueto, Jentadueto XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), Januvia, Tradjenta, or alogliptin (Nesina, authorized generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried Janumet XR. If Janumet XR is non-formulary, approve if the patient has tried metformin (Glucopage, Glucophage ER, generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Jentadueto	linagliptin and metformin tablets	**1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto XR, alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, saxagliptin tablets (Onglyza, generics), or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried ONE of Jentadueto XR, Janumet or Janumet XR, if one is formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Jentadueto XR	linagliptin and metformin extended-release tablets	**1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list: (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto (NOT XR), alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, saxagliptin tablets (Onglyza, generics), or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure or renal impairment: approve if the patient has tried one of Jentadueto (NOT XR), Janumet or Janumet XR, if formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Kazano and authorized generic	alogliptin and metformin tablets	Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto, Jentadueto XR, Janumet, Janumet XR, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), alogliptin tablets (Nesina, authorized generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadeuto and Jentadueto XR would count as one alternative. Janumet and Janumet XR would count as one alternative. A brand product and its generic or authorized generic would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Kombiglyze XR	saxagliptin plus metformin extended-release tablets	If requesting brand Kombiglyze XR: Approve if the patient has tried generic Kombiglyze XR tablets (saxagliptin plus metformin ER tablets), if formulary. If requesting brand Kombiglyze XR and generic Kombiglyze XR tablets (saxagliptin plus metformin ER tablets) are non-formulary (or if requesting generic Kombiglyze), approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, Janumet, or Janumet XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin tablets (Onglyza, generic), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. Janumet and Janumet XR would count as one alternative. A brand product and its generic or authorized generic would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Oseni and authorized generic	alogliptin and pioglitazone tablets	Approve if the patient has tried pioglitazone (Actos, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin (Onglyza, generics), alogliptin tablets (Nesina, authorized generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried pioglitazone (Actos, generics). Note: A brand product and its generic or authorized generic would count as one alternative. **NOTE:** A trial of Oseni or is authorized generic would not count toward this requirement.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	sitagliptin and metformin hydrochloride tablets and Zituvimet	sitagliptin and metformin hydrochloride tablets 50-1000; 50-500	Approve if the patient has tried Janumet, if formulary. If Janumet is non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two or formulary or one if one is formulary): alogliptin and metformin tablets, Janumet XR, Jentadueto, Jentadueto XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), Januvia, Tradjenta, or alogliptin (Nesina, authorized generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried Janumet XR. If Janumet XR is non-formulary, approve if the patient has tried metformin (Glucopage, Glucophage ER, generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/ Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Steglujan	ertugliflozin/ sitagliptin tablets	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Glyxambi, if formulary **[documentation required]**. If Glyxambi is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) **[documentation required]** AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary) **[documentation required]**. **2.** Patient with a history of heart failure or renal impairment: Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Glyxambi, if formulary **[documentation required]**. If Glyxambi is not formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of 1) a dapagliflozin product (Farxiga or dapagliflozin) or 2) Jardiance, if formulary **[documentation required]**, AND one of 1) Tradjenta or 2) a sitagliptin product (Januvia, Zituvio, or sitagliptin), if formulary **[documentation required]**. If a 1) dapagliflozin product (Farxiga and dapagliflozin) and 2) Jardiance are both non-formulary, approve. If 1) Tradjenta and 2) a sitagliptin product (Januvia, Zituvio, or sitagliptin) are both non-formulary, approve. Note: SGLT-2 inhibitors: Brenzavvy, Farxiga or dapagliflozin, Invokana, Jardiance, Steglatro. Farxiga and dapagliflozin would count as one alternative. DPP-4 inhibitors: Januvia or sitagliptin or Zituvio, Nesina or alogliptin, saxagliptin, Tradjenta. Sitagliptin products would count as one alternative: Januvia, sitagliptin or Zituvio. Nesina and alogliptin would count as one alternative. Note: If the patient has tried a combination product containing the DPP-4 inhibitor or the SGLT-2 inhibitor, this would count as a trial of the respective product.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/ Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Qtern	dapagliflozin/ saxagliptin tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both Glyxambi and Steglujan, if formulary. If one is formulary, try one, if neither are formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary). SGLT-2 inhibitors: Brenzavvy, Farxiga or dapagliflozin, Invokana, Jardiance, Steglatro. Farxiga and dapagliflozin would count as one alternative. DPP-4 inhibitors: Januvia or sitagliptin or Zituvio, Nesina or alogliptin, saxagliptin, Tradjenta. Sitagliptin products would count as one alternative: Januvia, sitagliptin, or Zituvio. Nesina or alogliptin would count as one alternative. Note: If the patient has tried a combination product containing a DPP-4 inhibitor or an SGLT-2 inhibitor, this would count as a trial of the respective product.	1 year

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Formulary Exception Criteria

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Zituvio and authorized generic sitagliptin	sitagliptin 100 mg, 50 mg, 25 mg tablets	Approve if the patient has tried Januvia, if formulary. If Januvia is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): saxagliptin (Onglyza, generics), Tradjenta, or alogliptin tablets (Nesina, authorized generics). If none are formulary, approve. Note: Saxagliptin and Onglyza count as one alternative. Alogliptin and Nesina count as one alternative. **2.** Patients with a history of heart failure or a history of renal impairment: approve if the patient has tried Tradjenta, if formulary. If Tradjenta is non-formulary, approve.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Brynovin	sitagliptin oral solution	**1.** Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin (Onglyza, generics), Tradjenta, or a sitagliptin product (Januvia, Zituvio, or sitagliptin tablets). If none are formulary, approve. Note: Alogliptin and Nesina count as one alternative. Saxagliptin and Onglyza count as one alternative. Sitagliptin, Januvia, and Zituvio count as one alternative. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Januvia	sitagliptin 100 mg, 50 mg, 25 mg tablets	Approve if the patient has tried Zituvio, if formulary. If Zituvio is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): saxagliptin (Onglyza, generics), Tradjenta, or alogliptin tablets (Nesina, authorized generics). If none are formulary, approve. Note: Saxagliptin and Onglyza count as one alternative. Alogliptin and Nesina count as one alternative. **2.** Patients with a history of heart failure or a history of renal impairment: approve if the patient has tried Tradjenta, if formulary. If Tradjenta is non-formulary, approve.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Nesina and authorized generic	alogliptin tablets	Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): saxagliptin (Onglyza, generics), Tradjenta, or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Saxagliptin and Onglyza count as one alternative. Januvia and Zituvio would count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Onglyza	saxagliptin tablets	If requesting brand Onglyza: Approve if the patient has tried saxagliptin tablets (generic for Onglyza), if formulary. If requesting brand Onglyza and generic saxagliptin tablets are non-formulary (or if requesting generic Onglyza), approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Alogliptin and Nesina count as one alternative. Januvia and Zituvio count as one alternative.	1 year
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Tradjenta	linagliptin tablets	**1.** Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin (Onglyza, generics), or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Alogliptin and Nesina count as one alternative. Saxagliptin and Onglyza count as one alternative. Januvia and Zituvio count as one alternative. **2.** Patients with a history of heart failure or a history of renal impairment: Approve if the patient has tried a stiagliptin product (Januvia or Zituvio), if formulary. If neither Januvia nor Zituvio is formulary, approve.	1 year
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	exenatide injection	exenatide injection	Type 2 Diabetes Mellitus. **1.** Approve if the patient has tried at least three of the following **[documentation required]**, if formulary (or two if two are formulary or one if one is formulary): 1) Trulicity, 2) liraglutide (Victoza, generics), 3) a semaglutide product (Ozempic injection, Ozempic tablets, or Rybelsus), or 4) Mounjaro. If none are formulary, approve. Note: A product and its generic would count as one alternative. Note: All the semaglutide products would count as one alternative. **2.** Patient with a personal or family history of medullary thyroid carcinoma or a patient with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2), approve.	1 year
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Ozempic injection	semaglutide injection	Type 2 Diabetes Mellitus. **1.** Approve if the patient has tried at least TWO of the following: 1) liraglutide (Victoza, generics), 2) Trulicity, 3) a semaglutide product (Ozempic tablets or Rybelsus), or 4) Mounjaro **[documentation required]**, if formulary (or one if one is formulary). If none are formulary, approve. Note: A product and its generic count as one alternative. Note: All the semaglutide products would count as one alternative. **2.** Patient has Type 2 diabetes mellitus AND, according to the prescriber, the patient has chronic kidney disease (CKD), approve.	1 year
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Ozempic tablets	semaglutide tablets (1.5 mg, 4 mg and 9 mg strengths)	Type 2 Diabetes Mellitus. Approve if the patient has tried at least TWO of the following: 1) liraglutide (Victoza, generics), 2) Trulicity, 3) a semaglutide product (Ozempic injection or Rybelsus), or 4) Mounjaro **[documentation required]**, if formulary (or only one if one is formulary). If none are formulary, approve. Note: A product and its generic count as one alternative. Note: All the semaglutide products would count as one alternative.	1 year
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Rybelsus	semaglutide tablets (3 mg, 7 mg, and 14 mg)	Type 2 Diabetes Mellitus. Approve if the patient has tried at least TWO of the following **[documentation required]**, if formulary (or one if one is formulary): 1) a semaglutide product (Ozempic injection, Ozempic tablets), 2) Trulicity, 3) liraglutide (Victoza, generics), or 4) Mounjaro. If none are formulary, approve. Note: A product and its generic would count as one alternative. Note: All the semaglutide products would count as one alternative.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Trulicity	dulaglutide injection	Type 2 Diabetes Mellitus. **1.** Approve if the patient has tried at least TWO of the following **[documentation required]**, if formulary (or one if one is formulary): 1) liraglutide (Victoza, generics), 2) a semaglutide product (Ozempic injection, Ozempic tablets, or Rybelsus), or 3) Mounjaro. If none are formulary, approve. **2.** If the patient is less than 18 years of age, approve if the patient has tried at least ONE of 1) liraglutide (Victoza, generics) or 2) Mounjaro **[documentation required]**, if formulary. If neither are formulary, approve. Note: A product and its generic count as one alternative. Note: All the semaglutide products would count as one alternative.	1 year
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Victoza and generic	liraglutide (rDNA origin) injection	Type 2 Diabetes Mellitus. If requesting brand Victoza: Approve if the patient has tried and cannot take generic liraglutide due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic liraglutide or generic liraglutide is non-formulary: **1.** Approve if the patient has tried at least TWO of the following: 1) a semaglutide product (Ozempic injection, Ozempic tablets, or Rybelsus), 2) Trulicity, or 3) Mounjaro **[documentation required]**, if formulary (or one if one is formulary). If none are formulary, approve. Note: All the semaglutide products would count as one alternative. **2.** If the patient is less than 18 years of age, approve if the patient has tried at least ONE of 1) Trulicity or 2) Mounjaro **[documentation required]**, if formulary. If neither are formulary, approve.	1 year
Diabetes Agents - Glucose-dependent Insulinotropic Polypeptide (GIP) and Glucagon-Like Peptide-1 (GLP-1) Agonist	Mounjaro	tirzepatide subcutaneous injection	Type 2 Diabetes Mellitus. **1.** Approve if the patient has tried at least TWO formulary alternative from the following list (or one if one is formulary): 1) a semaglutide product (Ozempic injection, Ozempic tablets, Rybelsus), 2) Trulicity, or 3) liraglutide (Victoza, generics). If none are formulary, approve. Note: A product and its generic count as one alternative. Note: All the semaglutide products would count as one alternative. **2.** If the patient is less than 18 years of age, approve if the patient has tried at least ONE of 1) liraglutide (Victoza, generics) or 2) Trulicity, if formulary. If neither are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Diabetes Agents - Insulin (Basal)	Insulin glargine U300	insulin glargine U-300 SoloStar pen	~~Direct to Toujeo (brand), if formulary.~~ If Toujeo (brand) is non-formulary, approve if the patient meets (1, 2, 3 or 4): Type 2 Diabetes, (initial user) OR taking Toujeo/Insulin glargine U300 < 100 Units/injection (all others taking < 100 units/injection). **1.** Approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a. would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve. Type 2 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300 ≥ 100 units per injection (and all others taking ≥ 100 units/injection). **2.** Patients currently taking Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection, approve if the patient has tried one of Tresiba U-200 or Insulin Degludec U-200, if formulary. If neither are formulary, approve. Note: If the patient has tried either product listed in 2. regardless of formulary status, criterion 2 would be satisfied. Note: A patient who has previously tried Tresiba U-100 is not required to try Tresiba U-200. Type 1 Diabetes (initial user). **3.** Patients with Type 1 diabetes- approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300. **4.** Patients with Type 1 diabetes currently taking Toujeo or Insulin glargine U300- approve if the patient meets the following (a or b): a. Patient has tried one of Rezvoglar, Basaglar, Semglee (YFGN), Insulin Glargine (YFGN), or Lantus, if formulary. If none are formulary, approve; OR Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient is currently receiving a Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Insulin (Basal)	Toujeo	insulin glargine U-300 SoloStar pen	Direct to Insulin glargine U300, if formulary. If Insulin glargine U300 is non-formulary, approve if the patient meets (1, 2, 3 or 4): Type 2 Diabetes, (initial user) OR taking Toujeo/Insulin glargine U300 < 100 Units/injection (all others taking < 100 units/injection). **1.** Approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a. would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve. Type 2 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300 ≥ 100 units per injection (and all others taking ≥ 100 units/injection). **2.** Patients currently taking Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection, approve if the patient has tried one of Tresiba U-200 or Insulin Degludec U-200, if formulary. If neither are formulary, approve. Note: If the patient has tried either product listed in 2. regardless of formulary status, criterion 2 would be satisfied. Note: A patient who has previously tried Tresiba U-100 is not required to try Tresiba U-200. Type 1 Diabetes (initial user). **3.** Patients with Type 1 diabetes- approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300. **4.** Patients with Type 1 diabetes currently taking Toujeo or Insulin glargine U300- approve if the patient meets the following (a or b): a. Patient has tried one of Rezvoglar, Basaglar, Semglee (YFGN), Insulin Glargine (YFGN), or Lantus, if formulary. If none are formulary, approve; OR Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient is currently receiving a Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection.	1 year
Diabetes Agents - Insulin (Basal)	Lantus and Insulin glargine (by Winthrop, A-S Medication)	insulin glargine U-100 vial and SoloStar device	**1.** Patient is directed to use Semglee (YFGN) or Insulin glargin (YFGN) [authorized generic of Semglee {YFGN}], if formulary. If neither are formulary, approve. **2.** Approve if the patient has tried and cannot use Semglee (YFGN) or Insulin glargine (YFGN) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: If the patient had a trial of Insulin glargine (YFGN) and cannot use due to a formulation difference, an additional trial of Semglee (YFGN) would not be required and vice-versa, regardless of the formulary status of these products.	1 year
Diabetes Agents - Insulin (Basal)	Rezvoglar	insulin glargine-aglr 100 units/mL Kwikpen	**1.** Patient is directed to use Semglee (YFGN) or Insulin glargine (YFGN) [authorized generic of Semglee {YFGN}], if formulary. If neither are formulary, approve. **2.** Approve if the patient has tried and cannot use Semglee (YFGN) or Insulin glargine (YFGN) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: If the patient had a trial of Insulin glargine (YFGN) and cannot use due to a formulation difference, an additional trial of Semglee (YFGN) would not be required and vice-versa, regardless of the formulary status of these products.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Insulin (Basal)	Basaglar	Insulin glargine U-100 KwikPen	Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Rezvoglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. If none of the above are formulary, see, 1, 2, and 3 below. Type 2 Diabetes (Initial user and a patient Currently Receiving Basaglar) [and all others]. **1.** If all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, approve if the patient meets the following (a and b): a. Patient has tried one of Toujeo or Insulin glargine U300, if formulary; AND b. Patient has tried one of Tresiba or Insulin Degludec; if formulary. Note: If the patient has tried any product from a. or b. regardless of formulary status, that criterion would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes (initial user). **2.** If the patient has Type 1 diabetes and all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, approve if the patient meets (a and b): a. Patient has tried one of Toujeo or Insulin glargine U300, if formulary; AND b. Patient has tried one of Tresiba or Insulin Degludec, if formulary. Note: If the patient has tried any product from a. or b. regardless of formulary status, that criterion would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes, Continuation of Therapy with Basaglar. **3.** If all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, the patient has Type 1 diabetes, and the patient is currently taking Basaglar, approve if the patient has tried one of Toujeo or Insulin glargine U300, if formulary. If neither are formulary, approve. Note: If the patient has tried either product above, regardless of formulary status, the criterion would be satisfied.	1 year
Diabetes Agents - Insulin (Basal)	Basaglar Tempo Pen	Insulin glargine U-100 Tempo Pen	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using Basaglar Tempo Pen with the Tempo Smart Button; AND **2.** Patient has tried a basal insulin pen; AND **3.** Patient was unable to adhere to a regimen using a standard basal insulin pen, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.	6 months
Diabetes Agents - Insulin (Basal)	Insulin Glargine-YFGN (authorized generic of Semglee-YFGN)	insulin glargine U-100 vial and pen	**1.** Patient is directed to use Semglee (YFGN) [brand], if formulary. **2.** If Semglee (YFGN) [brand] is non-formulary, approve if the patient has tried one of Rezvoglar, Lantus, or Basaglar, if formulary. If Rezvoglar, Lantus and Basaglar are non-formulary, approve. Note: If the patient has tried any product from 2. regardless of formulary status, criterion 2 would be satisfied.	1 year
Diabetes Agents - Insulin (Basal)	Levemir	insulin detemir U-100 vial and FlexTouch pen	Type 2 Diabetes (Initial user and a patient Currently Receiving Levemir); AND Type 1 Diabetes (Initial user) [and all others]. **1.** Approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a. would be satisfied. b. Patient has tried one of Rezvoglar, Toujeo, Basaglar, Lantus, Insulin Glargine (YFGN), or Semglee (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b. would be satisfied. Note: If there are no formulary products in a or b, approve. **2.** Patients < 6 years of age: approve if the patient has tried one of Tresiba or Insulin Degludec, if formulary. If neither are formulary, approve. Note: If the patient has tried either product listed in 2. regardless of formulary status, criterion 2. would be satisfied. **3.** Pregnant patients: approve. Type 1 Diabetes, Continuation of Therapy with Levemir. **4.** If the patient has Type 1 diabetes and is currently taking Levemir, approve.	1 year
Diabetes Agents - Insulin (Basal)	Semglee (YFGN)	insulin glargine U-100 vial and pen	**1.** Patient is directed to use Insulin glargine-YFGN (authorized generic of Semglee [YFGN]), if formulary. **2.** If Insulin glargine-YFGN (authorized generic of Semglee [YFGN]) is non-formulary, approve if the patient has tried one of Rezvoglar, Lantus, or Basaglar, if formulary. If Rezvoglar, Lantus, and Basaglar are non-formulary, approve. Note: If the patient has tried any product from 2. regardless of formulary status, criterion 2 would be satisfied.	1 year
Diabetes Agents - Insulin (Basal)	Awiqli	insulin icodec-abae subcutaneous injection	Type 2 diabetes in a patient ≥ 18 years of age. Approve if the patient meets BOTH of the following (A and B): A. Patient has tried a daily basal insulin product; AND Note: Examples of daily basal insulin products include: Lantus (insulin glargine, authorized generic), Rezvoglar (insulin glargine-aglr), Semglee (insulin glargine-yfgn, authorized generics), Toujeo (insulin glargine U-300, authorized generic), Tresiba (insulin degludec, authorized generic). B. Patient was unable to achieve desired glucose control on a once daily basal insulin regimen, according to the prescriber.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents – Insulin (Basal)	Insulin Degludec	insulin degludec vial and FlexTouch pen U-100 and U-200	Patient is directed to use Tresiba (brand), if formulary. If Tresiba (brand) is non-formulary, approve if the patient meets 1, 2, 3, or 4 below: All patients < 6 years (Type 1, Type 2, all others). **1.** Patients < 6 years of age: approve. Type 2 Diabetes (Initial user and a Patient Currently Receiving Tresiba) [and all others]. 2. Approve if the patient has tried one of Rezvoglar, Toujeo, Insulin glargine U300, Basaglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product above regardless of formulary status, this criterion would be satisfied. Note: If there are no formulary products in this criterion, approve. Type 1 Diabetes (Initial user). **3.** Patients with Type 1 diabetes- approve if the patient has tried one formulary product from the following list: Rezvoglar, Basaglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN), Toujeo, or Insulin glargine U300. If none are formulary, approve. Note: If the patient has tried any product from 3. regardless of formulary status, criterion 3 would be satisfied. Type 1 Diabetes, Continuation of therapy with Insulin Degludec or Tresiba. **4.** If the patient has Type 1 diabetes and is currently taking Tresiba or Insulin Degludec, approve.	1 year
Diabetes Agents – Insulin (Basal)	Tresiba	insulin degludec vial and FlexTouch pen U-100 and U-200	Patient is directed to use Insulin Degludec (authorized generic of Tresiba), if formulary. If Insulin Degludec (authorized generic of Tresiba) is non-formulary, approve if the patient meets 1, 2, 3, or 4 below: All patients < 6 years (Type 1, Type 2, all others). **1.** Patients < 6 years of age: approve. Type 2 Diabetes (Initial user and a Patient Currently Receiving Tresiba) [and all others]. 2. Approve if the patient has tried one of Rezvoglar, Toujeo, Insulin glargine U300, Basaglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product above regardless of formulary status, this criterion would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes (Initial user). **3.** Patients with Type 1 diabetes- approve if the patient has tried one formulary product from the following list: Rezvoglar, Basaglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN), Toujeo, or Insulin glargine U300. If none are formulary, approve. Note: If the patient has tried any product from 3. regardless of formulary status, criterion 3 would be satisfied. Type 1 Diabetes, Continuation of therapy with Tresiba or Insulin Degludec. **4.** If the patient has Type 1 diabetes and is currently taking Tresiba or Insulin Degludec, approve.	1 year
Diabetes Agents – Insulin (Basal) and Glucagon-Like Peptide-1 (GLP-1) Agonist Combination	Soliqua	insulin glargine/lixisenatide injection	**1.** Approve if the patient has tried Xultophy, if formulary. If Xultophy is non-formulary, approve if the patient has tried two formulary basal insulins (if two are formulary or one if one is formulary): a glargine product (Basaglar, Lantus, Insulin Glargine [YFGN], Semglee [YFGN], Toujeo, and Insulin glargine U300) or a degludec product (Tresiba or Insulin Degludec) AND three formulary glucagon-like peptide-1 (GLP-1) agonists (if three are formulary, or two if two are formulary or one if one is formulary): 1) exenatide injection, 2) Ozempic, 3) Trulicity, or 4) liraglutide (Victoza, generics). If none of the basal insulin products or none of the GLP-1 agonists are formulary, approve. Note: Lantus, Insulin Glargine (YFGN), Semglee (YFGN), Basalgar, Toujeo, and Insulin glargine U300 would count as one alternative. Note: Tresiba and Insulin Degludec would count as one alternative. Note: Victoza and its generic would count as one alternative. Note: A trial of Rybelsus or Mounjaro would also count as a trial of a GLP-1 agonist. Note: If exenatide injection is formulary, a previous trial of Byetta or Bydureon BCise would satisfy a trial of exenatide injection. **2.** Patient with a personal or family history of medullary thyroid carcinoma or a patient with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2): Approve if the patient has tried two formulary basal insulins (if two are formulary or one if one is formulary): a glargine product (Basaglar, Lantus, Insulin Glargine [YFGN], Semglee [YFGN], Toujeo, and Insulin glargine U300), or a degludec product (Tresiba or Insulin Degludec) AND the patient has tried exenatide injection, if formulary. If exenatide injection is non-formulary, approve. Note: If the patient has previously tried Bydureon BCise or Byetta, this would also satisfy the requirement for a trial of exenatide injection. Note: Lantus, Insulin Glargine (YFGN), Semglee (YFGN), Basalgar, Toujeo, and Insulin glargine U300 would count as one alternative. Note: Tresiba and Insulin Degludec would count as one alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents – Insulin (Basal) and Glucagon-Like Peptide-1 (GLP-1) Agonist Combination	Xultophy	insulin degludec/liraglutide injection	Approve if the patient has tried Soliqua, if formulary. If Soliqua is non-formulary, approve if the patient has tried two formulary basal insulins (if two are formulary or one if one is formulary): a glargine product (Basaglar, Lantus, Insulin Glargine [YFGN], Semglee [YFGN], Toujeo, Insulin glargine U300), or a degludec product (Tresiba or Insulin Degludec) AND three formulary glucagon-like peptide-1 (GLP-1) agonists (if three are formulary, or two if two are formulary or one if one is formulary): 1) exenatide injection, 2) Ozempic, 3) Trulicity, or 4) liraglutide (Victoza, generics). If none of the basal insulin products or none of the GLP-1 agonists are formulary, approve. Note: Lantus, Insulin Glargine (YFGN), Semglee (YFGN), Basalgar, Toujeo, and Insulin glargine U300 would count as one alternative. Note: Tresiba and Insulin Degludec would count as one alternative. Note: Victoza and its generic would count as one alternative. Note: A trial of Rybelsus or Mounjaro would also count as a trial of a GLP-1 agonist. Note: If exenatide injection is formulary, a previous trial of Byetta or Bydureon BCise would satisfy a trial of exenatide injection.	1 year
Diabetes Agents - Insulin (Human)	Novolin 70/30 Flexpen and Relion Novolin 70/30 Flexpen	insulin, 70/30 pen	**1.** Approve if the patient has tried Humulin 70/30 Kwikpens or Humulin 70/30 vials, if formulary. If both Humulin 70/30 Kwikpens and Humulin 70/30 vials are non-formulary, approve. **2.** If only Humulin 70/30 vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year
Diabetes Agents - Insulin (Human)	Novolin 70/30 vials and Relion Novolin 70/30 vials	insulin, 70/30 vials	Approve if the patient has tried Humulin 70/30 vials or Humulin 70/30 Kwikpens, if formulary. If both Humulin 70/30 vials and Humulin 70/30 Kwikpens are non-formulary, approve.	1 year
Diabetes Agents - Insulin (Human)	Novolin N Flexpen and Relion Novolin N Flexpen	insulin, NPH pen	**1.** Approve if the patient has tried Humulin N Kwikpens or Humulin N vials, if formulary. If both Humulin N Kwikpens and Humulin N vials are non-formulary, approve. **2.** If only Humulin N vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year
Diabetes Agents - Insulin (Human)	Novolin N vials and Relion Novolin N vials	insulin, NPH vials	Approve if the patient has tried Humulin N vials or Humulin N Kwikpens, if formulary. If both Humulin N vials and Humulin N Kwikpens are non-formulary, approve.	1 year
Diabetes Agents - Insulin (Human)	Novolin R Flexpen and Relion Novolin R U-100 Flexpen	insulin, regular pen	**1.** Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve. **2.** Approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disable), or have coordination issues.	1 year
Diabetes Agents - Insulin (Human)	Novolin R R U-100 vials and Relion Novolin R vials	insulin, regular vials	Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve.	1 year
Diabetes Agents - Insulin (Human)	Humulin 70/30 Kwikpen	insulin, 70/30 pen	**1.** Approve if the patient has tried Novolin 70/30 Flexpen or Novolin 70/30 vials, if formulary. If both Novolin 70/30 Flexpens and Novolin 70/30 vials are non-formulary, approve. **2.** If only Novolin 70/30 vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year
Diabetes Agents - Insulin (Human)	Humulin 70/30 vials	insulin, 70/30 vials	Approve if the patient has tried Novolin 70/30 vials or Novolin 70/30 Flexpens, if formulary. If both Novolin 70/30 vials and Novolin 70/30 Flexpens are non-formulary, approve.	1 year
Diabetes Agents - Insulin (Human)	Humulin N Kwikpen	insulin, NPH pen	**1.** Approve if the patient has tried Novolin N vials or Novolin N Flexpen, if formulary. If both Novolin N vials and Novolin N Flexpen are non-formulary, approve. **2.** If only Novolin N vials are formulary, approve if the patient is visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year
Diabetes Agents - Insulin (Human)	Humulin N vials	insulin, NPH vials	Approve if the patient has tried Novolin N vials or Novolin N Flexpen, if formulary. If both Novolin N vials and Novolin N Flexpen are non-formulary, approve.	1 year
Diabetes Agents - Insulin (Human)	Humulin R U-100 vials	insulin, regular vials	Approve if the patient has tried Novolin R U-100 vials or Novolin R Flexpens, if formulary. If both Novolin R U-100 vials and Novolin R Flexpens are non-formulary, approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Admelog	insulin lispro vial, SoloStar (prefilled pen)	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, or Lyumjev; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: NovoLog, or Insulin Aspart (authorized generic of NovoLog), Fiasp, or Merilog; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Insulin (Rapid-Acting and Other)	Afrezza	insulin human [rDNA origin] inhalation powder	Approve if the patient meets the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic), Fiasp, or Merilog; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic), Humalog, Lyumjev, or Admelog. Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Apidra	insulin glulisine vial/Solostar (prefilled pen)	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets both of the following (A and B): A. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; AND Note: If the patient has tried any product from A. regardless of formulary status, criterion A would be satisfied. B. Patient has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic of NovoLog), Fiasp, or Merilog; OR Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. Note: If no products in A or B are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Fiasp	insulin aspart injection vial, pen, cartridge, PumpCart	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Merilog; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Humalog 50/50	insulin lispro protamine/insulin lispro Kwikpen	Approve if the patient has tried two formulary rapid-acting insulin or rapid-acting insulin containing products from the following list (or one if only one is formulary): Apidra, Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, Admelog, NovoLog, Insulin Aspart (authorized generic of Novolog), Merilog, NovoLog 70/30, Insulin aspart protamine-insulin aspart (authorized generic of Novolog 70/30), Humalog 75/25, or Fiasp. If none are formulary, approve. Note: Insulin aspart products would count as one alternative: Fiasp, Merilog, Novolog, Insulin Aspart. Note: Insulin lispro products would count as one alternative: Admelog, Humalog, Insulin Lispro, Lyumjev.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Humalog JR	insulin lispro JR	Direct the patient to Insulin Lispro JR. If Insulin Lispro JR is non-formulary, approve if the patient meets the following (A or B): A. Patient meets the following (i, ii, and iii): i. Patient has tried Apidra, if formulary; AND ii. Patient has tried one of the following, if formulary: Novolog, Insulin Aspart (authorized generic of Novolog), Fiasp, or Merilog; AND Note: If the patient has tried any product from ii. regardless of formulary status, criterion ii would be satisfied. iii. Patient has tried one of Admelog or Lyumjev, if formulary; OR Note: If the patient has tried any product from iii. regardless of formulary status, criterion iii would be satisfied. B. Patient requires ½ unit dosing. Note: If no products in A i, ii, or iii are formulary, approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Insulin Lispro JR	Insulin lispro JR	Direct the patient to Humalog JR (brand). If Humalog JR (brand) is non-formulary, approve if the patient meets the following (A or B): A. Patient meets the following (i, ii, and iii): i. Patient has tried Apidra, if formulary; AND ii. Patient has tried one of the following, if formulary: Novolog, Insulin Aspart (authorized generic of Novolog), Fiasp, or Merilog; AND Note: If the patient has tried any product from ii. regardless of formulary status, criterion ii would be satisfied. iii. Patient has tried one of Admelog or Lyumjev, if formulary; OR Note: If the patient has tried any product from iii. regardless of formulary status, criterion iii would be satisfied. B. Patient requires ½ unit dosing. Note: If no products in A i, ii, or iii are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Insulin (Rapid-Acting and Other)	Humalog	insulin lispro syringe, cartridge/Kwikpen/vial 100 units/mL, and Kwikpen 200 units/mL	**1.** If the patient is requesting Humalog vial 100 units/mL or Humalog Kwikpen 100 units/mL, direct the patient to Insulin Lispro (authorized generic of Humalog), if formulary. If Insulin Lispro (authorized generic of Humalog) is non-formulary, then approve if the patient meets one of the following (A or B): A. Patient meets all of the following (i, ii, and iii): i. Patient has tried Apidra, if formulary; AND ii. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), Fiasp, or Merilog; AND Note: If the patient has tried any product from ii. regardless of formulary status, criterion ii would be satisfied. iii. Patient has tried one of Admelog or Lyumjev, if formulary; OR Note: If the patient has tried any product from iii. regardless of formulary status, criterion iii would be satisfied. Note: If no products in i, ii, or iii are formulary, approve. B. Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve. **2.** If the patient is requesting Humalog cartridge, or Humalog KwikPen U-200, approve if the patient has tried Insulin Lispro (authorized generic of Humalog), if formulary. If Insulin Lispro (authorized generic of Humalog) is non-formulary, then approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), Fiasp, or Merilog; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of Admelog or Lyumjev, if formulary. Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Lispro (authorized generic to Humalog)	Insulin lispro vial/Kwikpen	Direct the patient to brand Humalog, if formulary. If brand Humalog is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), Fiasp, or Merilog; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of Admelog or Lyumjev, if formulary; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Lyumjev	insulin lispro-aabc injection for subcutaneous or intravenous use; Kwikpen, vial	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic), Humalog, or Admelog; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic), Fiasp, or Merilog. Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Merilog	insulin aspart-szjj subcutaneous injection Solostar and vial	If any of the following products are formulary: Novolog, Insulin aspart (authorized generic of Novolog), or Kirsty: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried one of Novolog, Insulin aspart (authorized generic of Novolog), or Kirsty, if formulary; AND B. Patient cannot continue to use one of the formulary alternatives due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If the patient had a trial of Insulin aspart and cannot use due to a formulation difference, an additional trial of Novolog would not be required and vice-versa, regardless of the formulary status of these products. If none of the following products are formulary: Novolog, Insulin aspart (authorized generic of Novolog), or Kirsty: Approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried Fiasp, if formulary; AND C. Patient has tried one of following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Insulin (Rapid-Acting and Other)	Humalog 75/25	75% Insulin lispro protamine/25% insulin lispro Kwikpen/vial	Direct the patient to Insulin Lipro Mix 75/25. If Insulin Lipro Mix 75-25 is non-formulary, approve if the patient has tried one of Novolog 70/30 or Insulin Aspart Protamine-Insulin Aspart Mix, if one is formulary. If neither are formulary, approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Insulin Lispro Mix 75/25	75% Insulin lispro protamine/25% insulin lispro Kwikpen	Direct the patient is Humalog 75/25 (brand), if formulary. If Humalog 75/25 (brand) is non-formulary, approve if the patient has tried one of Novolog 70/30 or Insulin Aspart Protamine-Insulin Aspart Mix, if formulary. If neither are formulary, approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	NovoLog Mix 70/30 and authorized generic (insulin aspart protamine-insulin aspart) and Relion Novolog Mix 70/30	insulin aspart protamine/insulin aspart, Flexpen (prefilled syringe)/vial	Approve if the patient has tried one of Humalog Mix 75/25 or Insulin Lispro Mix 75/25. If neither are formulary, approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	Kirsty	insulin aspart-xjhz pen and vial	If any of the following products are formulary: Novolog, Insulin aspart (authorized generic of Novolog), or Merilog: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried one of Novolog, Insulin aspart (authorized generic of Novolog), or Merilog, if formulary; AND B. Patient cannot continue to use one of the formulary alternatives due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If the patient had a trial of Insulin aspart and cannot use due to a formulation difference, an additional trial of Novolog would not be required and vice-versa, regardless of the formulary status of these products. Note: If ONLY Merilog is formulary and the patient is using an insulin pump, approve if the patient has tried one of Insulin Lispro or Humalog. If neither are formulary, approve. If neither are compatible with the patient's insulin pump, approve. If none of the following products are formulary: Novolog, Insulin aspart (authorized generic of Novolog), or Merilog are formulary: Approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried Fiasp, if formulary; AND C. Patient has tried one of following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year
Diabetes Agents - Insulin (Rapid-Acting and Other)	NovoLog and authorized generic (insulin aspart) and Relion Novolog	insulin aspart syringe, cartridge/Flexpen (prefilled syringe)/vial	If either of the following products are formulary: Kirsty or Merilog: **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried one of Kirsty or Merilog, if formulary; AND B. Patient cannot continue to use one of the formulary alternatives due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If ONLY Merilog is formulary and the patient is using an insulin pump, approve if the patient has tried one of Insulin Lispro or Humalog. If neither are formulary, approve. If neither are compatible with the patient's insulin pump, approve. If neither Kirsty nor Merilog are formulary: Approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried Fiasp, if formulary; AND C. Patient has tried one of following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Insulin (Rapid-Acting and Other)	Humalog Tempo Pen	insulin lispro 100 units/ml Tempo Pen	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using Humalog Tempo Pen with the Tempo Smart Button; AND **2.** Patient has tried a rapid-acting insulin pen; AND **3.** Patient was unable to adhere to a regimen using a standard rapid-acting pen device, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.	6 months
Diabetes Agents - Insulin (Rapid-Acting and Other)	Lyumjev Tempo Pen	insulin lispro-aabc 100 units/ml Tempo Pen	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using Lyumjev Tempo Pen with the Tempo Smart Button; AND **2.** Patient has tried a rapid-acting insulin pen; AND **3.** Patient was unable to adhere to a regimen using a standard rapid-acting pen device, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.	6 months
Diabetes Agents - Other	metformin immediate release 625 mg and 750 mg	metformin immediate-release tablet 625 mg and 750 mg	Approve if the patient had inadequate efficacy OR significant intolerance with metformin 500 mg, 850 mg, or 1000 mg immediate-release tablets.	1 year
Diabetes Agents - Other	Glumetza	metformin extended-release tablets	Approve if the patient has tried BOTH one metformin immediate-release tablet product AND two other formulary metformin extended-release products (if two are formulary or one if one is formulary): metformin extended-release tablets or Fortamet (brand or generic). **NOTE:** A trial of Glumetza would NOT count toward this requirement.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Segluromet	ertugliflozine and metformin tablets	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Synjardy, Synjardy XR, or Xigduo XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND three formulary alternatives from the following list, if formulary (or two if two are formulary or one if one is formulary: Farxiga, Steglatro, or Jardiance. Note: Synjardy and Synjardy XR would count as one alternative.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Synjardy XR	empagliflozin and metformin extended-release tablets	Approve if the patient has tried three formulary alternatives from the following list, if formulary (or two if two are formulary or one if one is formulary): Synjardy (not XR), Xigduo XR, or Segluromet. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND three formulary alternatives from the following list, if formulary (or two if two are formulary or one if one is formulary): Farxiga, Jardiance, or Steglatro.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Invokamet	canagliflozin and metformin tablets	**1.** Approve if the patient has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet XR, Synjardy, Synjardy XR, Segluromet, or Xigduo XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if only one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative. **2.** Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried BOTH of 1) Synjardy and 2) one of dapagliflozin-metformin ER tablets (authorized generic of Xigduo XR), or Xigduo XR (brand), if formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Invokamet XR	canagliflozin and metformin extended-release tablets	**1.** Approve if the patient has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet (not XR), Synjardy, Synjardy XR, Xigduo XR, or Segluromet. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative. **2.** Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried BOTH of 1) Synjardy and 2) one of dapagliflozin-metformin ER tablets (authorized generic of Xigduo XR), or Xigduo XR (brand), if formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Synjardy	empagliflozin and metformin tablets	**1.** Approve if the patient has tried three formulary alternatives from the following list, if formulary (or two if two are formulary or one if one is formulary): Synjardy XR, Xigduo XR, or Segluromet. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND three formulary alternatives from the following list, if formulary (or two if two are formulary or one if one is formulary): Farxiga, Jardiance, or Seglatro. **2.** Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried one of dapagliflozin-metformin ER tablets (authorized generic of Xigduo XR) or Xigduo XR (brand), if formulary. If neither are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Xigduo XR 2.5 mg-1000 mg	dapagliflozin/metformin extended-release tablets 2.5 mg-1000 mg	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least one formulary alternative from the following list: Synjardy, Synjardy XR, or Segluromet. If none are formulary, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with metformin (Glucophage, Glucophage ER, generics) AND at least two formulary alternatives from the following list, if formulary (or one if one is formulary): dapagliflozin (Farxiga, generics), Jardiance, or Steglatro. **2.** Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Synjardy, if formulary. If Synjardy is non-formulary, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) dapagliflozin (Farxiga, generics) and 2) Jardiance, if formulary. If neither are formulary, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Xigduo XR (other strengths except 2.5 mg-1000 mg)	dapagliflozin/metformin extended-release tablets (other strengths except 2.5 mg-1000 mg)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Jardiance	empagliflozin tablet	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with dapagliflozin (Farxiga, generics), if formulary. If dapagliflozin (Farxiga, generics) are non-formulary, approve. **2.** If Jardiance is being used for glycemic control and the patient's estimated glomerular filtration rate is less than 45 mL/minute, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Inpefa	sotagliflozin tablets	Patients with one of the following: 1) Heart Failure OR 2) Type 2 diabetes, Chronic Kidney Disease (CKD), and Other cardiovascular (CV) risk factors. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH 1) dapagliflozin (Farxiga, generics) and 2) Jardiance, if formulary (or one if one is formulary). If neither are formulary, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Steglatro	ertugliflozin tablets	Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list (or one if only one is formulary): 1) dapagliflozin (Farxiga, generics) and 2) Jardiance. If neither are formulary, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Brenzavvy	bexagliflozin tablets	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH 1) dapagliflozin (Farxiga, generics) AND 2) Jardiance, if both are formulary (or one if one is formulary). If neither are formulary, approve. **2.** If the patient's estimated glomerular filtration rate is less than 45 mL/minute, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Jardiance, if formulary. If Jardiance is non-formulary, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Invokana	canagliflozin tablets	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list (or one if only one is formulary): 1) dapagliflozin (Farxiga, generics) and 2) Jardiance. If neither are formulary, approve. **2.** If Invokana is being used for glycemic control and the patient's estimated glomerular filtration rate is less than 45 mL/minute, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with Jardiance, if formulary. If Jardiance is non-formulary, approve.	1 year
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Farxiga	dapagliflozin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Diabetes Agents – Sulfonylurea	glipizide 2.5 mg (brand)	glipizide 2.5 mg tablets	Approve if the patient's prescribed dose cannot be obtained with glipizide 5 mg. Note: The patient is NOT required to split the 5 mg tablets in half.	1 year
Diabetes Agents – Sulfonylurea	glipizide 15 mg (brand)	glipizide 15 mg tablets	**1.** Patient is directed to generic glipizide 5 mg tablets and/or generic glipizide 10 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use glipizide 5 mg tablets and/or generic glipizide 10 mg tablets.	1 year
Diabetic Pen Needles	Pen needles by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other diabetic pen needles that are not BD	Pen needles by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other diabetic pen needles that are not BD	**1.** Approve if the patient has tried one formulary pen needle. If none are formulary, approve. **2.** Approve if the prescriber states the patient requires a needle of the requested length and/or gauge which is not available as a formulary product. Note: NPF prefers BD products.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetic Supplies	Diabetic Supplies	Blood glucose meters/test strips/control solutions	**1.** Approve if the patient has tried one formulary meter/test strip/control solution. If none are formulary, approve. **2.** Patients using an insulin pump/meter system that is not compatible with one of the available formulary alternatives: approve. **3.** If the request is for Freestyle Precision Neo strips for use in a Freestyle Libre reader, approve. **4.** Patients who are blind or significantly visually impaired who are requesting a meter with audio capabilities: approve if the patient has tried one other formulary meter with audio capabilities. If there are no formulary meters with audio capabilities, approve. Note: Meters with audio capabilities include Advocate (Redi-Code plus speaking meter), Arkray (Glucocard Expression, Glucocard Shine Express), Foracare (Fora D40D, Fora D40G, For a Gtel, Fora Premium V10 BLE, Fora Test N' Go Advance Voice, Fora Tn'G Voice, Fora V30), Oak Tree Health (EasyMax V, Fortiscare V3), Omnis Health (Embrace Talk), Prodigy (Prodigy Autocode, Prodigy Voice), Relion Premier Voice.	1 year
Diabetic Supplies – Continuous Glucose Monitoring Systems	Dexcom G6 system (receiver, transmitter, and sensor)	Dexcom G6 system (receiver, transmitter, and sensor)	Patient meets the following *Diabetes – Continuous Glucose Monitoring Systems Prior Authorization Policy* criteria AND Patient meets ONE of the following (1, 2, or 3): **1.** Approve if the patient has tried one of the Freestyle Libre 2 system, Freestyle Libe 2 Plus system, Freestyle Libre 3 system, or Freestyle Libre 3 Plus system, if formulary. If none are formulary, approve. Note: If the patient has tried a different Freestyle Libre product (e.g., Freestyle Libre 10- or 14 day- product), approve. **2.** If the patient is using an insulin pump that is not compatible with one of the formulary alternatives, approve. **3.** If the patient is < 4 years of age: approve if the patient has tried one of the Freestyle Libre 2 Plus system or Freestyle Libre 3 Plus system, if formulary. If neither are formulary, approve.	See PA duration
Diabetic Supplies – Continuous Glucose Monitoring Systems	Dexcom G7 system (receiver, transmitter, and sensor)	Dexcom G7 system (receiver, transmitter, and sensor)	Patient meets the following *Diabetes – Continuous Glucose Monitoring Systems Prior Authorization Policy* criteria AND Patient meets ONE of the following (1, 2, 3, or 4): **1**. Approve if the patient has tried one of the Freestyle Libre 2 system, Freestyle Libe 2 Plus system, Freestyle Libre 3 system, or Freestyle Libre 3 Plus system, if formulary. If none are formulary, approve. Note: If the patient has tried a different Freestyle Libre product (e.g., Freestyle Libre 10- or 14 day-product), approve. **2**. If the patient is using an insulin pump system that is not compatible with one of the formulary alternatives: approve. **3**. If the patient is < 4 years of age: approve if the patient has tried one of the Freestyle Libre 2 Plus system or Freestyle Libre 3 Plus system, if formulary. If neither are formulary, approve. **4**. If the patient is pregnant: approve if the patient has tried one of the Freestyle Libre 2 system, Freestyle Libre 2 Plus system, or Freestyle Libre 3, or Freestyle Libre 3 Plus system, if formulary. If none are formulary, approve.	See PA duration
Diabetic Supplies – Continuous Glucose Monitoring Systems	Freestyle Libre 2 system (reader and sensor); Freestyle Libre 2 Plus (sensor); Freestyle Libre 3 (reader and sensor); Freestyle Libre 3 Plus (sensor)	Freestyle Libre 2 system (reader and sensor)/Freestyle Libre 2 Plus (sensor) and Freestyle Libre 3 (reader and sensor)/Freestyle Libre 3 Plus (sensor)	Patient meets the following *Diabetes – Continuous Glucose Monitoring Systems Prior Authorization Policy* criteria AND Patient meets ONE of the following (1 or 2): **1**. Approve if the patient has tried the Dexcom G6 or Dexcom G7 system, if formulary. If neither are formulary, approve. Note: If the patient has tried a different Dexcom product (e.g., Dexcom G4 or G5), approve. **2**. If the patient is using an insulin pump system that is not compatible with one of the formulary alternatives: approve. **3**. If the patient is pregnant: approve if the patient has tried the Dexcom G7 system, if formulary. If the Dexcom G7 system is non-formulary, approve.	See PA duration
Diabetic Supplies – Continuous Glucose Monitoring Systems	Other continuous glucose monitoring systems (receiver/reader, transmitter, sensor) [That are NOT Dexcom G6, Dexcom G7, Freestyle Libre 2, Freestyle Libre 2 Plus, Freestyle Libre 3, Freestyle Libre 3 Plus]. This includes: Bigfoot Unity Program Kit, Eversense 365, Freestyle Libre 14-day, Guardian, MiniMed Instinct, Simplera, Simplera Sync	Other continuous glucose monitoring systems (receiver/reader, transmitter, sensor) [That are NOT Dexcom G6, Dexcom G7, or Freestyle Libre 2, Freestyle Libre 2 Plus, or Freestyle Libre 3, Freestyle Libre 3 Plus]	Patient meets the following *Diabetes – Continuous Glucose Monitoring Systems Prior Authorization Policy* criteria AND Patient meets ONE of the following (1, 2, or 3): **1**. Approve if the patient has tried BOTH of the following systems, if formulary: 1) Freestyle Libre 2, Freestyle Libre 2 Plus, Freestyle Libre 3, or Freestyle Libre 3 Plus AND 2) Dexcom G6 or Dexcom G7. If none are formulary, approve. Note: If only a Freestyle Libre product is formulary and the patient has tried a different Freestyle Libre product (e.g., Freestyle Libre 10- or 14 day- product), approve. Note: If only a Dexcom product is formulary and the patient has tried a different Dexcom product (e.g., Dexcom G4 or G5), approve. **2**. If the patient is using an insulin pump system that is not compatible with one of the formulary alternatives: approve. **3.** If requesting the Guardian Connect and the patient is pregnant: approve if the patient has tried BOTH of the following systems, if formulary: 1) Freestyle Libre 2, Freestyle Libre 2 Plus, Freestyle Libre 3, or Freestyle Libre 3 Plus AND 2) Dexcom G7 system. If none are formulary, approve.	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Diabetic Supplies – Other	Tempo Refill Kit	Tempo Lancets, strips, and Pen needles	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND **2.** Patient has tried standard insulin products; AND **3.** Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months
Diabetic Supplies – Other	Tempo Smart Button	Tempo Smart Button	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND **2.** Patient has tried standard insulin products; AND **3.** Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months
Diabetic Supplies – Other	Tempo Welcome Kit	Tempo Smart Button; Tempo Blood Glucose Monitoring System, Lancets, Strips, and Pen needles	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND **2.** Patient has tried standard insulin products; AND **3.** Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months
Diabetic Syringes	Syringes by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other syringes that are not BD	Syringes by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other syringes that are not BD	**1.** Approve if the patient has tried one formulary syringe. If none are formulary, approve. **2.** Approve if the prescriber states the patient requires a needle of the requested length and/or gauge which is not available as a formulary product. Note: NPF prefers BD products	1 year
Direct Renin Inhibitors	Tekturna	aliskiren tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Diuretics	Dyrenium capsules	triamterene capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Dronabinol Products	Syndros, dronabinol oral solution	dronabinol oral solution	**1.** Approve if the patient has tried dronabinol capsules (Marinol, generics), if formulary. If dronabinol capsules (Marinol, generics) is non-formualry, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing capsules.	1 year
Duchenne Muscular Dystrophy (DMD) Agents	Agamree	vamorolone oral suspension	See standard *Muscular Dystrophy – Agamree Prior Authorization Policy* criteria.	See PA duration
Duchenne Muscular Dystrophy (DMD) Agents	Brand Emflaza (tablets and oral suspension)	deflazacort tablets and oral suspension	See standard *Muscular Dystrophy – Deflazacort Preferred Specialty Management Policy* criteria.	See PSM duration
Duchenne Muscular Dystrophy (DMD) Agents	Generic deflazacort (tablets and oral suspension), Jaythari, Kymbee, Pyquvi	deflazacort tablets and oral suspension	See standard *Muscular Dystrophy – Deflazacort Prior Authorization Policy* criteria.	See PA duration
Duchenne Muscular Dystrophy (DMD) Agents	Exondys 51	eteplirsen injection for intravenous use	No exceptions are recommended. The effectiveness of Exondys 51 has not been established at this time. (NOTE**:** It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Exondys 51 has not been established at this time.)	N/A
Duchenne Muscular Dystrophy (DMD) Agents	Viltepso	viltolarsen injection for intravenous infusion	No exceptions are recommended. The effectiveness of Viltepso has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Viltepso has not been established at this time.)	N/A

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Duchenne Muscular Dystrophy (DMD) Agents	Vyondys 53	golodirsen injection for intravenous use	No exceptions are recommended. The effectiveness of Vyondys 53 has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Vyondys 53 has not been established at this time.)	N/A
Duchenne Muscular Dystrophy (DMD) Agents	Amondys 45	casimersen intravenous	No exceptions are recommended. The effectiveness of Amondys 45 has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Amondys 45 has not been established at this time.)	N/A
Duchenne Muscular Dystrophy (DMD) Agents	Elevidys	delandistrogene moxeparvovec-rokl intravenous infusion	See standard *Muscular Dystrophy – Gene Therapy – Elevidys Prior Authorization Policy* criteria.	See PA duration
Duchenne Muscular Dystrophy (DMD) Agents - Histone Deacetylase Inhibitor	Duvyzat	givinostat oral suspension	See standard *Muscular Dystrophy – Duvyzat Prior Authorization Policy* criteria	See PA duration
Endocrine Drugs – Repository Corticotropin	Cortrophin Gel (Purified)	repository corticotropin subcutaneous or intramuscular injection	No exceptions are recommended. There is a lack of updated clinical efficacy data and potential safety concerns with long-term use. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There is a lack of updated clinical efficacy data and insufficient information to determine clinically meaningful benefits.)	N/A
Endocrine Drugs – Repository Corticotropin - Acthar	Acthar Gel single-dose pre-filled SelfJect Injector (Self Injection)	repository corticotropin injection for for subcutaneous injection for adults only	All indications: Deny. Note: For a diagnosis of infantile spasms, could review under Acthar Gel vial criteria.	N/A
Endocrine Drugs – Repository Corticotropin - Acthar	Acthar Gel vial	repository corticotropin injection for intramuscular or subcutaneous injection	**1.** Treatment of infantile spasms: Approve if patient meets ALL of the following (A, B, and C): A. Child is less than 2 years of age; AND B. Acthar is being administered as an intramuscular injection; AND C. Medication is prescribed by a physician who has consulted with or specializes in neurology. **2.** All other indications: Deny.	1 month
Endocrine Drugs - Miscellaneous	Samsca	tolvaptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Endocrine Drugs - Miscellaneous	Sensipar	cinacalcet tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Endocrine Drugs – Miscellaneous	desmopressin spray (1.5 mg/mL) [brand]	desmopressin spray (1.5 mg/mL)	**1.** Patients with Hemophilia A, approve. **2.** Patients with von Willebrand's Disease, approve.	1 year
Endocrine Drugs – Miscellaneous	Desmoda	desmopressin acetate oral solution	**1.** Approve if the patient has tried at least one of the following: desmopressin tablets or desmopressin 10 mcg/0.1 mL (0.01%) nasal spray. If neither are formulary, approve. **2.** If the prescribed dose cannot be obtained with other desmopressin products, approve. **3.** Approve if the patient is unable to swallow oral dosage forms or has difficulty swallowing oral dosage forms.	1 year
Endocrine Drugs – Miscellaneous	Stimate Nasal Spray	desmopressin acetate nasal spray (1.5 mg/mL)	**1.** Patients with Hemophilia A, approve. **2.** Patients with von Willebrand's Disease, approve.	1 year
Endocrine Drugs – Miscellaneous	Somavert	pegvisomant injection	See standard *Somavert Prior Authorization Policy* criteria.	See PA duration
Endocrine Drugs – Miscellaneous	Myalept	metreleptin for injection	See standard *Lipodystrophy – Myalept Prior Authorization Policy* criteria.	See PA duration

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Endothelin Receptor Antagonist	Tryvio	aprocitentan tablets	**1.** Approve if the patient has tried, or is currently receiving, at least three other antihypertensive agents for the treatment of hypertension from at least three of the following pharmacological classes **[documentation required]** (i, ii, iii, iv, v, vi, vii, viii, ix, x). Note: A combination product from two or more different classes would count as an alternative from each class. i. Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB); Note: Examples of ACE inhibitors include benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, ramipril, and trandolapril. Examples of ARBs include azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, and valsartan. ii. Non-dihydropyridine calcium channel blocker; Note: Examples include diltiazem and verapamil. iii. Dihydropyridine calcium channel blocker; Note: Examples include amlodipine, felodipine, isradipine, nicardipine, nifedipine, and nisoldipine. iv. Diuretic; Note: Examples of thiazide diuretics include chlorthalidone, chlorothiazide, hydrochlorothiazide, indapamide, and metolazone. Examples of potassium-sparing diuretics are amiloride and triamterene. v. Mineralocorticoid receptor antagonist; Note: Examples of mineralocorticoid receptor antagonists include eplerenone and spironolactone. vi. Beta-blocker; Note: Examples of beta blockers include acebutolol, atenolol, betaxolol, bispoprolol, carvedilol, metoprolol, nadolol, nebivolol, pindolol, propranolol, and timolol. vii. Alpha-adrenergic blocker; Note: Examples of alpha-adrenergic blockers are doxazosin, prazosin, and terazosin. viii. Central alpha-adrenergic agonist; Note: Examples of central alpha-adrenergic agonists are clonidine, guanfacine, and methyldopa. ix. Direct vasodilator; Note: Examples of direct vasodilators are hydralazine and minoxidil. x. Direct renin inhibitor. Note: An example of a direct renin inhibitor is aliskiren. **2.** Approve if the patient has already been started on therapy with Tryvio.	1 year
Enzyme Replacement Therapy	Revcovi	elapegademase-lvlr injection for intramuscular use	See standard *Enzyme Replacement Therapy – Revcovi Prior Authorization Policy* criteria.	See PA duration
Enzyme Replacement Therapy	Lamzede	velmanase alfa-tycv intravenous infusion	See standard *Enzyme Replacement Therapy – Lamzede Prior Authorization Policy* criteria.	See PA duration
Enzyme Replacement Therapy	Loargys	pegzilarginase-nbln injection for intravenous or subcutaneous use	See standard *Enzyme Replacement Therapy – Loargys Prior Authorization Policy* criteria.	See PA duration
Enzyme Replacement Therapy	Aldurazyme	laronidase intravenous infusion [recombinant]	See standard *Enzyme Replacement Therapy – Aldurazyme Prior Authorization* criteria	See PA duration
Enzyme Replacement Therapy	Kanuma	sebelipase alfa intravenous injection	See standard *Enzyme Replacement Therapy – Kanuma Prior Authorizatio* n criteria	See PA duration
Enzyme Replacement Therapy	Mepsevii	vestronidase alfa-vjbk injection for intravenous use	See standard *Enzyme Replacement Therapy – Mepseviie Prior Authorization* criteria	See PA duration
Enzyme Replacement Therapy	Naglazyme	galsulfase for intravenous infusion	See standard *Enzyme Replacement Therapy – Naglazyme Prior Authorization* criteria	See PA duration
Enzyme Replacement Therapy	Vimizim	elosulfase alfa injection for intravenous use	See standard *Enzyme Replacement Therapy –Vimizim Prior Authorization* criteria	See PA duration
Enzyme Replacement Therapy	Elaprase	idursulfase solution for intravenous infusion	See standard *Enzyme Replacement Therapy – Elaprase Prior Authorization* criteria	See PA duration
Enzyme Replacement Therapy	Sucraid	sacrosidase oral solution	See standard *Enzyme Replacement Therapy – Sucraid Prior Authorization Policy* criteria.	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Enzyme Replacement Therapy	Strensiq	asfotase alfa injection for subcutaneous use	See standard *Enzyme Replacement Therapy – Strensiq Prior Authorization Policy* criteria	See PA duration
Enzyme Replacement Therapy - Fabry Disease	Elfabrio	pegunigalsidase alfa intravenous infusion	Fabry disease in a patient ≥ 18 years of age. Approve if the patient has tried Fabrazyme, if formulary. If Fabrazyme is non-formulary, approve.	1 year
Enzyme Replacement Therapy - Fabry Disease	Fabrazyme	agalsidase beta intravenous infusion [recombinant]	Fabry Disease. **1.** Approve if the patient has tried Elfabrio, if formulary. If Elfabrio is non-formulary, approve. **2.** Patient is < 18 years of age, approve.	1 year
Enzyme Replacement Therapy - Hunter Syndrome	Avlayah	tividenofusp alfa-eknm intravenous infusion	See standard *Enzyme Replacement Therapy – Avlayah Prior Authorization Policy* criteria	See PA duration
Enzyme Replacement Therapy - Pompe disease	Nexviazyme	avalglucosidase alfa-ngpt intravenous infusion	Late (non-infantile) onset Pompe disease (Late-onset Acid Alpha-Glucosidase Deficiency). **1.** Approve if the patient has tried Lumizyme, if formulary. If Lumizyme is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Nexviazyme.	1 year
Enzyme Replacement Therapy - Pompe disease	Opfolda	miglustat tablets	Late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease). **1.** Approve if the patient has tried Lumizyme, if formulary. If Lumizyme is non-formulary, approve. Note: If the patient has already tried Nexviazyme, this would satisfy the criteria. **2.** Approve if the patient has already been started on therapy with Pombiliti and Opfolda.	1 year
Enzyme Replacement Therapy - Pompe disease	Pombiliti	cipaglucosidase alfa intravenous infusion	Late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease). **1.** Approve if the patient has tried Lumizyme, if formulary. If Lumizyme is non-formulary, approve. Note: If the patient has already tried Nexviazyme, this would satisfy the criteria. **2.** Approve if the patient has already been started on therapy with Pombiliti and Opfolda.	1 year
Enzyme Replacement Therapy - Pompe disease	Lumizyme	alglucosidase alfa for intravenous infusion	See standard *Pompe Disease - Enzyme Replacement Therapy – Lumizyme Prior Authorization* criteria	See PA duration
Epinephrine Nasal Spray	Neffy	epinephrine nasal spray	Approve if the patient or patient's caregiver is unable to use a self-injectable epinephrine product.	1 year
Epinephrine Self-Administered Injectables	Auvi-Q	epinephrine 0.1 mg auto-injector	**1.** Approve if the patient has tried and could not appropriately administer one product from the following list, if formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve. **2.** Approve if the patient or his/her caregiver is blind or significantly visually-impaired. **3.** Patient weighs less than 33 pounds (15 kg): approve.	1 year
Epinephrine Self-Administered Injectables	Auvi-Q	epinephrine 0.15 mg and 0.3 mg auto-injector	**1.** Approve if the patient has tried and could not appropriately administer one product from the following list, if formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve. **2.** Approve if the patient or his/her caregiver is blind or significantly visually-impaired.	1 year
Epinephrine Self-Administered Injectables	epinephrine auto-injector	epinephrine 0.15 mg, 0.3 mg auto-injector authorized generic (Amneal Pharmace, Avkare, A-S Medication)	Approve if the patient has tried one product from the following list: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement	1 year
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	tadalafil 5 mg tablets	tadalafil 5 mg tablets	Approve if the patient is using tadalafil for benign prostatic hypertrophy (BPH) AND the patient has tried either 1.) An alpha-blocker (e.g., Cardura XL [doxazosin extended-release tablets], terazosin capsules, tamsulosin capsules, silodosin capsules, alfuzosin extended-release tablets) or 2.) A 5-alpha-reductase inhibitor (e.g., finasteride, dutasteride).	1 year

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Formulary Exception Criteria

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	Vybrique	sildenafil oral film	Erectile Dysfunction. **1.** Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy or significant intolerance with three of the following, if formulary (or two if two are formulary or one if one is formulary): 1) tadalafil tablets (Cialis, generics), 2) a vardenafil product (tablets or orally disintegrating tablets [ODT]), 3) sildenafil tablets (Viagra, generics), or 4) avanafil tablets (Stendra, generics). Note: Each chemical counts as one alternative. For example, vardenafil tablets and ODT count as one alternative **2.** If the patient is unable to or has difficulty swallowing oral dosage forms, approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy or significant intolerance with vardenafil ODT, if formulary. If vardenafil ODT is non-formulary, approve.	1 year
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	Cialis	tadalafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	Viagra	sildenafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Erectile Dysfunction Agents - Prostaglandins	Caverject	alprostadil for injection	Approve if the patient has tried one of Edex or Caverject Impulse, if formulary. If neither are formulary, approve.	1 year
Erectile Dysfunction Agents - Prostaglandins	Caverject Impulse	alprostadil for injection	Approve if the patient has tried one of Edex or Caverject, if formulary. If neither are formulary, approve.	1 year
Erectile Dysfunction Agents - Prostaglandins	Edex	alprostadil for injection	Approve if the patient has tried one of Caverject or Caverject Impulse, if formulary. If neither are formulary, approve.	1 year
Erythropoiesis-Stimulating Agents (ESAs)	Aranesp	darbepoetin alfa	Approve if the patient has tried one product from the following list: Epogen, Procrit or Retacrit **[documentation required]**, if one is formulary. If none are formulary, approve.	1 year
Erythropoiesis-Stimulating Agents (ESAs)	Epogen	epoetin alfa	**1.** Approve if the patient meets the following criteria (A and B): A. Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Procrit and Retacrit **[documentation required]**; AND Note: If neither are formulary, would still need to meet criteria B, if Aranesp is formulary. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction; AND B. Patient has tried Aranesp, if formulary **[documentation required]**. Note: If none of the following products are formulary: Aranesp, Procrit, and Retacrit, approve. **2.** Pediatric patients with anemia due to cancer chemotherapy; Patients undergoing surgery requesting agent for the reduction of allogeneic red blood cell transfusion; Patients with anemia and human immunodeficiency virus (HIV) infection who are receiving zidovudine: Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Procrit and Retacrit **[documentation required]**; AND Note: If neither are formulary, approve. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Erythropoiesis-Stimulating Agents (ESAs)	Mircera	methoxy polyethylene glycol-epoetin beta solution for injection	Approve if the patient meets the following criteria (1 AND 2): 1. Patient has tried one epoetin alpha product from the following list, if formulary: Epogen, Procrit, or Retacrit **[documentation required]**; AND Note: If none are formulary, would still need to meet criteria 2, if Aranesp is formulary. 2. Patient has tried Aranesp, if formulary **[documentation required]**. Note: If none of the following products are formulary: Aranesp, Epogen, Procrit, and Retacrit, approve. Note: The requirements are that one epoetin alpha product and Aranesp have been tried, if both are formulary. If only epoetin alpha product(s) is/are formulary and the patient has tried an epoetin alpha product, then the request should be approved.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Erythropoiesis-Stimulating Agents (ESAs)	Procrit	epoetin alfa	**1.** Approve if the patient meets the following criteria (A and B): A. Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Epogen and Retacrit; AND Note: If neither formulary, would still need to meet criteria B, if Aranesp is formulary. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction; AND B. Patient has tried Aranesp, if formulary. Note: If none of the following products are formulary: Aranesp, Epogen, and Retacrit, approve. **2.** Pediatric patients with anemia due to cancer chemotherapy; Patients undergoing surgery requesting agent for the reduction of allogeneic red blood cell transfusion; Patients with anemia and human immunodeficiency virus (HIV) infection who are receiving zidovudine: Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Epogen and Retacrit; AND Note: If neither is formulary, approve. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction	1 year
Erythropoiesis-Stimulating Agents (ESAs)	Retacrit	epoetin alfa-epbx (biosimilar to Epogen/Procrit)	**1.** Approve if the patient meets the following criteria (A and B): A. Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Epogen and Procrit; AND Note: If neither are formulary, would still need to meet criteria B, if Aranesp is formulary. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction; AND B. Patient has tried Aranesp, if formulary. Note: If none of the following products are formulary: Aranesp, Procrit, and Epogen, approve. **2.** Pediatric patients with anemia due to cancer chemotherapy; Patients undergoing surgery requesting agent for the reduction of allogeneic red blood cell transfusion; Patients with anemia and human immunodeficiency virus (HIV) infection who are receiving zidovudine: Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Epogen and Procrit; AND Note: If neither are formulary, approve. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Erythropoietic protoporphyria (EPP) Agents	Scenesse	afamelanotide implant for subcutaneous use	See standard *Scenesse Prior Authorization Policy* criteria.	See PA duration
Estrogen and Estrogen Combination Products (Topical)	Estrogel	estradiol gel 0.06%	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Estrogen and Estrogen Combination Products (Topical)	Climara Pro	estradiol/ levonorgestrel patch	Approve if the patient has tried CombiPatch, if formulary. If CombiPatch is non-formulary, approve if the patient has tried one oral estrogen/progestin combination product (e.g., estradiol/norethindrone [Activella, generics], Prempro, Premphase, ethinyl estradiol/norethindrone acetate [Femhrt, generics], Prefest, Angeliq).	1 year
Estrogen and Estrogen Combination Products (Topical)	Combipatch	estradiol/ norethindrone patch	Approve if the patient has tried Climara Pro, if formulary. If Climara Pro is non-formulary, approve if the patient has tried one oral estrogen/progestin combination product (e.g., estradiol/norethindrone [Activella, generics], Prempro, Premphase, ethinyl estradiol/norethindrone acetate [Femhrt, generics], Prefest, Angeliq).	1 year
Estrogen and Estrogen Combination Products (Topical)	Elestrin	estradiol gel 0.06%	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried at least one formulary non-patch topical estradiol product: estradiol 0.06% gel (transdermal) [Estrogel, generics], estradiol 0.1% gel (transdermal) [Divigel, generics], Evamist, if one is formulary; AND B. Patient has tried at least one estradiol patch. Note: Examples of estradiol patch products include: estradiol patch [Climara, Vivelle Dot, generics], Minivelle [generics]. Note: If no transdermal gels or sprays are formulary, the patient would still need to try an estradiol patch.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Estrogen and Estrogen Combination Products (Topical)	Evamist	estradiol transdermal spray	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried at least one formulary non-patch topical estradiol product: Elestrin, estradiol 0.1% gel (transdermal) [Divigel, generics], estradiol 0.06% gel (transdermal) [Estrogel, generics], if one is formulary; AND B. Patient has tried at least one estradiol patch. Note: Examples of estradiol patch products include: estradiol patch [Climara, Vivelle Dot, generics], Minivelle [generics]. Note: If no transdermal gels or sprays are formulary, the patient would still need to try an estradiol patch.	1 year
Estrogen and Estrogen Combination Products (Topical)	Divigel	estradiol gel 0.1%	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Estrogen and Estrogen Combination Products (Topical)	Minivelle	estradiol transdermal patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Estrogen and Estrogen Combination Products (Topical)	Vivelle-Dot	estradiol transdermal patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Estrogen and Progestin Combination Products (Oral)	Angeliq	estradiol/drospirenone tablets	Approve if the patient meets the following (A, B, C, and D): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey and estradiol-norethindrone); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Premphase or Prempro, if formulary; AND D. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva, if formulary. Note: If none are formulary in A, B, C and D, approve. If none are formulary in A, B, C, or D, the other(s) would still need to be tried.	1 year
Estrogen and Progestin Combination Products (Oral)	Duavee	conjugated estrogens/bazedoxifene tablets	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Prempro, Premphase, Angeliq, Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol), Activella (including generics of Activella: Mimvey and estradiol-norethindrone), or Bijuva. If none are formulary, approve.	1 year
Estrogen Combination Products (Oral)	Bijuva	estradiol and progesterone capsules	Approve if the patient meets the following (A, B and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey and estradiol-norethindrone); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Premphase or Prempro, if formulary. Note: If none are formulary in A, B and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.	1 year
Estrogen Combination Products (Oral)	Premphase	conjugated estrogens/medroxyprogesterone tablets	Approve if the patient meets the following (A, B, and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey and estradiol-norethindrone); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.	1 year
Estrogen Combination Products (Oral)	Prempro	conjugated estrogens/medroxyprogesterone tablets	Approve if the patient meets the following (A, B, and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey and estradiol-norethindrone); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Estrogen Products (Oral)	Menest	esterified estrogens tablets	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH products (or one if one is formulary) from the following list: 1) estradiol tablets (Estrace, generics) and 2) conjugated estrogen tablets (Premarin, generics). If neither are formulary, approve. Note: A brand and its generic would count as one alternative. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Estrogen Products (Oral)	Premarin (brand) and generic conjugated estrogen tablets	conjugated estrogens tablets	If requesting brand Premarin tablets: Approve if the brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent generic products, generic conjugated estrogen tablets, if the generic is formulary. If requesting generic conjugated estrogen tablets or generic conjugated estrogen tablets are non-formulary: Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with estradiol tablets (Estrace, generics), if formulary. If estradiol tablets (Estrace, generics) are non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Estrogen Products (Vaginal)	Estring	estradiol 2 mg vaginal ring	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Femring vaginal ring, Premarin Cream, estradiol 0.01% cream (Estrace Cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** If according to the prescriber, the patient requires a low-dose vaginal product, approve if the patient has tried one of Imvexxy vaginal insert or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve. Note: A brand and any generic of a product would count as one alternative.	1 year
Estrogen Products (Vaginal)	Imvexxy	estradiol vaginal insert	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Premarin vaginal cream, Femring vaginal ring, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** If according to the prescriber, the patient requires a low-dose vaginal product, approve if the patient has tried one of Estring or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve. Note: A brand and any generic of a product would count as one alternative.	1 year
Estrogen Products (Vaginal)	Premarin Vaginal Cream	conjugated estrogens, cream	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Femring vaginal ring, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. Note: A brand and any generic of a product would count as one alternative.	1 year
Estrogen Products (Vaginal)	Femring	estradiol vaginal ring (0.05 mg and 0.10 mg)	Approve if the patient has tried at least two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Premarin cream, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), estradiol patch (Climara, generics), estradiol patch (Vivelle Dot, generics), Menostar patch, estradiol tablets (Estrace, generics), or conjugated estrogen tablets (Premarin tablets, generics). If none are formulary, approve. Note: A brand and any generic of a product would count as one alternative.	1 year
Estrogen Products (Vaginal)	Estrace Cream	estradiol cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Estrogen Products (Vaginal)	Vagifem	estradiol vaginal tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Fabry Disease Agents	Galafold	migalastat capsules	Fabry disease. Approve if the patient meets the following criteria (A, B,C, and D): A. Patient is ≥ 18 years of age; AND B. Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data; AND C. The medication is prescribed by or in consultation with a geneticist, nephrologist, or a physician who specializes in the treatment of Fabry disease; AND D. Patient meets one of the following (i or ii): i. The patient has tried one of Fabrazyme or Elfabrio, if formulary. If Fabrazyme is non-formulary, approve; OR ii If the patient has already been started on therapy with Galafold, approve.	1 year
Factor Deficiency Agents and Related Products	Vonvendi	von Willebrand factor [recombinant] for intravenous injection	See standard *Hematology - Vonvendi Prior Authorization Policy* criteria	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Factor Deficiency Agents and Related Products	Ceprotin	protein C concentrated [human] lyophilized powder for solution for injection	See standard *Hematology – Ceprotin Prior Authorization Policy* criteria	See PA duration
Factor Deficiency Agents and Related Products	Coagadex	coagulation Factor X [human] for intravenous injection	See standard *Hematology – Coagadex Prior Authorization Policy* criteria	See PA duration
Factor Deficiency Agents and Related Products	Corifact	factor XIII concentrate [human]	See standard *Hematology – Corifact Prior Authorization Policy* criteria	See PA duration
Factor Deficiency Agents and Related Products	Feiba	anti-inhibitor coagulant complex injection	See standard *Hemophilia – FEIBA Prior Authorization Policy* criteria	See PA duration
Factor Deficiency Agents and Related Products	Tretten	coagulation Factor XIII A-subunit [recombinant] injection	See standard *Hematology – Tretten Prior Authorization Policy* criteria	See PA duration
Factor Deficiency Agents and Related Products	Obizur	antihemophilic Factor [recombinant] procine sequence lyophilized powder for solution for intravenous injection	Acquired Hemophilia A, approve.	1 year
Factor Deficiency Agents and Related Products	NovoSeven RT	Factor VIIa (recombinant) powder for injection	**1.** Hemophilia A with Inhibitors; Hemophilia B with Inhibitors: Approve if the patient meets the following criteria (a, b, c, or d): a. The patient has tried Sevenfact, if formulary. If Sevenfact is non-formulary, approve; OR b. The patient is less than 12 years of age; OR c. The patient has an allergy to rabbits or rabbit-derived products; OR d. The patient is currently receiving NovoSeven RT or has received NovoSeven RT in the past. **2.** Congenital Factor VII Deficiency, approve. **3.** Glanzmann's Thrombasthenia, approve. **4.** Hemophilia, Aquired, approve.	1 year
Factor Deficiency Agents and Related Products	Sevenfact	factor VIIa [recombinant]-jncw for intravenous infusion	**1.** Approve if the patient has tried NovoSeven RT, if formulary. If NovoSeven RT is non-formulary, approve. **2.** Approve if the patient is currently receiving Sevenfact or has received Sevenfact in the past.	1 year
Factor Deficiency Agents and Related Products	Fesilty	fibrinogen-chmt [human] intravenous infusion	Congenital Fibrinogen Deficiency (Factor I Deficiency), Including Afibrinogenemia and Hypofibrinogenemia. **1.** Approve if the patient has tried one of RiaSTAP or Fibryga, if formulary. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Fesilty or has received Fesilty in the past.	1 year
Factor Deficiency Agents and Related Products	Fibryga	fibrinogen [human] lyophilized powder for reconstitution for intravenous use	Congenital Fibrinogen Deficiency (Factor I Deficiency), Including Afibrinogenemia and Hypofibrinogenemia: **1.** Approve if the patient has tried one of RiaSTAP or Fesilty, if formulary. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Fibryga or has received Fibryga in the past. Acquired Fibrinogen Deficiency: approve.	1 year
Factor Deficiency Agents and Related Products	RiaSTAP	fibrinogen concentrate (human) lyophilized powder for reconstitution for intravenous use	Congenital Fibrinogen Deficiency (Factor I Deficiency), Including Afibrinogenemia and Hypofibrinogenemia: **1.** Approve if the patient has tried one of Fibryga or Fesilty, if formulary. If neither are formulary, approve. **2.** Approve if the patient is currently receiving RiaSTAP or has received RiaSTAP in the past.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Familial Chylomicronemia Syndrome Medications	Redemplo	plozasiran subcutaneous injection	Familial chylomicronemia syndrome in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Tryngolza, if formulary. If Tryngolza is non-formulary, approve. **2.** If, according to the prescriber, the patient has decreased platelets or is at risk of decreased platelets, approve.	1 year
Familial Chylomicronemia Syndrome Medications	Tryngolza	olezarsen subcutaneous injection	See standard *Hypertriglyceridemia - Tryngolza Prior Authorization Policy* criteria.	See PA duration
Fc receptor blocker	Imaavy	nipocalimab-aahu intravenous infusion	Generalized Myasthenia Gravis, anti-acetylcholine receptor antibody-positive OR anti-muscle-specific tyrosine kinase antibody-positive, in a patient ≥12 years of age. **1.** Patient ≥ 18 years of age, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of 1) Rystiggo, 2) an efgartigimod alfa product (Vyvgart intravenous or Vyvgart Hytrulo), or 3) Uplizna, if formulary. If none are formulary, approve. **2.** Patient is ≥ 12 years of age and < 18 years of age, approve. **3.** If the patient is pregnant or planning to become pregnant, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of 1) Rystiggo, or 2) an efgartigimod alfa product (Vyvgart intravenous or Vyvgart Hytrulo), if formulary. If none are formulary, approve. **4.** Approve if the patient has already been started on therapy with Imaavy.	1 year
Fc receptor blocker	Rystiggo	rozanolixizumab-noli subcutaneous infusion	Generalized Myasthenia Gravis, anti-acetylcholine receptor antibody-positive OR anti-muscle-specific tyrosine kinase antibody-positive, in a patient ≥18 years of age. **1.** Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of 1) Imvaavy, 2) an efgartigimod alfa product (Vyvgart intravenous or Vyvgart Hytrulo), or 3) Uplizna, if formulary. If none are formulary, approve. **2.** If the patient is unable to obtain and/or maintain intravenous access, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with Vyvgart Hytrulo, if formulary. If Vyvgart Hytrulo is non-formulary, approve. **3.** If the patient is pregnant or planning to become pregnant, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of 1) Imaavy or 2) an efgartigimod alfa product (Vyvgart intravenous or Vyvgart Hytrulo), if formulary. If none are formulary, approve. **4.** Approve if the patient has already been started on therapy with Rystiggo.	1 year
Fc receptor blocker	Vyvgart Hytrulo	efgartigimod alfa and hyaluronidase-qvfc subcutaneous infusion	Generalized Myasthenia Gravis, anti-acetylcholine receptor (AChR) antibody-positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody-positive, in a patient ≥ 18 years of age. **1.** Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of Imaavy, Vyvgart intravenous, Rystiggo, or Uplizna, if formulary. If none are formulary, approve. **2.** If the patient is unable to obtain and/or maintain intravenous access, approve if the patient tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with Rystiggo, if formulary. If Rystiggo is non-formulary, approve. **3.** If the patient is pregnant or planning to become pregnant, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of Imaavy, Vyvgart intravenous, or Rystiggo, if formulary. If none are formulary, approve. **4.** Approve if patient has already been started on therapy with Vyvgart Hytrulo or Vyvgart intravenous. Generalized Myasthenia Gravis, Anti-low-density lipoprotein receptor related protein (LRP4) antibody-positive or Triple Seronegative (no detectable autoantibodies against AChR, MuSK, or LRP4), in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Vyvgart intravenous, if formulary. If Vyvgart intravenous is non-formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. Chronic Inflammatory Demyelinating Polyneuropathy in a patient ≥ 18 years of age. **1.** Approve if the patient meets ONE of the following (A or B): A. Patient has previously received treatment with an intravenous or subcutaneous immunoglobulin; OR B. According to the prescriber, the patient is not a candidate for immunoglobulin therapy. **2.** Approve if patient has already been started on therapy with Vyvgart Hytrulo.	1 year
Fc receptor blocker	Vyvgart Intravenous	efgartigimod alfa-fcab intravenous infusion	Generalized Myasthenia Gravis, anti-acetylcholine receptor (AChR) antibody-positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody-positive, in a patient ≥ 18 years of age. **1.** Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of Imaavy, Vyvgart Hytrulo, Rystiggo, or Uplizna, if formulary. If none are formulary, approve. **2.** If the patient is pregnant or planning to become pregnant, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of Imaavy, Vyvgart Hytrulo, or Rystiggo, if formulary. If none are formulary, approve. **3.** If the patient has already been started on Vyvgart intravenous or Vyvgart Hytrulo, approve. Generalized Myasthenia Gravis, Anti-low-density lipoprotein receptor related protein (LRP4) antibody-positive or Triple Seronegative (no detectable autoantibodies against AChR, MuSK, or LRP4), in a patient ≥ 18 years of age. Approve if the patient has tried Vyvgart Hyrulo, if formulary. If Vyvgart Hyrulo is non-formulary, approve.	1 year
Fecal Microbiota Agent (spore)	Vowst	fecal microbiota spores, live-brpk capsules	For the prevention of recurrent Clostridioides difficile infection in a patient ≥ 18 years of age: Approve.	30 days

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Fecal Microbiota Agents	Rebyota Rectal Suspension	fecal microbiota, live – jslm suspension, for rectal use	For the prevention of recurrent Clostridioides difficile infection in a patient ≥ 18 years of age. Approve if the patient has tried Vowst, if formulary. If Vowst is non-formulary, approve.	30 days
Fenofibrates	Antara, Lipofen and authorized generics	fenofibrate capsules or tablets	Approve if the patient has tried three other formulary fenofibrate products (e.g., TriCor or generic, Lipofen, Fenoglide or generic, Trilipix or generic, generic fenofibrate capsule/ tablets, Fibricor or generic, generic fenofibric acid tablets) or two if only two are formulary, or one if only one is formulary. If none are formulary approve the requested agent.	1 year
Fertility Agents – Follitropin Ovulatory Stimulants	Follistim AQ	follitropin beta	**1.** Approve if the patient has tried one product from the following list: Gonal-F/Gonal-F RFF, if formulary. If Gonal-F/Gonal-F RFF is non-formulary, approve. **2.** Patient has been started on a current cycle of therapy with Follistim AQ: approve to complete the current cycle.	1 year
Fertility Agents – Follitropin Ovulatory Stimulants	Gonal-F/Gonal-F RFF	follitropin alfa	**1.** Approve if the patient has tried Follistim AQ, if formulary. If Follistim AQ is non-formulary, approve. **2.** Patient has been started on a current cycle of therapy with Gonal-F/Gonal-F RFF: approve to complete the current cycle.	1 year
Fertility Agents – Gonadotropin-Releasing Hormone (GnRH) Antagonists	Cetrotide injection and cetrorelix acetate injection	cetrorelix acetate injection	**1.** Approve if the patient has tried ganirelix acetate injection, if formulary. If ganirelix acetate injection is non-formulary, approve. **2.** Patient has been started on a current cycle of therapy with Cetrotide: approve to complete the current cycle.	1 year
Fertility Agents – Gonadotropin-Releasing Hormone (GnRH) Antagonists	ganirelix injection	ganirelix acetate injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Fibromyalgia - cyclobenzaprine Products	Tonmya	cyclobenzaprine hydrochloride sublingual tablets	Fibromyalgia. **1.** Approve if the patient meets ALL of the following (A, B, and C): A. Patient is ≥ 18 years of age and < 65 years of age; AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE of duloxetine (Cymbalta, generics) or Savella; AND Note: If neither product is formulary, would still need to meet criteria A and C. C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with pregabalin (Lyrica, generics). Note: If pregabalin is non-formulary, would still need to meet criteria A and B. **2.** If the patient has already been started on therapy with Tonmya, approve if, according to the prescriber, the patient is having a positive response to Tonmya therapy.	1 year
Fluoride (Oral) Products	Various	Various	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required.* Approve if the patient meets all of the following criteria (i, ii and iii): i. The patient is greater than or equal to 6 months of age but less than 17 years of age; AND ii. The prescribed dose of oral fluoride is less than or equal to 1 mg/day; AND iii. The patient meets one of the following (a or b): a. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with the preferred formulary alternatives; OR b. According to the prescriber, other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year
Folic Acid Products	Quiofic and folic acid oral solution	folic acid oral solution	**1.** Approve if the prescribed dose cannot be obtained with a whole folic acid 1 mg tablet. **2.** Approve if the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms. **3.** Approve if prescription folic acid 1 mg is non-formulary.	1 year
Folic Acid Products	Various	Various	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required.* Approve if the patient meets all of the following criteria (i, ii, and iii): i. The requested medication is being prescribed for a patient who is planning or capable of pregnancy; AND ii. The prescribed dose is 0.4 - 0.8 mg/day (400 - 800 mcg/day) of folic acid; AND iii. The patient meets one of the following (a or b): a. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with the preferred formulary alternatives; OR b. According to the prescriber, other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year
Gabapentin and Gabapentin-Like Medications	Gabarone	gabapentin tablets	Approve if the patient tried and CANNOT TAKE gabapentin CAPSULES.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Gabapentin and Gabapentin-Like Medications	Relgaabi 200 mg capsule (brand)	gabapentin capsule 200 mg	**1.** Approve if the patient has tried and is unable to take generic gabapentin 100 mg capsules. **2.** If generic gabapentin 100 mg capsules are non-formulary, approve.	1 year
Gabapentin and Gabapentin-Like Medications	Gralise	gabapentin extended-release tablets	Approve if the patient has tried one formulary alternative from the following list: gabapentin capsules/tablets (Neurontin, generics), Horizant tablets, pregabalin capsules (Lyrica, generics), or pregabalin ER (Lyrica CR, generics). If none are formulary, approve.	1 year
Gabapentin and Gabapentin-Like Medications	Horizant	gabapentin enacarbil extended-release tablets	Approve if the patient has tried one formulary alternative from the following list: gabapentin capsules/tablets (Neurontin, generics), Gralise tablets, pregabalin capsules (Lyrica, generics), or pregabalin ER (Lyrica CR, generics). If none are formulary, approve.	1 year
Gabapentin and Gabapentin-Like Medications	Lyrica	pregabalin capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Gabapentin and Gabapentin-Like Medications	Lyrica CR	pregabalin controlled-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Gabapentin and Gabapentin-Like Medications	Neurontin	gabapentin tablet, capsule and solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Gamma secretase inhibitors	Ogsiveo	nirogacestat tablets	See standard *Oncology – Ogsiveo Prior Authorization Policy* criteria.	See PA duration
Gastrointestinal Antispasmodic Agents	dicyclomine 40 mg	dicyclomine 40 mg tablets	Approve if the prescribed dose cannot be obtained with dicyclomine 20 mg tablets.	1 year
Gastrointestinal Drugs - Miscellaneous	Dartisla ODT	glycopyrrolate orally disintegrating tablets	**1.** Direct to glycopyrrolate tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use glycopyrrolate tablets.	1 year
Gastrointestinal Drugs - Miscellaneous	Mytesi	crofelemer delayed-release tablets	For the symptomatic relief of non-infectious diarrhea in adult patients with Human immunodeficiency virus (HIV) or Acquired immunodeficiency syndrome (AIDS): Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both diphenoxylate-atropine tablets AND loperamide.	1 year
Gastrointestinal Drugs - Miscellaneous	Chenodal	chenodiol tablets	See standard *Chenodiol Products Prior Authorization Policy* criteria.	See PA duration
Gastrointestinal Drugs - Miscellaneous	Gattex	teduglutide (recombinant DNA origin) for injection, for subcutaneous use	Approve for patients with Short Bowel Syndrome if, according to the prescriber, the patient is unable to receive adequate total parenteral nutrition (TPN) required for caloric needs.	1 year
Gastrointestinal Drugs - Miscellaneous	Cholbam	cholic acid capsules	See standard *Cholbam Prior Authorization Policy* criteria	See PA duration
Gastrointestinal Drugs - Miscellaneous	Carafate	sulcralfate tablets and oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Gastrointestinal Drugs - Miscellaneous	Cuvposa	glycopyrrolate oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Gastroparesis Agents	Gimoti	metoclopramide nasal spray	No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Gimoti. (**NOTE**: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)	N/A

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Gaucher Disease Medications	Cerezyme	Imiglucerase for injection	Gaucher Disease Type 1. Note: Type 1 Gaucher disease is also known as non-neuronopathic Gaucher disease. **1.** Approve if the patient has tried ONE product from the following list: Vpriv or Elelyso, if formulary. If neither are formulary, approve. **2.** Patient < 4 years of age, approve. **3.** Approve if the patient has already been started on therapy with Cerezyme. Gaucher Disease Type 3. Note: Type 3 Gaucher disease is also known as chronic neuronopathic Gaucher disease. Approve.	1 year
Gaucher Disease Medications	Elelyso	taliglucerase alfa for injection	Gaucher Disease Type 1. Note: Type 1 Gaucher disease is also known as non-neuronopathic Gaucher disease. **1.** Approve if the patient has tried ONE product from the following list: Cerezyme or Vpriv, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Elelyso. Gaucher Disease Type 3. Note: Type 3 Gaucher disease is also known as chronic neuronopathic Gaucher disease. **1.** Approve if the patient has tried Cerezyme, if formulary. If Cerezyme is non-formulary, approve. **2.** Approve if the patient has already been started on therapy Elelyso.	1 year
Gaucher Disease Medications	Vpriv	velaglucerase alfa for injection	Gaucher Disease Type 1. Note: Type 1 Gaucher disease is also known as non-neuronopathic Gaucher disease. **1.** Approve if the patient has tried ONE product from the following list: Cerezyme or Elelyso, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Vpriv. Gaucher Disease Type 3. Note: Type 3 Gaucher disease is also known as chronic neuronopathic Gaucher disease. **1.** Approve if the patient has tried Cerezyme, if formulary. If Cerezyme is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Vpriv.	1 year
Gaucher Disease Medications	Cerdelga	eliglustat capsules	See standard *Gaucher Disease Substrate Reduction Therapy - Cerdelga Prior Authorization Policy* criteria.	See PA duration
Gaucher Disease Medications	Zavesca	miglustat capsules	**NOTE**: A multisource Brand product is being requested. See standard *Gaucher Disease – Substrate Reduction Therapy Preferred Specialty Management Policy* criteria	See PSM duration
Gemcitabine Cancer Agents (Injectable)	Avgemsi	gemcitabine intravenous infusion	Approve if the patient has tried and cannot take gemcitabine for injection. If gemcitabine for injection is non-formulary, approve.	1 year
Gemcitabine Cancer Agents (Injectable)	Infugem	gemcitabine in sodium chloride injection for intravenous use	Approve if the patient has tried and cannot take gemcitabine for injection. If gemcitabine for injection is non-formulary, approve.	1 year
Genitourinary Agents	Renacidin	citric acid, glucono-delta-lactone, and magnesium carbonate irrigation solution	**1.** Bladder calculi, struvite or apatite: approve. **2.** Prevention of encrustations of indwelling urethral catheters and cystostomy tubes: Approve.	1 year
Genitourinary Agents	K-Phos Original	500 mg potassium acid phosphate tablets	**1.** For the treatment or prevention of hypophosphatemia: Approve. **2.** For the treatment of hypercalcemia: Approve. **3.** Patient requires a sodium-free product, Approve. **4.** For use in patients with elevated urinary pH: Approve. **5.** To acidify the urine: Approve. **6.** To increase the antibacterial activity of methenamine products: Approve. **7.** To reduce odor and skin irritation caused by high ammonia urine: Approve. **8.** For the treatment or prevention of kidney stones: Approve. **9.** Approve if the patient has already been started on therapy with the requested medication.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Glucocorticoids	Rayos	prednisone delayed-release tablets	Approve if the patient has tried prednisone immediate-release tablets AND had inadequate efficacy with the product, according to the prescriber, OR experienced adverse events severe enough to warrant discontinuation of the product.	1 year
Glucose-Elevating Drugs	Zegalogue	dasiglucagon subcutaneous injection	**1.** Approve if the patient has tried BOTH of Gvoke and Baqsimi, if formulary (or one if one is formulary). If neither are formulary, approve. **2.** Patient is < 2 years of age, approve if the patient has tried Baqsimi, if formulary. If Baqsimi is non-formulary, approve.	1 year
Glucose-Elevating Drugs	Baqsimi	glucagon nasal powder	**1.** Approve if the patient has tried Gvoke, if formulary. If Gvoke is non-formulary, approve. **2.** Patient is < 2 years of age, approve.	1 year
Glucose-Elevating Drugs	Glucagon/Glucagon Emergency Kit	glucagon/glucagon Emergency Kit	**1.** Approve if the patient has tried BOTH products from the following list: Baqsimi intranasal and Gvoke, if formulary (or only one if one is formulary). If neither are formulary, approve. **2.** Patient weighs < 20 kg and is ≥ 2 years of age, approve if the patient has tried one of Baqsimi or Gvoke, if formulary. If neither are formulary, approve. **3.** If the patient is < 2 years of age and ≥ 1 year of age, approve if the patient has tried Baqsimi, if formulary. If Baqsimi is non-formulary, approve. **4.** If the patient is < 1 year of age, approve.	1 year
Glucose-Elevating Drugs	Gvoke	glucagon injection for subcutaneous use	Approve if patient has tried Baqsimi, if formulary. If Baqsimi is non-formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs	Synarel	nafarelin acetate nasal spray	**1.** Endometriosis: Approve if the patient meets one of the following (A, B, or C): A. Patient has tried one of Lupron Depot (3.75 mg or 11.25 mg), Orilissa, or Myfembree, if formulary. If none are formulary, approve; OR B. Patient is unable to use products containing estrogens or progestins: Approve if the patient has tried one of Lupron Depot (3.75 mg or 11.25 mg) or Orilissa, if formulary. If none are formulary, approve; OR C. Patient has already been started on therapy with Synarel. **2.** For a diagnosis of central precocious puberty, approve if the patient has tried one of Fensolvi, Lupron Depot-Ped, or Triptodur, if one is formulary. If none are formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs	Lupron Depot	leuprolide acetate 3.75 mg and 11.25 mg for depot suspension	**1**. Endometriosis: approve if the patient meets one of the following (A, B, or C): A. Patient has tried one of Orilissa or Myfembree, if formulary. If neither are formulary, approve; OR B. Patient is unable to use products containing estrogens or progestins: Approve if the patient has tried Orilissa, if formulary. If Orilissa is non-formulary, approve; OR C. Patient has already been started on therapy with Lupron Depot. **2**. Uterine Leiomyomata (fibroids): approve if the patient meets one of the following (A, B, C, D, E, or F): A. Patient has tried one of Myfembree or Oriahnn, if formulary. If neither are formulary, approve; OR B. Lupron Depot is being used for treatment of "bulk symptoms" associated with uterine fibroids (i.e., pelvic pressure, urinary frequency, or constipation); OR C. Lupron Depot is being used to treatment uterine or fibroid enlargement associated with uterine fibroids; OR D. Lupron Depot is being used prior to interventional procedures or surgical management of uterine fibroids; OR Note: Examples of interventional procedure for uterine fibroids include uterine artery embolization, radiofrequency ablation, focused ultrasound. E. Patient is unable to use products containing estrogens or progestins; OR F. Patient has already been started on therapy with Lupron Depot. **3**. Abnormal uterine bleeding (not associated with fibroids); Breast cancer; Gender dysphoria, gender-incongruent persons, persons undergoing gender reassignment; Ovarian cancer (including Fallopian Tube Cancer and Primary Peritoneal Cancer); Premenstrual Disorders (including Premenstrual Syndrome and Premenstrual Dysphoric Disorder); Preservation of ovarian function/fertility in patients undergoing chemotherapy; Prophylaxis or treatment of uterine bleeding or menstrual suppression in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation; Uterine Cancer: approve. **4**. Head and Neck Cancer – Salivary Gland Tumors: approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs	Zoladex	goserelin acetate subcutaneous implant	**1.** Endometriosis: Approve if the patient meets one of the following (A, B, or C): A. Patient has tried one of Lupron Depot (3.75 mg or 11.25 mg), Orilissa, or Myfembree, if formulary. If none are formulary, approve; OR B. Patient is unable to use products containing estrogens or progestins: Approve if the patient has tried one of Lupron Depot (3.75 mg or 11.25 mg) or Orilissa, if formulary. If none are formulary, approve; OR C. Patient has already been started on therapy with Zoladex. **2.** Abnormal Uterine Bleeding; Breast Cancer; Prostate Cancer; Gender Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male [FTM] or Male-to-Female [MTF]); Head and Neck Cancer – Salivary Gland Tumors; Ovarian Cancer, including Fallopian Tube Cancer and Primary Peritoneal Cancer; Preservation of Ovarian Function/Fertility in Patients Undergoing Chemotherapy; Prophylaxis or Treatment of Uterine Bleeding or Menstrual Suppression in Patients with Hematologic Malignancy, or Undergoing Cancer Treatment, or Prior to Bone Marrow/Stem Cell Transplantation; Uterine Cancer: Approve	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - CPP	Supprelin LA	histrelin subcutaneous [SC] implant	Approve if the patient has tried one of Fensolvi, Lupron Depot-Ped, or Triptodur, if one is formulary. If none are formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - CPP	Fensolvi	leuprolide acetate for injectable suspension	Central Precocious Puberty; Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female). Approve if the patient has tried both Lupron Depot-Ped and Triptodur, if formulary, (or one if one is formulary). If neither are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Gonadotropin-Releasing Hormone (GnRH) Analogs - CPP	Lupron Depot-Ped	leuprolide acetate for depot suspension	Central Precocious Puberty; Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female). **1.** Approve if the patient has tried both Triptodur and Fensolvi, if formulary (or one if one is formulary) **[documentation required]**. If neither are formulary, approve. **2.** Patients < 2 years of age, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - CPP	Triptodur	triptorelin for extended-release injectable suspension	Central Precocious Puberty; Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female). Approve if the patient has tried one of Lupron Depot-Ped or Fensolvi, if formulary. If neither are formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Firmagon	degarelix for injection	Prostate Cancer. **1.** Approve if the patient has tried one of the following: Lutrate, Camcevi, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Eligard, Trelstar, or Orgovyx. If none are formulary, approve. **2.** If only Lutrate is formulary and the prescriber prefers monthly dosing, approve the patient has tried one of Lupron Depot 7.5 mg, Eligard, or Trelstar. If none are formulary, approve. **3.** Patients currently receiving therapy with Firmagon: approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Orgovyx	relugolix tablets	Prostate Cancer. **1.** Approve if the patient has triedone of the following: Lutrate, Camcevi, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Trelstar, Firmagon, or Eligard. If none are formulary, approve. **2.** If, according to the prescriber, the patient is at risk of cardiovascular disease, approve. **3.** If the patient is using for intermittent androgen deprivation therapy, approve. **4.** Patients currently receiving therapy with Orgovyx: approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Eligard	leuprolide acetate for injectable suspension	Prostate Cancer. **1.** Approve if the patient has tried one of the following: Lutrate, Camcevi, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Trelstar, Firmagon, or Orgovyx. If none are formulary, approve. **2.** If ONLY Lutrate is formulary and the prescriber prefers monthly dosing, approve. **3.** Patients currently receiving therapy with Eligard: Approve if the patient has tried one of Lupron Depot or Camcevi. If neither are formulary, approve. Head and Neck Cancer – Salivary Gland Tumors. **1.** Approve if the patient has tried one of Lupron Depot, Camcevi, or Trelstar. If none are formulary, approve. **2.** Patients currently receiving therapy with Eligard: Approve if the patient has tried one of Lupron Depot or Camcevi. If neither are formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Vabrinty	leuprolide acetate for injectable suspension	If Eligard is formulary, direct to Eligard. If Eligard is non-formulary, Prostate Cancer. **1.** Approve if the patient has tried one of the following: Lutrate, Camcevi, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Trelstar, Firmagon, or Orgovyx. If none are formulary, approve. **2.** If ONLY Lutrate is formulary and the prescriber prefers monthly dosing, approve. **3.** Patients currently receiving therapy with Vabrinty: approve if the patient has tried one of Lupron Depot or Camcevi. If neither are formulary, approve. Head and Neck Cancer – Salivary Gland Tumors. **1.** Approve if the patient has tried one of Lupron Depot, Camcevi, or Trelstar. If none are formulary, approve. **2.** Patients currently receiving therapy with Vabrinty: Approve if the patient has tried one of Lupron Depot or Camcevi. If neither are formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Camcevi	leuprolide injectable emulsion for subcutaneous use	Prostate Cancer. **1.** Approve if the patient has tried one of the following: leuprolide depot 22.5 mg (formerly Lutrate), Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Eligard, Firmagon, Trelstar or Orgovyx. If none are formulary, approve. **2.** Patients currently receiving therapy with Camcevi, approve if the patient has tried one of Lupron Depot or Eligard. If neither are formulary, approve. Head and Neck Cancer – Salivary Gland Tumors. Approve if the patient has tried one of Lupron Depot or Eligard. If neither are formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Leuprolide Depot 22.5 mg and Lutrate Depot 22.5 mg	leuprolide acetate 22.5 mg for depot suspension	Prostate Cancer: Approve if patient has tried Lupron Depot 22.5 mg, if formulary. If Lupron Depot, 22.5 mg is non-formulary, approve if the patient meets (1 or 2): 1. Approve if the patient has tried one of Camcevi, Eligard, Firmagon, Trelstar, or Orgovyx, if formulary. If none are formulary, approve. 2. Patient who has already been started on therapy with Leuprolide Depot, approve if the patient has tried one of Camcevi or Eligard, if formulary. If neither are formulary, approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Lupron Depot	leuprolide acetate 7.5 mg, 22.5 mg, 30 mg, 45 mg for depot suspension	**1.** Prostate cancer: approve if the patient meets the following (A, B, or C): A. Patient has tried one of the following: leuprolide depot 22.5 mg (formerly Lutrate), Camcevi, Eligard, Trelstar, Firmagon, or Orgovyx. If none are formulary, approve; OR B. If only leuprolide depot 22.5 mg (formerly Lutrate) is formulary and the prescriber prefers monthly dosing, approve the patient has tried one of Eligard, Firmagon, or Trelstar. If none are formulary, approve. C. Patient has already been started on therapy with Lupron Depot, approve if the patient has tried one of Camcevi or Eligard. If neither are formulary, approve. **2.** Head and Neck Cancer – Salivary Gland Tumors, approve if the patient has tried one of Camcevi or Eligard. If neither are formulary, approve. **3.** Gender dysphoria, gender-incongruent persons, persons undergoing gender reassignment; Ovarian Cancer, including Fallopian Tube Cancer and Primary Peritoneal Cancer; Breast Cancer; Uterine Cancer: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Trelstar	triptorelin pamoate for injectable suspension	Prostate Cancer: **1.** Approve if the patient has tried one of the following: leuprolide depot 22.5 mg (formerly Lutrate), Camcevi, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Eligard, Firmagon, or Orgovyx. If none are formulary, approve. **2.** If only leuprolide depot 22.5 mg (formerly Lutrate) is formulary and the prescriber prefers monthly dosing, approve the patient has tried one of Lupron Depot 7.5 mg, Eligard, or Firmagon. If none are formulary, approve. **3.** Patients currently receiving therapy with Trelstar: approve. Head and Neck Cancer – Salivary Gland Tumors: approve.	1 year
Gonadotropin-Releasing Hormone (GnRH) Antagonists - Endometriosis	Orilissa	elagolix tablets	Endometriosis: **1.** Approve if the patient has tried one of Lupron Depot (3.75 mg or 11.25 mg) or Myfembree, if formulary. If none are formulary, approve. **2.** Patient is unable to use products containing estrogens or progestins: Approve if the patient has tried Lupron Depot (3.75 mg or 11.25 mg), if formulary. If neither Lupron Depot (3.75 nor 11.25 mg) are formulary, approve. **3.** Approve if the patient has already started Orilissa to complete the course of therapy.	6 months
Gonadotropin-Releasing Hormone (GnRH) Antagonists – Uterine Fibroids	Oriahnn	elagolix, estradiol, and norethindrone acetate capsules; elagolix capsules	Uterine Fibroids: **1.** Approve if the patient has tried one of Myfembree or Lupron Depot, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already started on Oriahnn therapy.	1 year
Gonadotropin-Releasing Hormone (GnRH) Antagonists – Uterine Fibroids	Myfembree	relugolix, estradiol, and norethindrone tablets	Uterine Fibroids: **1.** Approve if the patient has tried one of Oriahnn or Lupron Depot (3.75 mg or 11.25 mg), if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on Myfembree therapy. Endometriosis: **1.** Approve if the patient has tried one of Orilissa or Lupron Depot (3.75 mg or 11.25 mg), if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on Myfembree therapy.	1 year
Gout Medications	Allopurinol 200 mg tablets (brand)	allopurinol 200 mg tablets	**1.** Direct the patient to allopurinol 100 mg or 300 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the allopurinol 100 mg or 300 mg tablet.	1 year
Gout Medications	Gloperba	colchicine oral solution	**1.** Approve if the patient has tried one product from the following list: colchicine tablets (Colcrys, generics) or colchicine capsules (Mitigare, generics), if formulary. If neither are formulary, approve. **2.** Approve if the patient is unable to swallow tablets or capsules or has difficulty swallowing tablets or capsules.	1 year
Gout Medications	Krystexxa	pegloticase injection for intravenous infusion	See standard *Gout - Krystexxa Prior Authorization Policy* criteria	See PA duration
Gout Medications	Colcrys	colchicine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Gout Medications	Uloric	febuxostat tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Growth Disorders – Miscellaneous	Increlex	mecasermin [rDNA origin] injection	See standard *Growth Disorders – Increlex Prior Authorization Policy* criteria.	See PA duration
Growth Hormone Products	Egrifta SV and Egrifta WR	tesamorelin subcutaneous injection	Approve for the reduction of excess abdominal fat in human immunodeficiency virus (HIV)-infected patients with lipodystrophy.	1 year
Growth Hormone Products	Serostim	somatropin injection	Patients with HIV infection with wasting or cachexia: approve.	1 year
Growth Hormone Products	Genotropin	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation requied]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Growth Hormone Products	Humatrope	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Growth Hormone Products	Norditropin Flexpro	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Growth Hormone Products	Nutropin AQ Nuspin	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Growth Hormone Products	Omnitrope	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Growth Hormone Products	Saizen/SaizenPrep	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Growth Hormone Products	Zomacton (formerly Tev-Tropin)	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Saizen **[documentation required]**;AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Growth Hormone Products – Weekly Dosed	Ngenla	somatrogon-ghla subcutaneous injection	Growth hormone deficiency in patients ≥ 3 years of age to < 18 years of age, approve if the patient has tried one of Skytofa or Sogroya for 6 months OR experienced an intolerance with the respective agent, if formulary. If neither Skytrofa nor Sogroya are formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient has been able to adhere to somatropin product(s) administered daily AND has experienced inadequate efficacy (i.e., patient has tried for 12 months and has a growth rate of less than 2 cm per year) **[documentation required]** with ONE product from the following list: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton; OR **2.** Patient meets BOTH of the following (A and B): A. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND B. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE.	1 year
Growth Hormone Products – Weekly Dosed	Skytrofa	lonapegsomatropin-tcgd subcutaneous injection	**1.** Growth hormone deficiency in a patient ≥ 2.5 years of age to < 3 years of age, approve if the patient has tried Sogroya for 6 months OR experienced an intolerance with Sogroya, if formulary. If Sogroya is non-formulary, approve if the patient meets criteria #3. **2.** Growth hormone deficiency in patients ≥ 3 years of age to < 18 years of age, approve if the patient has tried one of Sogroya or Ngenla for 6 months OR experienced an intolerance with the respective agent, if one is formulary. **3.** If neither Sogroya nor Ngenla are formulary (in patients ≥ 2.5 years of age to < 18 years of age) OR the patient is ≥ 1 year of age and < 2.5 years of age, approve if the patient meets ONE of the following (A or B): A. Patient has been able to adhere to somatropin product(s) administered daily AND has experienced inadequate efficacy (i.e., patient has tried for 12 months and has a growth rate of less than 2 cm per year) **[documentation required]** with ONE product from the following list: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND ii. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE. **4.** Adults with growth hormone deficiency (patients ≥ 18 years of age). Approve if the patient has tried Sogroya for 6 months OR experienced an intolerance with Sogroya, if formulary. If Sogroya is non-formulary, approve if the patient meets BOTH of the following (A and B): A. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND B. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Growth Hormone Products – Weekly Dosed	Sogroya	somapacitan-beco subcutaneous injection	**1.** Growth hormone deficiency in patients ≥ 2.5 years of age to < 3 years of age, approve if the patient has tried Skytrofa for 6 months OR experienced an intolerance with Skytrofa, if formulary. If Skytrofa is non-formulary, approve if the patient meets criteria #3. **2.** Growth hormone deficiency in patients ≥ 3 years of age to < 18 years of age, approve if the patient has tried one of Skytrofa or Ngenla for 6 months OR experienced an intolerance with the respective agent, if one is formulary. **3.** Growth hormone deficiency in patients ≥ 2.5 years of age to < 18 years of age AND neither Skytrofa nor Ngenla are formulary; OR the diagnosis is Idiopathic Short Stature (patients ≥ 5 years of age), Noonan Syndrome (no age specified), Born Small for Gestational Age (patients ≥ 2 years of age). Approve if the patient meets ONE of the following (A or B): A. Patient has been able to adhere to somatropin product(s) administered daily AND has experienced inadequate efficacy (i.e., patient has tried for 12 months and has a growth rate of less than 2 cm per year) **[documentation required]** with ONE product from the following list: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND ii. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE. **4.** Adults with growth hormone deficiency (patients ≥ 18 years of age). Approve if the patient has tried Skytrofa for 6 months OR experienced an intolerance with Skytrofa, if formulary. If Skytrofa is non-formulary, approve if the patient meets BOTH of the following (A and B): A. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND B. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE.	1 year
Guanylate cyclase stimulators	Verquvo	vericiguat tablets	Heart Failure: **1.** Approve if Verquvo is being used with at least three other medications for heart failure. Note: Examples of medications used for heart failure include an angiotensin converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril), an angiotensin receptor blocker (ARB) [e.g., valsartan, candesartan]), a beta-blocker (e.g., metoprolol succinate sustained-release, carvedilol), Entresto (sacubutril and valsartan tablets), an aldosterone antagonist (e.g., spironolactone, eplerenone), diuretics (e.g., furosemide, bumetanide, metolazone), Corlanor (ivabradine tablets and oral solution), a sodium glucose co-transporter 2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin tablets] or Jardiance [empagliflozin tablets]), hydralazine and isosorbide dinitrate. **2.** Approve if the patient has already been started on Verquvo.	1 year
Head Lice Treatments (Topical)	Ulesfia	benzyl alcohol lotion	**1.** Approve if the patient has tried one of the following, if one is formulary: ivermectin 0.5% lotion, malathion lotion 0.5% (Ovide, generics), or spinosad topical suspension (Natroba, generics). If none are formulary, approve if the patient has tried an OTC product (e.g., RID, NIX), unless resistance to the OTC products is prevalent in the area. If resistance to permetherin 1% (NIX) or pyrethins plus piperonyl butoxide (RID, others) is prevalent, approve Ulesfia. **2.** Patients < 6 years of age: approve if the patient has tried ivermectin 0.5% lotion, or spinosad topical suspension (Natroba, generics), if one is formulary. If none are formulary, approve if the patient has tried an OTC product (e.g., RID, NIX) unless resistance to the OTC products is prevalent in the area. If resistance to permetherin 1% (NIX) or pyrethins plus piperonyl butoxide (RID, others) is prevalent, approve Ulesfia.	1 year
Head Lice Treatments (Topical)	Natroba	spinosad topical suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Helicobacter Pylori Agents	Omeclamox-Pak	omeprazole capsules, clarithromycin tablets, and amoxicillin capsules	**1.** Approve if the patient meets ONE of the following (A or B): A. The patient has tried and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with TWO different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth-containing product + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]; Voquezna + amoxicillin +/- clarithromycin); OR B. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with any TWO pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole [Prevpac, generics], Talicia, Voquezna Pak, or Pylera). **2.** Approve if the patient has already been started on Omeclamox-Pak in order to complete the course of therapy.	1 month

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Helicobacter Pylori Agents	Pylera	bismuth subcitrate potassium, metronidazole plus tetracycline capsules	If requesting brand Pylera: Approve if the patient has tried generic Pylera (bismuth-metronidazole-tetracycline 140-125-125), if formulary. If requesting brand Pylera and generic Pylera (bismuth-metronidazole-tetracycline 140-125-125), is non-formulary (or if requesting generic Pylera), approve if the patient meets ONE of the following (A or B): A. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with TWO different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth-containing product + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]; Voquezna + amoxicillin +/- clarithromycin); OR B. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with any TWO pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole [Prevpac, generics], Omeclamox-Pak, Voquezna Pak, or Talicia).	1 month
Helicobacter Pylori Agents	Talicia	omeprazole, amoxicillin, and rifabutin capsules	**1.** Approve if the patient meets ONE of the following (A or B): A. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth-containing product + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]; Voquezna + amoxicillin +/- clarithromycin); OR B. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with any ONE pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole [Prevpac, generics], Omeclamox-Pak, Voquezna Pak, or Pylera). **2.** Approve if the patient has already been started on Talicia in order to complete the course of therapy.	1 month
Helicobacter Pylori Agents	Voquezna Dual Pak and Triple Pak	vonoprazan tablets and amoxicillin capsules; vonoprazan tablets, amoxicillin capsules, and clarithromycin	**1.** Approve if the patient meets ONE of the following (A or B): A. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth-containing product + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]; Voquezna + amoxicillin +/- clarithromycin); OR B. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with any ONE pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole [Prevpac, generics], Talicia, Omeclamox-Pak, or Pylera). **2.** Approve if the patient has already been started on Voquezna in order to complete the course of therapy.	1 month
Hematology - Disintegrin and metalloproteinase with thrombospondin motifs 13 (ADAMTS13)	Adzynma	ADAMTS13 recombinant-krhn intravenous infusion	See standard *Hematology – Adzynma Prior Authorization Policy* criteria.	See PA Duration
Hematology - Miscellaneous	Cablivi	caplacizumab-yhdp injection for intravenous or subcutaneous use	See standard *Hematology – Cablivi Prior Authorization Policy* criteria.	See PA duration
Hematology – Miscellaneous	Thrombate III	antithrombin III (human) intravenous infusion	**1.** Patient with hereditary antithrombin deficiency: Approve. **2.** Patient with acquired antithrombin deficiency: Approve. **3.** Patient with antithrombin-mediated heparin resistance: Approve. **4.** Approve if the patient has already been started on therapy with Thrombate.	1 year
Hematology Agents - Miscellaneous	Rytelo	imetelstat intravenous injection	Myelodysplastic Syndromes with Transfusion-Dependent Anemia. **1.** Approve if the patient tried Reblozyl, if formulary. If Reblozyl is non-formulary, approve. **2.** Aprove if the patient is ineligible for erythropoiesis-stimulating agents; OR Note: An example is a patient with a serum EPO level > 500 mU/mL. **3.** Approve if the patient has already been started on therapy with Rytelo.	1 year
Hematology Agents - Miscellaneous	Aqvesme	mitapivat tablets	Alpha-Thalassemia. Approve. Transfusion-dependent Beta-Thalassemia. **1.** Approve if the patient has tried Reblozyl. If Reblozyl is non-formulary, approve. **2.** If, according to the prescriber, the patient has an increased risk for thrombosis, stroke, or hypertension, approve. **3.** Approve if the patient is pregnant or planning to become pregnant OR is breastfeeding. **4.** Approve if the patient has already been started on therapy with Aqvesme. Non-Transfusion-dependent Beta-Thalassemia. Approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hematology Agents - Miscellaneous	Reblozyl	luspatercept-aamt for subcutaneous injection	See standard *Hematology – Reblozyl Prior Authorization Policy* criteria.	See PA duration
Hematopoietic/Thrombopoietic Agents	Aphexda	motixafortide subcutaneous injection	Peripheral blood stem cell mobilization for collection and subsequent autologous transplantation in patients with Multiple myeloma. **1.** Approve if the patient has tried plerixafor injection (Mozobil, generics), if formulary. If plerixafor injection (Mozobil, generics) are non-formulary, approve. **2.** Approve if the patient has already started therapy with Aphexda.	1 year
Hemophilia	Roctavian	valoctocogene roxaparvovec-rvox intravenous infusion	See standard *Hemophilia – Gene Therapy – Roctavian Prior Authorization Policy* criteria.	See PA duration
Hemophilia - Factor IX Products (plasma-derived)	AlphaNine SD	coagulation factor IX [plasma-derived] injection	Hemophillia B: Approve.	1 year
Hemophilia - Factor IX Products (plasma-derived)	Profilnine	factor IX complex [plasma-derived] injection	**1.** Approve if the patient has tried AlphaNine SD, if formulary. If AlphaNine SD is non-formulary, approve. **2.** For patients with a deficiency of Factors II or X, approve. **3.** Approve if the patient is currently receiving Profilnine or has received Profilnine in the past.	1 year
Hemophilia - Factor IX Products (recombinant extended half-life products)	Alprolix	coagulation factor IX [recombinant] Fc fusion protein lyophylized powder for solution for intravenous injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Idelvion or Rebinyn. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Alprolix or has received Alprolix in the past.	1 year
Hemophilia - Factor IX Products (recombinant extended half-life products)	Idelvion	coagulation factor IX [recombinant] albumin fusion protein for IV injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Alprolix or Rebinyn. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Idelvion or has received Idelvion in the past.	1 year
Hemophilia - Factor IX Products (recombinant extended half-life products)	Rebinyn	coagulation Factor IX [recombinant], glycoPEGylated for IV injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Alprolix or Idelvion. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Rebinyn or has received Rebinyn in the past.	1 year
Hemophilia - Factor IX Products (recombinant standard half-life products)	BeneFIX	coagulation factor IX [recombinant] injection	**1.** Approve if the patient has tried one of Rixubis or Ixinity, if formulary. If neither are formulary, approve. **2.** Approve if the patient is currently receiving BeneFIX or has received BeneFIX in the past. **3.** Patients previously untreated with factor IX therapy: approve.	1 year
Hemophilia - Factor IX Products (recombinant standard half-life products)	Rixubis	coagulation factor IX [recombinant]	**1.** Approve if the patient has tried one of BeneFIX or Ixinity, if formulary. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Rixubis or has received Rixubis in the past.	1 year
Hemophilia - Factor IX Products (recombinant standard half-life products)	Ixinity	coagulation factor IX [recombinant] solution for intravenous injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Rixubis or BeneFIX. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Ixinity or has received Ixinity in the past.	1 year
Hemophilia - Factor VIII Products (recombinant standard half-life)	Afstyla	antihemophilic factor [recombinant] single chain for intravenous injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulay):, Advate, Kogenate FS, Recombinate, Xyntha, Novoeight, Nuwiq, Kovaltry). If none are formulary, approve. **2.** Patient is currently receiving Afstyla or has received Afstyla in the past: approve.	1 year
Hemophilia - Factor VIII Products (recombinant DNA-derived)	Altuviiio	antihemophilic factor [recombinant] Fc-VWF-XTEN fusion protein-ehtl intravenous injection	See standard *Hemophilia – Altuviiio Prior Authorization Policy* criteria.	See PA Duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hemophilia - Factor VIII Products (recombinant extended half-life)	Adynovate	antihemophilic factor [recombinant] PEGylated for IV injection	**1.** Approve if the patient has tried Eloctate or Esperoct, if formulary. If neither are formulary, approve. **2.** Approve if the patient has previously tried Jivi. **3.** Approve if the patient is currently receiving Adynovate or has received Adynovate in the past.	1 year
Hemophilia - Factor VIII Products (recombinant extended half-life)	Eloctate	antihemophilic factor [recombinant] Fc fusion protein for intravenous injection	**1.** Approve if the patient has tried Adynovate or Esperoct, if formulary. If neither are formulary, approve. **2.** Approve if the patient has previously tried Jivi. **3.** Approve if the patient is currently receiving Eloctate or has received Eloctate in the past.	1 year
Hemophilia - Factor VIII Products (recombinant extended half-life)	Esperoct	antihemophilic factor [recombinant] glycopegylated-exei injection for intravenous use	**1.** Approve if the patient has tried Adynovate or Eloctate, if formulary. If neither are formulary, approve. **2.** Approve if the patient has tried Jivi. **3.** Approve if the patient is currently receiving Esperoct or has received Esperoct in the past.	1 year
Hemophilia - Factor VIII Products (recombinant extended half-life)	Jivi	antihemophilic factor [recombinant] PEGylated-aucl lyophilized power for solution for intravenous use	**1.** Approve if the patient has tried Adynovate, Eloctate, or Esperoct, if formulary. If none are formulary, approve. **2.** Approve if the patient is currently receiving Jivi or has received Jivi in the past.	1 year
Hemophilia - Factor VIII Products (recombinant standard half-life)	Kogenate FS	antihemophilic factor [recombinant] injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulary): Advate, Recombinate, Xyntha, Novoeight, Nuwiq, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Kogenate FS or has received Kogenate FS in the past: approve.	1 year
Hemophilia - Factor VIII Products (recombinant standard half-life)	Novoeight	antihemophilic factor [recombinant] for intravenous injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulary): Advate, Recombinate, Xyntha, Kogenate FS, Nuwiq, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Novoeight or has received Novoeight in the past: approve.	1 year
Hemophilia - Factor VIII Products (recombinant standard half-life)	Xyntha/ Xyntha Solofuse	antihemophilic factor [recombinant], plasma/albumin-free injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulary): Advate, Kogenate FS, Recombinate, Novoeight, Nuwiq, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Xyntha or has received Xyntha in the past: approve.	1 year
Hemophilia - Factor VIII Products (recombinant standard half-life)	Nuwiq	antihemophilic factor [recombinant] for intravenous injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulary): Advate, Recombinate, Kogenate FS, Xyntha, Novoeight, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Nuwiq or has received Nuwiq in the past: approve	1 year
Hemophilia - Factor VIII Products (recombinant standard half-life)	Recombinate	antihemophilic factor [recombinant] injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary or one if one is formulary): Advate, Kogenate FS, Xyntha, Novoeight, Nuwiq, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Recombinate or has received Recombinate in the past: approve.	1 year
Hemophilia – Non-Factor Routine Prophylaxis Products	Hemlibra	emicizumab-kxwh injection for subcutaneous use	See standard *Hemophilia – Non-Factor Routine Prophylaxis Products – Hemlibra Prior Authorization Policy* criteria	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hemophilia – Non-Factor Routine Prophylaxis Products	Alhemo	concizumab-mtci subcutaneous injection	For Hemophilia A with inhibitors. 1. Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. 2. Approve if, according to the prescriber, there is concern for a drug-drug interaction (e.g., drug-drug interaction between Hemlibra and Feiba). 3. Approve if the patient has already been started on therapy with Alhemo. For Hemophilia A without inhibitors. 1. Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. 2. Approve if the patient has already been started on therapy with Alhemo. For Hemophilia B with inhibitors. 1. Approve if the patient has tried at least one of Hympavzi or Qfitlia, if formulary. If neither are formulary, approve. 2. Approve if the patient has already been started on therapy with Alhemo. For Hemophilia B without inhibitors. **1.** Approve if the patient has tried at least one of Hympavzi or Qfitlia, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Alhemo.	1 year
Hemophilia – Non-Factor Routine Prophylaxis Products	Qfitlia	fitusiran subcutaneous injection	For Hemophilia A with inhibitors. **1.** Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. **2.** If, according to the prescriber, there is concern for a drug-drug interaction with Hemlibra (e.g., drug-drug interaction between Hemlibra and Feiba), approve. **3.** Approve if the patient has already been started on therapy with Qfitlia. For Hemophilia A without inhibitors. **1.** Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Qfitlia. For Hemophilia B with inhibitors. **1.** Approve if the patient has tried at least one of Alhemo or Hympavzi, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Qfitlia. For Hemophilia B without inhibitors. **1.** Approve if the patient has tried at least one of Alhemo or Hympavzi, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Qfitlia.	1 year
Hemophilia – Non-Factor Routine Prophylaxis Products	Hympavzi	marstacimab-hncq subcutaneous injection	For Hemophilia A with inhibitors. **1.** Approve if the patient tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. **2.** If, according to the prescriber, there is a concern for a drug-drug interaction with Hemlibra (e.g., drug-drug ineraction between Hemlibra and Feiba), approve. **3.** Approve if the patient has already started on therapy with Hympavzi. For Hemophilia A without inhibitors. **1.** Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Hympavzi. For Hemophilia B with inhibitors. **1.** Approve if the patient has tried at least one of Alhemo or Qfitlia, if formulary. If neither are formulary, approve. **2.** Approve if the patient is < 12 years of age. **3.** Approve if the patient has already been started on therapy with Hympavzi. For Hemophilia B without inhibitors. **1.** Approve if the patient has tried at least one of Alhemo or Qfitlia, if formulary. If neither are formulary, approve. **2.** Approve if the patient is < 12 years of age. **3.** Approve if the patient has already been started on therapy with Hympavzi.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hemophilia - Plasma-derived Factor VIII Products with Von Willebrand Factor	Koate	antihemophilic factor [plasma-derived] injection	**1.** Approve if the patient has tried one of Hemofil M, Alphanate, Wilate, or Humate P, if one is formulary. If none are formulary, approve. **2.** Approve if the patient is currently receiving Koate or has received Koate in the past.	1 year
Hemophilia - Plasma-derived Factor VIII Products with Von Willebrand Factor	Alphanate	antihemophilic factor/von Willebrand factor complex (human) injection	**1.** For hemophilia A: Approve if the patient has tried one formulary plasma-derived Factor VIII product: Hemofil M, Koate, Wilate, Humate P, if one is formulary. If none are formulary, approve. a. Patient < 18 years of age, approve if the patient has tried Hemofil M, Koate, or Wilate, if formulary. If none are formulary, approve. b. Patient ≤ 12 years of age, approve. **2.** For von Willebrand disease: Approve if the patient has tried one of Humate P or Wilate, if one is formulary. If neither are formulary, approve. **3.** Approve if the patient is currently receiving Alphanate or has received Alphanate in the past.	1 year
Hemophilia - Plasma-derived Factor VIII Products with Von Willebrand Factor	Humate P	antihemophilic factor/von Willebrand factor complex (human) injection	**1.** For hemophilia A: Approve if the patient has tried one formulary plasma-derived Factor VIII product: Hemofil M, Koate, Wilate, Alphanate, if one is formulary. If none are formulary, approve. **2.** For von Willebrand disease: Approve if the patient has tried one of Alphanate or Wilate, if one is formulary. If neither are formulary, approve. a. Patient < 7 years of age, approve. **3.** Patients with severe von Willebrand disease, according to the prescriber, approve. **4.** Approve if the patient is currently receiving Humate P or has received Humate P in the past.	1 year
Hemophilia - Plasma-derived Factor VIII Products with Von Willebrand Factor	Wilate	von Willebrand Factor/Coagulation Factor VIII Complex (human)	**1.** For hemophilia A: Approve if the patient has tried one formulary plasma-derived Factor VIII product: Hemofil M, Humate-P, Koate, Alphanate, if one is formulary. If none are formulary, approve. a. For routine prophylaxis therapy for hemophilia A, approve. b. Patient < 18 years of age, approve if the patient has tried Hemofil M, Alphanate, or Koate, if formulary. If none are formulary, approve. **2.** For von Willebrand disease (VWD): Approve if the patient has tried one of Alphanate or Humate P, if one is formulary. If neither are formulary, approve. a. For routine prophylaxis therapy for VWD, approve. b. Patients < 7 years of age, approve if the patient has tried Humate P, if formulary. If Humate P is not formulary, approve. **3.** Approve if the patient is currently receiving Wilate or has received Wilate in the past.	1 year
Hemophilia - Plasma-derived Factor VIII Products without Von Willebrand Factor	Hemofil M	antihemophilic factor [plasma-derived] injection	**1.** Approve if the patient has a diagnosis of hemophilia A. **2.** Approve if the patient is currently receiving Hemofil M OR has received Hemofil M in the past: approve.	1 year
Hemophilia Gene Therapy	Hemgenix	etranacogene dezaparvovec-drlb intravenous infusion	See standard *Hemophilia – Gene Therapy – Hemgenix Prior Authorization Policy* criteria.	See PA duration
Hepatic Porphyria Agents	Givlaari	givosiran injection solution	See standard *Hepatology – Givlaari Prior Authorization Policy* criteria	See PA duration
Hepatitis B - Immune Globulins	HepaGam B	hepatitis B immune globulin (human) injection	**1.** Approve if the patient has tried one product from the following list: HyperHEP B S/D or Nabi-Hb, if one is formulary. If neither are formulary, then approve. **2.** For prevention of hepatitis B recurrence following liver transplantation: approve.	1 year
Hepatitis B - Immune Globulins	HyperHEP B S/D	hepatitis B immune globulin (human) injection	Approve if the patient has tried one product from the following list: Nabi-HB or HepaGam B, if one is formulary. If neither are formulary, then approve.	1 year
Hepatitis B - Immune Globulins	Nabi-HB	hepatitis B immune globulin (human) injection	Approve if the patient has tried one product from the following list: HyperHEP B S/D or HepaGam B, if one is formulary. If neither are formulary, then approve.	1 year
Hepatitis B - Oral Agents	Viread	tenofovir powder for oral use	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried tenofovir tablets (Viread tablets, generics), if formulary. If tenofovir tablets (Viread tablets, generics) are non-formulary, approve.	1 year
Hepatitis B - Oral Agents	Baraclude	entecavir oral solution	**1.** Approve if the patient has tried entecavir tablets (Baraclude tablets, generics), if formulary. If entecavir tablets (Baraclude tablets) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hepatitis B Agents	Baraclude tablets	entecavir tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Hepatitis C - Oral Agents	Harvoni tablets 90 mg/400 mg	ledipasvir/sofosbuvir tablets 90 mg/400 mg	Patient is directed to use the authorized generic for Harvoni 90 mg/400 mg: ledipasvir/sofosbuvir 90 mg/400 mg. If the authorized generic for Harvoni 90 mg/400 mg (ledipasvir/sofobuvir) is non-formulary, approve.	24 Weeks
Hepatitis C - Oral Agents	ledipasvir/sofosbuvir tablets 90 mg/400 mg (Authorized generic for Harvoni)	ledipasvir/sofosbuvir tablets 90 mg/400 mg	Patient is directed to use Harvoni 90 mg/400 mg. If Harvoni 90 mg/400 mg is non-formulary, approve.	24 weeks
Hepatitis C - Oral Agents	Vosevi	sofosbuvir/velpatasvir /voxilaprevir tablets	**1.** Genotype 1, 2, 3, 4, 5, or 6 chronic HCV: Approve if the patient has tried one of the following direct-acting-antiviral (DAA) regimens for hepatitis C virus infection: Mavyret, Epclusa (brand or generic), Harvoni (brand or generic), Zepatier, or Sovaldi + ribavirin ± pegylated interferon. Note: If the patient has tried Daklinza in the past, this would satisfy criteria; however, Daklinza is no longer on the market. If the patient has tried Sovaldi + Olysio, Victrelis, or Incivek, this would satisfy criteria; however, Olsio, Victrelis, and Incivek are no longer on the market. **2.** Patients already started on a course of therapy with Vosevi for HCV infection: approve to complete up to a 12-week course of therapy. **NOTE:** Approvals will be provided for 12 weeks or to complete the course of therapy, whichever is shorter.	Up to 12 weeks
Hepatitis C - Oral Agents	Zepatier	grazoprevir/elbasvir tablets	**1.** Genotype 1 or 4 chronic HCV: Approve if the patient has tried one of Epclusa (brand or generic), Harvoni (brand or generic), or Mavyret. Note: If the patient has tried Daklinza in the past, this would satisfy criteria; however, Daklinza is no longer on the market. **2.** Patients already started on a course of therapy with Zepatier for HCV infection: approve to complete up to a 16-week course of therapy. **NOTE:** Approvals will be provided for 16 weeks or to complete the course of therapy, whichever is shorter.	16 weeks
Hepatitis C - Oral Agents	Sovaldi 200 mg tablets and oral pellets	sofosbuvir tablets and oral pellets	If Epclusa (brand) is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start: Sovaldi is not approved. Offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria. **2.** Patient Continuing Therapy with Sovaldi: Refer to the standard *Hepatitis C – Sovaldi PA Policy* criteria. If Epclusa (brand) is non-formulary and sofosbuvir/velpatasvir is formulary: 1. Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start. Approve for the duration specified in the standard *Hepatitis C – Sovaldi PA Policy* criteria if the patient has met the standard H*epatitis C- Sovaldi PA Policy* criteria. **2.** Patient Continuing Therapy with Sovaldi. Refer to the standard *Hepatitis C – Sovaldi PA Policy* criteria. If neither Epclusa (brand) nor sofosbuvir/velpatasvir are formulary, approve if both of the following are met: The patient will not be receiving Sovaldi as monotherapy and Solvadi will not be used in combination with direct-acting antivirals (DAAs) other than ribavirin.	Varies
Hepatitis C - Oral Agents	Sovaldi 400 mg tablets	sofosbuvir tablets	If Epclusa (brand) is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start: Sovaldi is not approved. Offer to review for Epclusa (brand only) using the standard *Hepatitis C – Epclusa PA Policy* criteria. **2.** Patient Continuing Therapy with Sovaldi: Refer to the standard *Hepatitis C – Sovaldi PA Policy* criteria. If Epclusa (brand) is non-formulary and sofosbuvir/velpatasvir is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start. Sovaldi is not approved. Offer to review for sofosbuvir/velpatasvir 400 mg/100 mg tablets (generic only) using the standard *Hepatitis C – Epclusa PA Policy* criteria. **2.** Patient Continuing Therapy with Sovaldi. Refer to the standard *Hepatitis C – Sovaldi PA Policy* criteria. If neither Epclusa (brand) nor sofosbuvir/velpatasvir are formulary, approve if both of the following are met: The patient will not be receiving Sovaldi as monotherapy and Solvadi will not be used in combination with direct-acting antivirals (DAAs) other than ribavirin.	Varies
Hepatitis C - Oral Agents	Harvoni low-dose tablets and oral pellets	ledipasvir/sofosbuvir tablets 45 mg/200 mg and oral pellets 45 mg/200mg and 33.75mg/150 mg	See *Hepatitis C Virus Direct Acting Antiviral Preferred Specialty Management (PSM) for National Preferred FLEX Formulary (Harvoni low-dose tablet and oral pellets Criteria*)	See PSM duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hepatitis C - Oral Agents	Mavyret	glecaprevir/ pibrentasvir tablets and oral pellets	See *Hepatitis C Virus Direct Acting Antivirals Preferred Specialty Management (PSM) for National Preferred Formulary and Basic Formulary (Mavyret Criteria)*	See PSM duration
Hepatitis C - Oral Agents	Epclusa 400 mg/100 mg tablets	sofosbuvir/velpatasvir 400 mg/100 mg tablets	Patient is directed to use the authorized generic for Epclusa: sofosbuvir/velpatasvir. If the authorized generic for Epclusa, sofosbuvir/velpatasvir, is non-formulary, approve.	24 weeks
Hepatitis C - Oral Agents	sofosbuvir/velpatasvir (Authorized generic for Epclusa) 400 mg/100 mg tablets	sofosbuvir/velpatasvir tablets 400 mg/100 mg tablets	Patient is directed to use Epclusa. If Epclusa is non-formulary, approve.	24 weeks
Hepatitis C – Oral Agents	Epclusa (200 mg/50 mg tablets and 200 mg-50 mg, 150 mg-37.5 mg oral pellets)	sofosbuvir/velpatasvir 200 mg/50 mg tablets and 200 mg-50 mg, 150 mg-37.5 mg oral pellets	See *Hepatitis C Virus Direct Acting Antivirals Preferred Specialty Management (PSM) for National Preferred FLEX Formulary (Epclusa 200 mg/50 mg tablet and 200 mg-50mg, 150-37.5 mg oral pellets Criteria)*	See PSM duration
Hepatitis D Virus (chronic)	Hepcludex	bulevirtide-gmod subcutaneous injection	See standard *Hepatitis D Virus – Hepcludex Prior Authorization Policy* criteria.	See PA duration
Hepatology – Ileal Bile Acid Transporter Inhibitors	Bylvay	odevixibat capsules and oral pellets	Alagille syndrome in a patient ≥ 12 months of age. Approve if the patient meets ONE of the following (1 or 2): **1.** If Livmarli is formulary, patient has tried Livmarli; OR **2.** If Livmarli is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has already been started on therapy with either Livmarli or Bylvay; OR B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with at least two of the following products: cholestyramine, fenofibrate, naltrexone, rifampicin (rifampin), sertraline, or ursodeoxycholic acid (ursodiol). Progressive Familial Intrahepatic Cholestasis in a patient ≥ 3 months of age. Approve if the patient meets ONE of the following (1 or 2): **1.** If Livmarli is formulary, patient meets ONE of the following (A or B): A. Patient has tried Livmarli; OR B. Patient is < 12 months of age; OR **2.** If Livmarli is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has already been started on therapy with either Livmarli or Bylvay; OR B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with at least two of the following products: cholestyramine, fenofibrate, naltrexone, rifampicin (rifampin), sertraline, or ursodeoxycholic acid (ursodiol).	1 year
Hepatology – Ileal Bile Acid Transporter Inhibitors	Livmarli	maralixibat tablets and oral solution	Alagille syndrome in a patient ≥ 3 months of age. Approve if the patient meets ONE of the following (1 or 2): **1.** If Bylvay is formulary, patient meets ONE of the following (A or B): A. Patient has tried Bylvay; OR B. Patient is < 12 months of age; OR **2.** If Bylvay is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has already been started on therapy with either Livmarli or Bylvay; OR B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with at least two of the following products: cholestyramine, fenofibrate, naltrexone, rifampicin (rifampin), sertraline, or ursodeoxycholic acid (ursodiol). Progressive Familial Intrahepatic Cholestasis in a patient ≥ 12 months of age. Approve if the patient meets ONE of the following (1 or 2): **1.** If Bylvay is formulary, patient has tried Bylvay; OR **2.** If Bylvay is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has already been started on therapy with either Livmarli or Bylvay; OR B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or a significant intolerance with at least two of the following products: cholestyramine, fenofibrate, naltrexone, rifampicin (rifampin), sertraline, or ursodeoxycholic acid (ursodiol).	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hepatology - Primary Biliary Cholangitis Agents	Livdelzi	seladelpar capsules	Primary Biliary Cholangitis. Approve if the patient has tried **[documentation required]**, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with Iqirvo, if formulary. If Iqirvo is non-formulary, approve.	1 year
Hepatology - Primary Biliary Cholangitis Agents	Lynavoy	linerixibat tablets	For the treatment of pruritus associated with primary biliary cholangitis. **1.** Approve if the patient has tried at least ONE of the following products: cholestyramine, rifampicin, naltrexone, sertraline, or fenofibrate. If none are formulary, approve. **2.** If the patient had an inadequate response to ursodeoxycholic acid therapy (e.g., Ursodiol) or could not tolerate ursodeoxycholic acid therapy (e.g., Ursodiol), approve if the patient has tried at least ONE of Iqirvo or Livdelzi, if formulary. If neither are formulary, approve.	1 year
Hepatology - Primary Biliary Cholangitis Medications	Iqirvo	elafibranor tablets	Primary Biliary Cholangitis. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Livdelzi, if formulary. If Livdelzi is non-formulary, approve.	1 year
Hereditary Angioedema – Acute Treatment	Ekterly	sebetralstat tablets	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Treatment of Acute Attacks. Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. Approve if the patient meets BOTH of the following (A and B): A. Patient meets one of the following (1, 2, or 3): 1. Approve if the patient has tried one of Sajazir or icatibant injection (Firazyr, generics), if one is formulary. If none are formulary, approve. 2. Approve if the patient is ≥ 12 years of age and < 18 years of age. 3. Approve if the patient has previously treated an acute HAE attack with Ekterly. B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders.	1 year
Hereditary Angioedema – Acute Treatment	Firazyr	icatibant injection for subcutaneous use	See standard *Hereditary Angioedema – Icatibant Preferred Specialty Management Policy* criteria.	1 year
Hereditary Angioedema – Acute Treatment	Kalbitor	ecallantide injection, for subcutaneous use	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Treatment of Acute Attacks. Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1, 2, or 3): **1.** Approve if the patient has tried icatibant (Firazyr, Sajazir, generics) if formulary. If all icatibant products (Firazyr, Sajazir, generics) are non-formulary, approve Kalbitor. **2.** Approve if the patient has previously treated an acute HAE attack with Kalbitor. **3.** Patients less than 18 years of age, approve. B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders.	1 year
Hereditary Angioedema – Acute Treatment	Ruconest	C1 esterase inhibitor [recombinant] powder for intravenous injection	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Treatment of Acute Attacks. Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1 or 2): **1.** Approve if the patient has tried one of Cinryze or Berinert, if one is formulary. If neither are formulary, approve. **2.** Approve if the patient has previously treated an acute HAE attack with Ruconest. B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders.	1 year
Hereditary Angioedema – Prophylaxis Products	Andembry	garadacimab-gxii subcutaneous injection	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Prophylaxis. Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1 or 2): 1. Approve if the patient has tried at least TWO of Dawnzera, Haegarda or Takhzyro, if formulary (or one if one is formulary). If none are formulary, approve. 2. Approve if the patient is currently receiving Andembry. B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders. Condition not recommended for approval. **1.** Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda, Orladeyo, Takhzyro). **Note**: Patients may use other medications, including Cinryze, for on-demand treatment of acute HAE attacks, and for short-term (procedural) prophylaxis.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hereditary Angioedema – Prophylaxis Products	Dawnzera	donidalorsen subcutaneous injection	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Prophylaxis. Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1 or 2): 1. Approve if the patient has tried at least TWO of Andembry, Haegarda, or Takhzyro, if formulary (or one if one is formulary). If none are formulary, approve. 2. Approve if the patient is currently receiving Dawnzera. B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders. Condition not recommended for approval. **1.** Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda, Orladeyo, Takhzyro, Andembry). Note: Patients may use other medications, including Cinryze, for on-demand treatment of acute HAE attacks, and for short-term (procedural) prophylaxis.	1 year
Hereditary Angioedema – Prophylaxis Products	Haegarda	C1 esterase inhibitor [human] for subcutaneous injection	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Prophylaxis. Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1, 2, 3, or 4): 1. Approve if the patient has tried at least TWO of Andembry, Dawnzera, or Takhzyro, if formulary (or one if one is formulary). If none are formulary, approve. 2. If the patient is pregnant or lactating, approve. 3. Patient is < 12 years of age, approve if the patient has tried Takhzyro, if formulary. If Takhzyro is non-formulary, approve. 4. Approve if the patient is currently receiving Haegarda; AND B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders. Condition not recommended for approval. **1.** Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Orladeyo, Takhzyro, Andembry). **Note**: Patients may use other medications, including Cinryze, for on-demand treatment of acute HAE attacks, and for short-term (procedural) prophylaxis.	1 year
Hereditary Angioedema – Prophylaxis Products	Takhzyro	lanadelumab-flyo for subcutaneous injection	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Prophylaxis. Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1, 2, 3, or 4): 1. Approve if the patient has tried at least TWO of Andembry, Dawnzera, or Haegarda, if formulary (or one if one is formulary). If neither are formulary, approve. 2. Patients < 6 years of age: approve. 3. Patient is ≥ 6 years of age and < 12 years of age, approve if the patient has tried Haegarda, if formulary. If Haegarda is non-formulary, approve. 4. Approve if the patient is currently receiving Takhzyro; AND B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders. Condition not recommended for approval. **1.** Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Orladeyo, Haegarda, Andembry). **Note**: Patients may use other medications, including Cinryze, for on-demand treatment of acute HAE attacks, and for short-term (procedural) prophylaxis.	1 year
Hereditary Angioedema – Prophylaxis Products	Orladeyo	berotralstat capsules and oral pellets	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Prophylaxis. Note: A diagnosis of HAE with normal C1-INH (also referred to as HAE type III) does NOT satisfy this requirement. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1, 2, 3 or 4): 1. Approve if the patient has tried TWO of Andembry, Dawnzera, Haegarda, or Takhzyro, if formulary (or one if one is formulary). If none are formulary, approve. 2. Approve if patient is < 12 years of age and ≥ 6 years of age and has tried Haegarda or Takhzyro (or one if one is formulary). If none are formulary, approve. 3. Approve if patient is < 6 years of age and has tried Takhzyro. If Takhzyro is not formulary, approve. 4. Approve if the patient is currently receiving Orladeyo; AND B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders. Conditions not recommended for approval. **1.** Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda, Takhzyro, Andembry). **Note**: Patients may use other medications, including Cinryze, for on-demand treatment of acute HAE attacks, and for short-term (procedural) prophylaxis.	1 year
Hereditary Angioedema Products – IV C1 Esterase Products	Berinert	C1 esterase inhibitor [human] powder for intravenous injection	See Hereditary Angioedema Medications - Berinert FE	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hereditary Angioedema Products – IV C1 Esterase Products	Cinryze	C1 esterase inhibitor [human] powder for intravenous injection	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Prophylaxis. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1, 2, 3 or 4): 1. Approve if the patient has tried three of Andembry, Dawnzera, Berinert, Haegarda, Orladeyo, or Takhzyro, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. 2. If the patient is less than 12 years of age, approve if the patient has tried one of Berinert, Haegarda, Orladeyo, or Takhzyro, if formulary. If none are formulary, approve. 3. If the patient is pregnant or lactating, approve if the patient has tried one of Berinert or Haegarda, if formulary. If neither are formulary, approve. 4. If the patient is currently receiving Cinryze, approve if the patient has tried Berinert, if formulary. If Berinert is non-formulary, approve. B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders. Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] – Treatment of Acute Attacks. Approve if the patient meets both the following (A and B): A. Patient meets one of the following (1, 2, 3, 4, or 5): 1. Approve if the patient has tried one of Berinert or Ruconest, if one is formulary. If neither are formulary, approve. 2. If the patient has an allergy to rabbits or rabbit-derived products, approve if the patient has tried Berinert, if formulary. If Berinert is non-formulary, approve. 3. If the patient is less than 13 years of age, approve if the patient has tried Berinert, if formulary. If Berinert is non-formulary, approve. 4. If the patient has a history of a laryngeal attack, per the prescriber, approve if the patient has tried Berinert, if formulary. If Berinert is non-formulary, approve. 5. If the patient has previously treated an acute attack with Cinryze, approve if the patient has tried Berinert, if formulary. If Berinert is non-formulary, approve. B. The medication is prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders. Hereditary Angioedema (HAE) With Normal C1 Inhibitor (C1-INH) – Treatment of Acute Attacks: Approve. Note: This is also known as HAE type III.	1 year
HMG-CoA Reductase Inhibitors and Combination Products	Altoprev	lovastatin extended-release tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five statins from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** 1. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five statins from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
HMG-CoA Reductase Inhibitors and Combination Products	Atorvaliq	atorvastatin calcium oral suspension	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
HMG-CoA Reductase Inhibitors and Combination Products	Crestor	rosuvastatin tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
HMG-CoA Reductase Inhibitors and Combination Products	Ezallor Sprinkle	rosuvastatin capsules	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
HMG-CoA Reductase Inhibitors and Combination Products	FloLipid	simvastatin oral suspension	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), Altoprev, or a pitavastatin product (Livalo, Zypitamag). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules: approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), Altoprev, or a pitavastatin product (Livalo, Zypitamag). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules: approve. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
HMG-CoA Reductase Inhibitors and Combination Products	Lipitor	atorvastatin tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
HMG-CoA Reductase Inhibitors and Combination Products	Livalo	pitavastatin calcium tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), or fluvastatin (Lescol/XL, generics), or Altoprev. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** 1. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), or fluvastatin (Lescol/XL, generics), or Altoprev. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
HMG-CoA Reductase Inhibitors and Combination Products	Zocor	simvastatin tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
HMG-CoA Reductase Inhibitors and Combination Products	Zypitamag	pitavastatin magnesium tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), Altoprev or Livalo. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), Altoprev or Livalo. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
HMG-CoA Reductase Inhibitors and Combination Products	Lescol XL; fluvastatin ER; fluvastatin	fluvastatin ER tablets; fluvastatin capsules	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), or pitavastatin (Livalo). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin (Zocor, generics), pravastatin (Pravachol, generics), atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), or pitavastatin (Livalo). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
HMG-CoA Reductase Inhibitors and Combination Products	Roszet and authorized generic	rosuvastatin and ezetimibe	Approve if the patient meets the following criteria (A and B): A. Patient has tried ezetimibe; AND B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with atorvastatin (Lipitor, generics) or rosuvastatin (Crestor, generics). If neither of atorvastatin (Lipitor, generics) nor rosuvastatin (Crestor, generics) are formulary, approve.	1 year
HMG-CoA Reductase Inhibitors and Combination Products	Vytorin	ezetimibe/simvastatin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Homozygous Familial Hypercholesterolemia (HoFH) Medications	Juxtapid	lomitapide capsules	Homozygous familial hypercholesterolemia (HoFH) in patients ≥ 2 years of age: **1**. Patient ≥ 2 years of age and < 10, approve. **2**. Patient ≥ 10 years of age and < 18 years of age, approve if the patient has tried Repatha, if formulary. If Repatha is non-formulary, approve. **3**. Patient ≥ 18 years of age, approve if the patient has tried one of Repatha or Praluent, if formulary. If neither are formulary, approve. **4.** Patient with two low-density lipoprotein (LDL)-receptor negative alleles (little to no residual function), approve.	1 year
Homozygous Familial Hypercholesterolemia (HoFH) Medications	Evkeeza	evinacumab-dgnb injection for intravenous use	See standard *Homozygous Familial Hypercholesterolemia – Evkeeza Prior Authorization Policy* criteria.	See PA duration
Human Chorionic Gonadotropin, HCG Agents	chorionic gonadotropin	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Pregnyl, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried Pregnyl or Novarel, if formulary. If neither are formulary, approve. **3.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).	1 year
Human Chorionic Gonadotropin, HCG Agents	Novarel	chorionic gonadotropin 5000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): chorionic gonadotropin, Pregnyl or Ovidrel. If none are formulary, approve. 2. For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried chorionic gonadotropin or Pregnyl, if formulary. If neither are formulary, approve. **3.** Patients with a latex allergy: approve if the patient has tried Pregnyl, if formulary. If Pregnyl is non-formulary, approve. 4. For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).	1 year
Human Chorionic Gonadotropin, HCG Agents	Ovidrel	choriogonadotropin alfa 250 mcg for subcutaneous injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): chorionic gonadotropin, Pregnyl or Novarel. If none are formulary, approve. **2.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).	1 year
Human Chorionic Gonadotropin, HCG Agents	Pregnyl	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): chorionic gonadotropin, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried chorionic gonadotropin or Novarel, if formulary. If neither are formulary, approve. **3.** Patients with a latex allergy: approve if the patient has tried Novarel, if formulary. If Novarel is non-formulary, approve. **4.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).	1 year
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	Edurant	rilpivirine tablet and tablets for oral suspension	For the treatment or prevention of human immunodeficiency virus (HIV), approve.	1 year
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	Intelence 25 mg tablet	etravirine 25 mg tablets	**1.** Approve if the patient has tried one non-nucleoside reverse transcriptase inhibitor (NNRTI) or a NNRTI-containing product (e.g., Sustiva, Edurant, Delstrigo, Complera, Odefsey, Atripla, Symfi, Smyfi Lo). **2.** Patients already started on therapy with Intelence, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	Pifeltro	doravirine tablets	**1.** Approve if the patient has tried one non-nucleoside reverse transcriptase inhibitor (NNRTI) or a NNRTI-containing product (e.g., Sustiva, Edurant, Delstrigo, Complera, Odefsey, Atripla, Symfi, Smyfi Lo). **2.** Patients already started on therapy with Pifeltro, approve.	1 year
Human Immunodeficiency Virus (HIV-1) – Protease Inhibitor (PI) Based Agents	Prezcobix	darunavir and cobicistat tablets	**1.** Approve if the patient has tried one protease inhibitor (PI) or a PI-containing product (e.g., Aptivus, atazanavir [Reyataz, generics], Viracept, ritonavir [Norvir, generics], fosamprenavir, Prezista, Evotaz, lopinavir-ritonavir [Kaletra, generics]). **2.** Approve if, according to the prescriber, the patient meets BOTH of the following (A and B): A. Patient has a history of Apretude (cabotegravir extended-release injectable suspension) for pre-exposure prophylaxis (PrEP); AND B. Patient meets ONE of the following (i or ii): i. Results of resistance testing are not available; OR ii. Patient has integrase strand-transfer inhibitor (INSTI) resistance. **3.** If the patient, according to the prescriber, needs to begin antiretroviral therapy urgently, approve. **4.** Approve if the patient has already been started on therapy with Prezcobix.	1 year
Human Immunodeficiency Virus (HIV-1) - Protease Inhibitor (PIs) Agents	Reyataz	atazanavir oral powder	**1.** Approve if the patient has tried atazanavir capsules (Reyataz, generics), if formulary. If atazanavir capsules (Reyataz, generics) are non-formulary, approve. **2.** Approve if the patient is less than 25 kg (55 pounds). **3.** Approve if the patient is unable to or has difficulty swallowing atazanavir capsules (Reyataz, generics)	1 year
Human Immunodeficiency Virus (HIV-1) - Protease Inhibitor (PIs) Agents	Aptivus capsules	tipranavir capsules	**1.** Approve if the patient has tried one protease inhibitor (PI) or a PI-containing product (e.g., Kaletra, Reyataz, Norvir, Lexiva, Viracept, Prezista, Prezcobix, Evotaz). **2.** Approve if the patient has been started on Aptivus.	1 year
Human Immunodeficiency Virus (HIV-1) - Protease Inhibitor (PIs) Agents	Viracept	nelfinavir mesylate tablets	**1.** Approve if the patient has tried one protease inhibitor (PI) or a PI-containing product (e.g., Aptivus, Reyataz, Norvir, Lexiva, Prezista, Prezcobix, Evotaz, Kaletra). **2.** Approve if the patient has been started on Viracept.	1 year
Human Immunodeficiency Virus (HIV-1) - Protease Inhibitor (PIs) Agents	Norvir powder	ritonavir oral powder	**1.** Approve if the patient has tried ritonavir tablets (Norvir tablets, generics), if formulary. If ritonavir tablets (Norvir tablets, generics) are non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets. **3.** The prescribed dose cannot be obtained with ritonavir tablets (Norvir tablets, generics).	1 year
Human Immunodeficiency Virus (HIV-1) - Protease Inhibitors (PIs) Agents	Prezista suspension	darunavir oral suspension	**1.** Approve if the patient has tried darunavir tablets (Prezista tablets, generics), if formulary. If darunavir tablets (Prezista tablets, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow tablets or has difficulty swallowing tablets. **3.** The prescribed dose cannot be obtained with darunavir tablets (Prezista tablets, generics).	1 year
Human Immunodeficiency Virus (HIV-1) –integrase strand transfer inhibitor (INSTI)	Isentress chewable tablets	raltegravir chewable tablets	**1.** Approve if the patient has tried Isentress oral suspension, if formulary. If Isentress oral suspension is non-formulary, approve. **2.** If the patient requires the 25 mg chewable tablets to achieve the requested dose, approve.	1 year
Human Immunodeficiency Virus (HIV-1) –integrase strand transfer inhibitor (INSTI)	Isentress HD tablets	raltegravir tablets	Approve if the patient has tried Isentress tablets, if formulary. If Isentress tablets are non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Human Immunodeficiency Virus (HIV-1) –integrase strand transfer inhibitor (INSTI)	Isentress powder packets	raltegravir oral suspension	**1.** Approve if the patient has tried Isentress chewable tablets, if formulary. If Isentress chewable tablets are non-formulary, approve. **2.** If the patient has difficulty swallowing chewable tablets, approve.	1 year
Human Immunodeficiency Virus (HIV-1) –integrase strand transfer inhibitor (INSTI)	Isentress tablets	raltegravir tablets	Approve if the patient has tried Isentress HD tablets, if formulary. If Isentress HD tablets are non-formulary, approve.	1 year
Human Immunodeficiency Virus (HIV-1) –integrase strand transfer inhibitor (INSTI) PREP	Apretude	cabotegravir extended-release injectable intramuscular suspension	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Yeztugo (tablets or subcutaneous injection), if formulary. If neither Yeztugo tablets or subcuantous injection or only ONE of Yeztugo tables or subcutaneous injection are formulary, approve. **2.** Approve if the patient has already started taking Vocabria (the optional oral lead in product for Apretude). **3.** Patient has already started on therapy with Apretude. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Yeztugo (tablets or subcutaneous injection), if formulary. If neither Yeztugo tablets or subcuantous injection or only ONE of Yeztugo tables or subcutaneous injection are formulary, approve. **2.** Approve if the patient has already started taking Vocabria (the optional oral lead in product for Apretude). **3.** Patient has already started on therapy with Apretude. **4.** The patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for HIV Pre-Exposure Prophylaxis (PrEP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Human Immunodeficiency Virus (HIV-1) -Other ARVs	Fuzeon	enfuvirtide injection	**1.** Approve if the patient has tried two other antiretroviral agents. **2.** Approve if the patient has been started on Fuzeon.	1 year
Human Immunodeficiency Virus (HIV-1) -Other ARVs	Tybost	cobicistat tablets	**1.** Approve if the patient has tried ritonavir (Norvir, generics), if formulary. If ritonavir (Norvir, generics) are non-formulary, approve. **2.** Patients already started on therapy with Tybost: approve.	1 year
Human Immunodeficiency Virus (HIV-1) -Other ARVs	Selzentry	maraviroc oral solution	**1.** Approve if the patient has tried maraviroc tablets (Selzentry, generics), if formulary. If maraviroc tablets (Selzentry, generics) are non-formulary, approve if the patient meets (A or B): A. Approve if the patient has tried two other antiretroviral agents. B. Approve if the patient has been started on Selzentry. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year
Human Immunodeficiency Virus (HIV-1) –Protease Inhibitor (PI) Based Agents	Evotaz	cobicistat and atazanavir tablets	**1.** Approve if the patient has tried one protease inhibitor (PI) or a PI-containing product (e.g., Aptivus, Reyataz, Viracept, Norvir, Lexiva, Prezista, Prezcobix, Kaletra). **2.** Approve if the patient has been started on Evotaz.	1 year
Human Immunodeficiency Virus (HIV-1) –Protease Inhibitor (PI) Based Agents	Symtuza	darunavir/ cobicistat/ emtricitabine/ tenofovir alafenamide tablets	**1.** Approve if the patient has tried one of the following products: efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla, generics), Biktarvy, Genvoya, Odefsey, Stribild, emtricitabine/rilpivirine/tenofovir disoproxil (Complera, generics), Triumeq, efavirenz-lamivudine-tenofovir disoproxil fumarate (Symfi, Symfi Lo, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking single-entity or combination products containing darunavir, cobicistat, emtricitabine, and tenofovir alafenamide and is requesting Symtuza for a single tablet regimen. **3.** If the patient, according to the prescriber, needs to begin antiretroviral therapy urgently, approve. 4. Patients already started on therapy with Symtuza, approve.	1 year
Human Immunodeficiency Virus – Integrase Inhibitors	Tivicay PD	dolutegravir tablets for oral suspension	**1.** Approve if the patient has tried Tivicay tablets, if formulary. If Tivicay tablets are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets. **3.** Approve if the prescribed dose cannot be obtained with whole Tivicay tablets. **4.** Approve if the patient weighs less than 20 kg.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Human Immunodeficiency Virus – Protease Inhibitors	Prezista 75 mg and 150 mg	darunavir tablets 75 mg and 150 mg	For the treatment or prevention of human immunodeficiency virus (HIV), approve.	1 year
Human Immunodeficiency Virus (HIV) – Specialized	Trogarzo	ibalizumab-uiyk injection for intravenous use	Human Immunodeficiency Virus (HIV) infection, multi-drug treatment-resistant: **1.** Approve if the patient has tried one of Rukobia or Sunlenca OR is concomitantly receiving Rukobia and/or Sunlenca, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on Trogarzo.	1 year
Human Immunodeficiency Virus (HIV) – Specialized	Rukobia	fostemsavir extended-release tablets	Human Immunodeficiency Virus (HIV) infection, multi-drug treatment-resistant. **1.** Approve if the patient has tried Sunlenca or is concomitantly receiving Sunlenca, if formulary. If Sunlenca is non-formulary, approve. **2.** Approve if the patient has exhausted at least FOUR of the following antiretroviral classes defined as elimination of all antiretrovirals within a given class due to demonstrated or projected resistance to the agent(s) in that class OR due to significant intolerance (FOUR of a, b, c, d, e, or f): a) Nucleoside reverse transcriptase inhibitor; OR Note: Examples of nucleoside reverse transcriptase inhibitors include abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine. b) Non-nucleoside reverse transcriptase inhibitor; OR Note: Examples of non-nucleoside reverse transcriptase inhibitor include delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine. c) Protease inhibitor; OR Note: Examples of protease inhibitors include atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir. d) Fusion inhibitor; OR Note: Examples of fusion inhibitors include Fuzeon (enfuviritide for injection). e) Integrase strand transfer inhibitor; OR Note: Examples of integrase strand transfer inhibitors include raltegravir, dolutegravir, elvitegravir. f) CCR5 antagonist. Note: Examples of CCR5 antagonists include Selzentry (maraviroc tablets). **3.** Approve if the patient has already been started on Rukobia therapy.	1 year
Human Immunodeficiency Virus (HIV) – Specialized	Sunlenca	lenacapavir tablets and subcutaneous injection	Human Immunodeficiency Virus (HIV) infection, multi-drug treatment-resistant. **1.** Approve if the patient has tried Rukobia or is concomitantly receiving Rukobia, if formulary. If Rukobia is non-formulary, approve. **2.** Approve if, per the prescriber, the patient has significant adherence issues with antiretrovirals. **3.** Approve if the patient has QTc prolongation OR is or will be taking medications that can prolong the QTc interval. **4.** Approve if the patient has already been started on Sunlenca therapy.	1 year
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Genvoya	cobicistat/elvitegravir/ emtricitabine/tenofovir alafenamide tablets	**1.** Approve if the patient has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve. **2.** Approve if the patient has tried one integrase strand transfer inhibitor (INSTI) or an INSTI-containing product (e.g., Tivicay, Triumeq, Juluca, Stribild, Isentress or Isentress-HD). **3.** Patients already started on therapy with Genvoya: approve.	1 year
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Triumeq	abacavir 600 mg-dolutegravir 50 mg-lamivudine 300 mg tablets	**1.** Approve if the patient has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve. **2.** Approve if the patient has tried one integrase strand transfer inhibitor (INSTI) or an INSTI-containing product (e.g., Genvoya, Tivicay, Juluca, Stribild, Isentress or Isentress-HD). **3.** Patients already started on therapy with Triumeq: approve.	1 year
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Triumeq PD	abacavir 60 mg - dolutegravir 5 mg-lamivudine 30 mg dispersible tablets	Human immunodeficiency virus. Approve for a patient weighing < 25 kg (55 pounds).	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Dovato	dolutegravir/ lamivudine tablets	Approve if the patient has tried both Tivicay AND lamivudine (Epivir, generics), if both are formulary. If only one is formulary or if none are formulary, approve.	1 year
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Juluca	dolutegravir/rilpivirine tablets	Approve if the patient has tried both Tivicay AND Edurant, if both are formulary. If only one is formulary or if none are formulary, approve.	1 year
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Stribild	elvitegravir/ cobicistat/ emtricitabine/ tenofovir tablets	**1.** Approve if the patient has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve. **2.** Approve if the patient has tried one integrase strand transfer inhibitor (INSTI) or an INSTI-containing product (e.g., Genvoya, Tivicay, Triumeq, Juluca, Isentress or Intress-HD). **3.** Patients already started on therapy with Stribild: approve.	1 year
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Cabenuva	cabotegravir extended-release injectable suspension; rilpivirine extended-release injectable suspension, co-packaged	See standard *Human Immunodeficiency Virus – Cabenuva Prior Authorization Policy* criteria.	See PA duration
Human Immunodeficiency Virus (HIV-1) – non-nucleoside reverse transcriptase inhibitor (NNRTI) and nucleoside analog reverse transcriptase inhibitor (NRTI) Combination Products	Idvynso	doravirine and islatravir tablets	**1.** Patient has tried ONE other product for their condition (e.g., Biktarvy, Dovato, Juluca, Tivicay, Truvada, Descovy), approve. **2.** Approve if, per the prescriber, the patient is intolerant to tenofovir. **3.** Approve if, per the prescriber, there is concern regarding integrase strand-transfer inhibitor resistance AND a single tablet regimen is preferred, approve. **4.** Approve if the patient has already been started on therapy with Idvysno.	1 year
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Complera	emtricitabline/rilpivirine/tenofovir disoproxil fumarate (TDF) tablets	<u>If requesting brand Complera tablets</u>: Approve if the patient has tried and cannot take generic Complera tablets, emtricitabline-rilpivirine-tenofovir disoproxil fumarate tablets, due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. <u>If requesting generic Complera tablets or generic Complera tablets are non-formulary</u>: **1.** Approve if the patient has tried Odefsey, if formulary. If Odefsey is non-formulary, approve if the patient has tried one of the following products: Biktarvy, Genvoya, Stribild, Triumeq, Symtuza, efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla, generics), efavirenz-lamivudine-tenofovir (Symfi, Symfi Lo, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking single-entity or combination products containing emtricitabine, rilpivirine, and tenofovir disoproxil fumarate and is requesting Complera for a single-table regimen. **3.** Patient already started on therapy with Complera or generic Complera: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

EXPRESS SCRIPTS®

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Delstrigo	doravirine/lamivudine/tenofovir disoproxil fumarate tablets	**1.** Approve if the patient has tried one of the following products: Biktarvy, Genvoya, Odefsey, Stribild, emtricitabine/rilpivirine/tenofovir disoproxil (Complera, generics), Triumeq, Symtuza, efavirenz-lamivudine-tenofovir (Symfi, Symfi Lo, generics), if formulary. If none are formulary, approve. **2.** Patient < 18 years of age AND weighing ≥ 35 kg (77 pounds), approve if the patient has tried one of Biktarvy, Genvoya, Odefsey, Stribild, emtricitabine/rilpivirine/tenofovir disoproxil (Complera, generics), or efavirenz-lamivudine-tenofovir (Symfi Lo, generics), if formulary. If none are formulary, approve. **3.** Approve if the patient is currently taking single-entity or combination products containing doravirine, lamivudine, and tenofovir disoproxil fumarate and is requesting Delstrigo for a single tablet regimen. **4.** Patients already started on therapy with Delstrigo, approve.	1 year
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Odefsey	emtricitabine/rilpivirine/tenofovir alafenamide (TAF) tablets	**1.** Approve if the patient has tried one of the following products: Biktarvy, Genvoya, Stribild, emtricitabine/rilpivirine/tenofovir disoproxil (Complera, generics), Triumeq, Symtuza, efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla, generics), efavirenz-lamivudine-tenofovir (Symfi , Symfi Lo, generics), if formulary. If none are formulary, approve. 2. Approve if the patient is currently taking single-entity or combination products containing emtricitabine, rilpivirine, and tenofovir alafenamide and is requesting Odefsey for a single-tablet regimen. 3. Patients already started on therapy with Odefsey, approve.	1 year
Human Immunodeficiency Virus (HIV-1) – NRTI Based Combination Products	Truvada	emtricitabine/tenofovir tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for HIV Pre-Exposure Prophylaxis (PrEP) AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN HIV Pre-Exposure Prophylaxis (PrEP) AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Human Immunodeficiency Virus (HIV-1) – Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	Emtriva solution	emtricitabine oral solution	Human Immunodeficiency Virus (HIV) infection, treatment: Approve.	1 year
Human Immunodeficiency Virus (HIV-1) – Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	Retrovir Injection	zidovudine solution for injection	**1.** Human Immunodeficiency Virus (HIV) infection, treatment: Approve. **2.** Prevention of maternal-fetal HIV transmission: Approve.	30 days
Human Immunodeficiency Virus (HIV-1) – Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	Cimduo	lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg tablets	**1.** Approve if the patient has tried one nucleoside reverse transcriptase inhibitor (NRTI) or a NRTI-containing product (e.g., Truvada, Descovy, Ziagen, Epivir, Retrovir, Epzicom, Trizivir, Combivir). **2.** Approve if the patient has already been started on therapy with Cimduo.	1 year
Hutchinson-Gilford Progeria Syndrome Agent	Zokinvy	lonafarnib capsules	See standard *Zokinvy Prior Authorization Policy* criteria.	See PA duration
Hyaluronic Acid Derivatives	Gel-One	hyaluronate gel injection	Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hyaluronic Acid Derivatives	Hyalgan	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Hyalgan: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Supartz FX	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Supartz FX: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Synvisc	sodium hyaluronate injection	**1.** Approve if the patient has tried five other formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Synvisc: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Synvisc-One	sodium hyaluronate injection	Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve.	1 year
Hyaluronic Acid Derivatives	Triluron	sodium hyaluronate 1% injection	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Synojoynt, Visco-3, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Triluron: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Visco-3	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Visco-3: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Durolane	hyaluronic acid intraarticular injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Euflexxa, Monovisc, Hymovis, Hymovis One, GelSyn-3, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve.	1 year
Hyaluronic Acid Derivatives	Euflexxa	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Monovisc, Hymovis, Hymovis One, Durolane, GelSyn-3, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve. **3.** Patients who have already been started on an injection series with Euflexxa: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	GelSyn-3	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GenVisc 850, Hyalgan, Hymovisc, Hymovis One, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Monovisc, Durolane, Euflexxa, Hymovis, Hymovis One, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve. **3.** Patients who have already been started on an injection series with Gel-Syn: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hyaluronic Acid Derivatives	GenVisc 850	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary product from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Monovisc, Durolane, GelSyn-3, Hymovis, Hymovis One, Euflexxa, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve. **3.** Patients who have already been started on an injection series with Genvisc 850: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Hymovis	hyaluronic acid injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Hymovis One, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]** If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Hymovis One, Monovisc, Durolane, Euflexxa, GelSyn-3, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve. **3.** Patients who have already been started on an injection series with Hymovis: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Hymovis One	viscoelastic hyaluronan injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Hymovis, Monovisc, Durolane, Euflexxa, GelSyn-3, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve.	1 year
Hyaluronic Acid Derivatives	Monovisc	high molecular weight hyaluronan injection	**1.** Approve if the patient has tried five fomulary intra-articular hyaluronic products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Hymovis, Hymovis One, GelSyn-3, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve.	1 year
Hyaluronic Acid Derivatives	Orthovisc	high molecular weight hyaluronan	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Orthovisc: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Synojoynt	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid product from the following list ((if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Trivisc, Triluron, or Visco-3 **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Monovisc, Hymovis, Hymovis One, GelSyn-3, Trivisc, or GenVisc 850 **[documentation required]**. If none are formulary, approve. **3.** Patients who have already been started on an injection series with Synojoynt: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyaluronic Acid Derivatives	Trivisc	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid product from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Hymovis One, Synojoynt, Triluron, or Visco-3 **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Monovisc, Hymovis, Hymovis One, GelSyn-3, Synojoynt, or GenVisc 850 **[documentation required]**. If none are formulary, approve. **3.** Patients who have already been started on an injection series with Trivisc: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year
Hyperlipidemia - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors and Related Agents	Repatha/ Repatha Pushtronex	evolocumab injection for subcutaneous use/ evolucumab infusor with prefilled cartridge.	Established Cardiovascular Disease; Heterozygous Familial Hypercholesterolemia (HeFH); Homozygous Familial Hypercholesterolemia (HoFH); Hypercholesterolemia. **1.** Approve if the patient has tried Praluent, if formulary. If Praluent is non-formulary, approve. **2.** Patients with homozygous familial hypercholesterolemia (HoFH): approve if the patient is < 18 years of age.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hyperlipidemia - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors and Related Agents	Lerochol	lerodalcibep-liga subcutaneous injection	Heterozygous Familial Hypercholesterolemia; Hypercholesterolemia (both diagnoses in a patient ≥ 18 years of age). Approve if the patient has tried at least ONE of Repatha or Praluent, if formulary. If neither are formulary, approve.	1 year
Hyperlipidemia - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors and Related Agents	Leqvio	inclisiran subcutaneous injection	Established Cardiovascular Disease; Heterozygous Familial Hypercholesterolemia; Hypercholesterolemia. Approve if the patient has tried Repatha or Praluent, if formulary. If neither are formulary, approve. Homozygous familial hypercholesterolemia (HoFH). Approve if the patient has tried Repatha, if formulary. If Repatha is non-formulary, approve.	1 year
Hyperlipidemia - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors and Related Agents	Praluent	alirocumab injection for subcutaneous use	See standard *Hyperlipidemia – PCSK9 Inhibitors (**Praluent**) Care Value Policy* criteria.	See CV duration
Hyperlipidemia - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors and Related Agents	Lipfendra	enlicitide tablets	Heterozygous Familial Hypercholesterolemia; Hypercholesterolemia (both diagnoses in a patient ≥ 18 years of age). Approve if the patient has tried at least ONE of Repatha or Praluent, if formulary. If neither are formulary, approve.	1 year
Hyperlipidemia Agents	niacin 500 mg by Redmont Pharma	niacin 500 mg by Redmont Pharma	Approve if the patient has tried AND cannot take at least two other prescription or over-the-counter (OTC) niacin-containing products due to a significant allergy to an inactive ingredient (e.g., dyes, fillers, etc.) or due to significant adverse reactions to the other niacin-containing products. NOTE: The physician must provide what differences in the inactive ingredient(s) which leads to an allergy to the other niacin-containing products or provide what serious adverse reactions to the other niacin-containing products that are of concern.	1 year
Hyperlipidemia Agents	Niacor	Nicotinic acid tablet	Approve if the patient has tried AND cannot take at least two other prescription or over-the-counter (OTC) niacin-containing products due to a significant allergy to an inactive ingredient (e.g., dyes, fillers, etc.) or due to significant adverse reactions to the other niacin-containing products. NOTE: The physician must provide what differences in the inactive ingredient(s) which leads to an allergy to the other niacin-containing products or provide what serious adverse reactions to the other niacin-containing products that are of concern.	1 year
Hyperphagia Drugs for Prader-Willi	Vykat XR	diazoxide choline extended-release tablets	See standard *Prader-Willi Syndrome – Vykat XR Prior Authorization Policy* criteria	See PA duration
Hypoactive Sexual Desire Disorder Agents	Addyi	flibanserin tablets	**1.** Approve if the patient has tried Vyleesi, if formulary. If Vyleesi is non-formulary, approve. **2.** Approve if the patient is < 65 years of age AND postmenopausal. **3.** Approve if, according to the prescriber, the patient has uncontrolled hypertension or known cardiovascular disease. **4.** Approve if the patient has already been started on therapy with Addyi.	1 year
Hypoactive Sexual Desire Disorder Agents	Vyleesi	bremelanotide subcutaneous injection	**1.** Approve if the patient has tried Addyi, if formulary. If Addyi is non-formulary, approve. **2.** Approve if, according to the prescriber, the patient requires a treatment option that does NOT carry restrictions or safety risks related to alcohol use. **3.** Approve if, according to the prescriber, the patient has hepatic impairment. **4.** Approve if, per the prescriber Addyi is not clinically appropriate for the patient due to a drug-drug interaction. **5.** Approve if the patient has already been started on therapy with Vyleesi.	1 year
Hypolipoproteinemics	Welchol packets and tablets	colesevelam packets and tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Hypolipoproteinemics	Zetia	ezetimibe tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitor	Vafseo	vadadustat tablets	Treatment of anemia due to chronic kidney disease in a patient ≥ 18 years of age. Approve if the patient meets the following (1 and 2): **1.** Patient has been receiving dialysis for at least 3 consecutive months; AND **2.** Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of the following: an epoetin alfa product or Aranesp or Mircera. Note: Examples of epoetin alfa products are Procrit, Epogen, and Retacrit.	1 year
Idiopathic Macular Telangiectasia Type 2 (MacTel)	Encelto	revakinagene taroretcel-lwey intravitreal implant	See standard *Ophthalmology – Gene Therapy – Encelto Prior Authorization Policy* criteria.	See PA duration
Idiopathic Pulmonary Fibrosis Agents	Pirfenidone 534 mg tablet	pirfenidone 534 mg tablet	Idiopathic pulmonary fibrosis. Patient meets BOTH of the following (i and ii): i. Patient has tried generic pirfenidone tablets or capsules; AND Note: True generic tablets and capsules are available in 267 mg dose. Note: If neither generic pirfenidone tablets or capsules are formulary, approve. ii. Patient cannot continue to use generic pirfenidone due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent product which, per the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Idiopathic Pulmonary Fibrosis Agents	Jascayd	nerandomilast tablets	Idiopathic pulmonary fibrosis. **1.** Approve if the patient has tried or is currently receiving one of pirfenidone tablets or capsules (Esbriet, generics) OR nintedanib (Ofev, generics). If none are formulary, approve. **2.** Patient with hepatic impairment, approve. **3.** Approve if the patient's glomerular filtration rate (eGFR) is < 30 mL/min. **4.** Approve if the patient cannot swallow tablets or capsules OR has difficulty swallowing tablets or capsules. **5.** Patient is pregnant, approve if the patient has tried or is currently receiving pirfenidone tablets or capsules (Esbriet, generics). If none are formulary, approve. **6.** If, according to the prescriber, the patient has or is at risk of coronary artery disease, bleeding events, or gastrointestinal perforation, approve if the patient has tried or is currently receiving pirfenidone tablets or capsules (Esbriet, generics). If none are formulary, approve. **7.** Approve if the patient has already been started on therapy with Jascayd. Note: If the patient has tried Esbriet capsules or pirfenidone 534 tablets, this would satisfy the criteria. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. Progressive Pulmonary Fibrosis. Note: Examples of conditions include hypersensitivity pneumonitis; idiopathic non-specific interstitial pneumonitis; idiopathic non-specific interstitial pneumonia; unclassifiable idiopathic interstitial pneumonia; autoimmune interstitial lung disease (e.g., rheumatoid arthritis interstitial lung disease); exposure-related interstitial lung disease; and mixed connective tissue disease interstitial lung disease. This is not associated with idiopathic pulmonary fibrosis (see indication above). **1.** Approve if the patient has tried or is currently receiving nintedanib (Ofev, generics). If nintedanib (Ofev, generics) are non-formulary, approve. **2.** Patient with hepatic impairment, approve. **3.** Approve if the patient's glomerular filtration rate (eGFR) is < 30 mL/min. **4.** Approve if the patient cannot swallow tablets or capsules OR has difficulty swallowing tablets or capsules. **5.** Approve if the patient is pregnant. **6.** Approve if, according to the prescriber, the patient has or is at risk of coronary artery disease, bleeding events, or gastrointestinal perforation. **7.** Approve if the patient has already been started on therapy with Jascayd.	1 year
Idiopathic Pulmonary Fibrosis Agents	Esbriet	pirfenidone tablets and capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Immune Globulins - Intravenous (IVIG)	Alyglo	immune globulin intravenous, human-stwk, 10% solution	**1.** Approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammaked, Gammagard S/D, Gamunex-C, Octagam, Panzyga, Privigen, Qivigy, Gammaplex, or Yimmugo. If none are formulary, approve. **2.** Approve if, according to the prescriber, a product with minimal content of coagulation factor XIa is needed based on a comorbidity of the patient.	1 year
Immune Globulins - Intravenous (IVIG)	Gammagard S/D IgA ≤ 1 mcg/mL	immune globulin intravenous	**1.** Approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammaked, Gammaplex, Gamunex-C, Octagam, Privigen, Panzyga, Qivigy, or Yimmugo. If none are formulary, approve. **2.** Patient requires an IVIG product with the lowest IgA content: approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Immune Globulins - Intravenous (IVIG)	Panzyga	immune globulin intravenous, human - ifas, 10% liquid preparation	Approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammaked, Gammagard S/D, Gamunex-C, Octagam, Privigen, Qivigy, Gammaplex, or Yimmugo. If none are formulary, approve.	1 year
Immune Globulins - Intravenous (IVIG)	Qivigy	immune globulin intravenous (human) 10% liquid	Approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammaked, Gammagard S/D, Gamunex-C, Octagam, Panzyga, Privigen, Gammaplex, or Yimmugo. If none are formulary, approve.	1 year
Immune Globulins - Intravenous (IVIG)	Yimmugo	immune globulin intravenous, human-dira, 10% liquid	Approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, or Privigen, or Qivigy. If none are formulary, approve.	1 year
Immune Globulins - Intravenous (IVIG)	Asceniv	immune globulin intravenous ,human - slra, 10% liquid	**1.** Approve if the patient has tried three formulary immune globulin (IVIG) products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammaked, Gammagard S/D, Gamunex-C, Octagam, Panzyga, Privigen, Qivigy, Gammaplex, or Yimmugo. If none are formulary, approve. **2.** Approve if, according to the prescriber, the patient requires an immune globulin product with elevated levels of respiratory syncytial virus (RSV) antibodies (e.g., if the patient has repeated RSV infections despite adequate IVIG dosing in a compliant patient.)	1 year
Immune Globulins - Intravenous (IVIG)	Bivigam	immune globulin intravenous (human), 10% liquid	Approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammaked, Gammagard S/D, Gamunex-C, Octagam, Panzyga, Privigen, Qivigy, Gammaplex, or Yimmugo. If none are formulary, approve.	1 year
Immune Globulins - Intravenous (IVIG) and Subcutaneous (SCIG)	Gammagard Liquid	immune globulin intravenous	**1.** If using via the subcutaneous (SC) route: approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): Cuvitru, Hizentra, Xembify, Cutaquig, Gamunex-C, Gammagard Liquid ERC, or Gammaked, if one is formulary. If none are formulary, approve. **2.** If using via the intravenous (IV) route: approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard S/D, Gammagard Liquid ERC, Gammaked, Gammaplex, Gamunex-C, Octagam, Privigen, Panzyga, Qivigy, or Yimmugo. If none are formulary, approve.	1 year
Immune Globulins - Intravenous (IVIG) and Subcutaneous (SCIG)	Gammagard Liquid ERC	immune globulin infusion [human] 10% solution for intravenous or subcutaneous use (IgA Content: ≤ 2 mcg/mL in a 10% solution)	**1.** If using via the subcutaneous (SC) route: approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): Cuvitru, Hizentra, Xembify, Cutaquig, Gamunex-C, Gammaked, or Gammagard Liquid. If none are formulary, approve. **2.** If using via the intravenous (IV) route: approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaplex, Gamunex-C, Gammaked, Octagam, Privigen, Panzyga, Qivigy, or Yimmugo. If none are formulary, approve. **3.** Patient requires an IVIG product with a low IgA content: approve.	1 year
Immune Globulins - Intravenous (IVIG) and Subcutaneous (SCIG)	Gammaked	immune globulin injection (human), 10%	**1.** If using via the subcutaneous (SC) route: approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): Cuvitru, Hizentra, Xembify, Cutaquig, Gamunex-C, Gammagard Liquid ERC, or Gammagard Liquid. If none are formulary, approve. **2.** If using via the intravenous (IV) route: approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammagard S/D, Gammaplex, Gamunex-C, Octagam, Privigen, Panzyga, Qivigy, or Yimmugo. If none are formulary, approve.	1 year
Immune Globulins - Intravenous (IVIG) and Subcutaneous (SCIG)	Gamunex-C	immunoglobulin subcutaneous injection and immune globulin intravenous (IVIG), 10%	**1.** If using via the subcutaneous (SC) route: approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): Cuvitru, Hizentra, Xembify, Cutaquig, Gammaked, Gammagard Liquid ERC, or Gammagard Liquid. If none are formulary, approve. **2.** If using via the intravenous (IV) route: approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard Liquid ERC, Gammaked, Gammaplex, Gammagard S/D, Octagam, Privigen, Panzyga, Qivigy, or Yimmugo. If none are formulary, approve.	1 year
Immune Globulins - $Rh_0(D)$	HyperRHO S/D full dose	$Rh_0(D)$ immune globulin injection [human]	Approve if the patient has tried one formulary Rho(D) immune globlin from the following list: WinRho SDF, RhoGAM, HyperRHO S/D mini-dose, or Rhophylac. If none are formulary, approve.	1 year
Immune Globulins - $Rh_0(D)$	HyperRHO S/D mini-dose	$Rh_0(D)$ immune globulin injection [human]	Approve if the patient has tried one formulary Rho(D) immune globlin from the following list: WinRho SDF, RhoGAM, HyperRHO S/D full-dose, or Rhophylac. If none are formulary, approve.	1 year
Immune Globulins - $Rh_0(D)$	RhoGAM	$Rh_0(D)$ immune globulin injection [human]	Approve if the patient has tried one formulary Rho(D) immune globlin from the following list: WinRho SDF, HyperRHO S/D full-dose, HyperRHO SD mini-dose, or Rhophylac. If none are formulary, approve.	1 year
Immune Globulins - $Rh_0(D)$	Rhophylac	$Rh_0(D)$ immune globulin injection [human]	**1.** Patient has immune (idiopathic) thrombocytopenic purpura (ITP): approve if the patient has tried WinRho SDF, if formulary. If WinRho SDF is non-formulary, approve. **2.** Patient requires intravenous (IV) administration (e.g., either due to large doses or multiple doses needed): approve if the patient has tried WinRho SDF, if formulary. If WinRho SDF is non-formulary, approve. **3.** Patient has contraindications to intramuscular (IM) injections: approve if the patient has tried WinRho SDF, if formulary. If WinRho SDF is non-formulary, approve. **4.** Approve if the patient has tried one formulary Rho(D) immune globlin product from the following list: RhoGam, HyperRHO S/D full-dose, HyperRHO SD mini-dose, or WinRho SDF. If none are formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Immune Globulins - $Rh_0(D)$	WinRho SDF	$Rh_0(D)$ immune globulin injection [human]	**1.** Patient has immune (idiopathic) thrombocytopenic purpura (ITP): approve if the patient has tried Rhophylac, if formulary. If Rhophylac is non-formulary, approve. a. Patient is < 18 years of age, approve. **2.** Patient requires intravenous (IV) administration (e.g., either due to large doses or multiple doses needed): approve if the patient has tried Rhophylac, if formulary. If Rhophylac is non-formulary, approve. **3.** Patient has contraindications to intramuscular (IM) injections: approve if the patient has tried Rhophylac, if formulary. If Rhophylac is non-formulary, approve. **4.** Approve if the patient has tried one formulary Rho(D) immune globlin from the following list: RhoGam, HyperRHO S/D full-dose, HyperRHO SD mini-dose, Rhophylac. If none are formulary, approve.	1 year
Immune Globulins - Subcutaneous (SCIG)	Cutaquig	Immune globulin subcutaneous [human] 16.5% solution	Approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): Cuvitru, Hizentra, Xembify, Gamunex-C, Gammagard Liquid, Gammagard Liquid ERC, or Gammaked. If none are formulary, approve.	1 year
Immune Globulins - Subcutaneous (SCIG)	Cuvitru	immune globulin subcutaneous [human] 20% solution	**1.** Approve if the patient has tried BOTH Hizentra and Xembify, if formulary (try one if one is formulary). If neither are formulary, approve. **2.** Approve in patients with hypersensitivities to polysorbate 80. **3.** Patients with hyperprolinemia, approve.	1 year
Immune Globulins - Subcutaneous (SCIG)	Hizentra	immune globulin subcutaneous [human] 20% liquid	**1.** Approve if the patient has tried BOTH Cuvitru and Xembify, if formulary (try one if one is formulary). If neither are formulary, approve. **2.** Chronic inflammatory demyelinating polyneuropathy (CIDP), approve.	1 year
Immune Globulins - Subcutaneous (SCIG)	HyQvia	immune globulin infusion (human) 10% with recombinant human hyaluronidase subcutaneous	**1.** Approve if the patient has tried three products from the following list: Cuvitru, Hizentra, Xembify, Cutaquig, Gamunex-C, Gammagard Liquid ERC, Gammagard Liquid, or Gammaked, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** Chronic inflammatory demyelinating polyneuropathy (CIDP), approve if the patient tried Hizentra, if formulary. If Hizentra is non-formulary, approve.	1 year
Immune Globulins - Subcutaneous (SCIG)	Xembify	immune globulin subcutaneous, [human] 20% solution	**1.** Approve if the patient has tried BOTH Cuvitru and Hizentra, if formulary (try one if one is formulary). If neither are formulary, approve. **2.** Patients with hyperprolinemia, approve.	1 year
Immunological Agents	Cinqair	reslizumab for intravenous injection	Asthma with an eosinophilic phenotype. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 18 years of age: Patient has tried TWO formulary alternatives from the following list (or one if one is formulary): Nucala, Fasenra, or Exdensur. If none are formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve; OR B. Patient has already been started on therapy with Cinqair.	1 year
Immunological Agents	Exdensur	depemokimab-ulaa subcutaneous injection	Asthma with an eosinophilic phenotype. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 12 years of age: Patient has tried BOTH formulary alternatives from the following list (or one if one is formulary): Nucala and Fasenra. If neither are formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve; OR B. Patient has already been started on therapy with Exdensur.	1 year
Immunological Agents	Tezspire	tezepelumab-ekko subcutaneous injection	Asthma. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 12 years of age: Approve if the patient meets ONE of the following (i or ii): i. Patient has tried ONE of the following: Dupixent, Xolair, Nucala, Exdensur, or Fasenra. If none are formulary, approve; OR Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. ii. If, per the prescriber, based on the asthma phenotype, the patient is not a candidate for one of the following therapies: Dupixent, Xolair, Nucala, Exdensur, or Fasenra; OR B. Patient has already been started on therapy with Tezspire. Chronic Sinusitis with Nasal polyps. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 12 years of age: Patient has tried Dupixent, if formulary. If Dupixent is non-formulary, approve; OR B. Patient has already been started on therapy with Tezspire.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Immunological Agents	Nucala	mepolizumab for subcutaneous injection	Asthma with an eosinophilic phenotype. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 6 years of age: Approve if the patient meets ONE of the following (i or ii): i. Patient has tried BOTH formulary alternatives from the following list (or one if one is formulary): Fasenra and Exdensur. If neither are formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve; OR ii. Patient is ≥ 6 to < 12 years old: Patient has tried Fasenra, if formulary. If Fasenra is non-formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve; OR B. Patient has already been started on therapy with Nucala. Eosinophilic granulomatosis with polyangiitis (formerly known as Churg-Strauss Syndrome). Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 18 years of age: approve if the patient has tried Fasenra. If Fasenra is non-formulary, approve OR B. Patient has already been started on therapy with Nucala. Hypereosinophilic syndrome. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 12 years of age, patient has tried Fasenra. If Fasenra is non-formulary, approve; OR B. Patient has already been started on therapy with Nucala. Chronic Sinusitis with Nasal polyps. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 18 years of age: Patient has tried one of Dupixent or Tezspire, if formulary. If neither are formulary, approve; OR B. Patient has already been started on therapy with Nucala. Chronic obstructive pulmonary disease with an eosinophilic phenotype. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 18 years of age, the patient has tried Dupixent, if formulary. If Dupixent is non-formulary, approve; OR B. Patient has already been started on therapy with Nucala.	1 year
Immunological Agents	Fasenra	benralizumab for subcutaneous injection	Asthma with an eosinophilic phenotype. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 6 years of age: Approve if the patient meets one of the following (i or ii): i. Patient has tried BOTH formulary alternatives from the following list (or one if one is formulary): Nucala and Exdensur. If neither is formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve; OR ii. Patient is ≥ 6 to < 12 years old: Patient has tried Nucala if formulary. If Nucala is non-formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve; OR B. Patient has already been started on therapy with Fasenra. Eosinophilic granulomatosis with polyangiitis (formerly known as Churg-Strauss Syndrome). Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 18 years of age: Approve if the patient has tried Nucala. If Nucala is non-formulary, approve; OR B. Patient has already been started on therapy with Fasenra. Hypereosinophilic syndrome. Approve if the patient meets ONE of the following (A or B): A. Initial therapy in a patient ≥ 12 years of age, patient has tried Nucala. If Nucala is non-formulary, approve; OR B. Patient has already been started on therapy with Fasenra.	1 year
Immunologicals - Interleukin (IL)-13 antagonist	Adbry	tralokinumab-ldrm subcutaneous injection	Moderate to severe atopic dermatitis in a patient ≥ 12 years of age. **1.** Approve if the patient has tried one of Dupixent or Ebglyss, if formulary. If neither are formulary, approve. **2.** If the patient is < 40 kg, approve if the patient has tried Dupixent, if formulary. If Dupixent is non-formulary, approve. **3.** Approve if the patient is currently receiving and has already been on Adbry for ≥ 4 months.	1 year
Immunologicals - Interleukin (IL)-13 antagonist	Ebglyss	lebrikizumab-lbkz subcutaneous injection	Moderate to severe atopic dermatitis in a patient ≥ 12 years of age. **1.** Approve if the patient has tried one of Dupixent or Adbry, if formulary. If neither are formulary, approve. **2.** Approve if the patient is currently receiving and has already been on Ebglyss for ≥ 4 months.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Immunologicals - Other	Provenge	sipuleucel-T suspension for intravenous infusion	Prostate Cancer. Approve if the patient meets the following criteria (A, B, C, D, E, and F): A) Patient is ≥ 18 years of age; AND B) Patient has metastatic castration-resistant (hormone-refractory) prostate cancer; AND C) Patient has minimal or no disease symptoms, according to the prescriber; AND D) Patient does not have liver metastasis; AND E) Patient has not been previously treated with a complete course (3 doses) of Provenge for prostate cancer; AND F) The medication is prescribed by or in consultation with an oncologist.	3 months
Immunosuppressant Agents	Myhibbin	mycophenolate mofetil oral suspension	Approve if the patient has tried and cannot take mycophenolate mofetil oral suspension (Cellcept oral suspension), if formulary. If mycophenolate mofetil oral suspension (Cellcept oral suspension), is non-formulary, approve.	1 year
Immunosuppressant Agents	Astagraf XL	tacrolimus extended-release capsules	**1.** Approve if the patient has tried and cannot take tacrolimus immediate-release capsules (Prograf, generics), if formulary. If tacrolimus immediate-release capsules (Prograf, generics) are non-formulary, approve. **2.** If the patient has already started on therapy with Astagraf XL, approve.	1 year
Immunosuppressant Agents	Envarsus XR	tacrolimus extended-release tablets	**1.** Approve if the patient has tried and cannot take tacrolimus immediate-release capsules (Prograf, generics), if formulary. If tacrolimus immediate-release capsules (Prograf, generics) are non-formulary, approve. **2.** Approve if the patient has the CYP3A5*1 allele. Note: The CYP3A5*1 allele is a gene variant determined by testing that may confer faster metabolism of certain medications. **3.** If the patient has already started on therapy with Envarsus XR, approve.	1 year
Immunosuppressant Agents	Nulojix	belatacept injection for intravenous use	**1.** Kidney Transplantation – Prophylaxis of Organ Rejection. Approve if the patient meets the following criteria (A, B, and C): A. Patient is ≥ 18 years of age; AND B. Patient is Epstein-Barr virus (EBV) seropositive; AND C. Nulojix is prescribed by or in consultation with a transplant specialist physician or a physician associated with a transplant center. **2.** Solid Organ Transplantation Other Than Kidney – Prophylaxis of Solid Organ Rejection in a Patient Currently Receiving Nulojix. Approve if the patient if the patient meets the following criteria (A, B, and C): A. Patient is ≥ 18 years of age; AND B. Patient is Epstein-Barr virus (EBV) seropositive; AND C. Nulojix is prescribed by or in consultation with a transplant specialist physician or a physician associated with a transplant center.	1 year
Immunosuppressant Agents	Prograf Granules	tacrolimus for oral suspension	**1.** Approve if the patient has tried tacrolimus capsules (Prograf capsules, generics), if formulary. If tacrolimus capsules (Prograf capsules, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets. **3.** If the patient has already been started on Prograf granules, approve.	1 year
Immunosuppressant Agents – Cyclophosphamide Intravenous Agents	Frindovyx and cyclophosphamide intravenous (brand)	cyclophosphamide intravenous	Approve if the patient has tried one other formulary cyclophosphamide intravenous injection product. If none are formulary, approve.	1 year
Immunosuppressant Agents – Methotrexate Injections	Otrexup	methotrexate injection for subcutaneous use; 10mg, 12.5 mg, 15 mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg	Approve if the patient has tried Rasuvo, if formulary. If Rasuvo is non-formulary, approve if, according to the prescriber, the patient and caregiver are unable to administer methotrexate injection (NOT including Otrexup or Rasuvo).	1 year
Immunosuppressant Agents – Methotrexate Injections	Rasuvo	methotrexate injection for subcutaneous use; 7.5 mg, 10 mg, 12.5 mg, 15 mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg, 30 mg	Approve if the patient has tried Otrexup, if formulary. If Otrexup is non-formulary, approve if, according to the prescriber, the patient and caregiver are unable to administer methotrexate injection (NOT including Rasuvo or Otrexup).	1 year
Immunosuppressant Agents – Oral Methotrexate Agents	Jylamvo	methotrexate 2 mg/mL oral solution	Approve if the patient has tried Xatmep, if formulary. If Xatmep is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient cannot swallow or has difficulty swallowing oral methotrexate tablets; OR **2.** The dose prescribed cannot be obtained using whole methotrexate tablets.	1 year
Immunosuppressant Agents – Oral Methotrexate Agents	Xatmep	methotrexate 2.5 mg/mL oral solution	Approve if the patient has tried Jylamvo, if formulary. If Jylamvo is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient cannot swallow or has difficulty swallowing oral methotrexate tablets; OR **2.** The dose prescribed cannot be obtained using whole methotrexate tablets.	1 year
Immunosuppressant Agents – Oral Methotrexate Agents	Trexall	methotrexate tablets 5 mg, 7.5 mg, 10 mg, 15 mg	**1.** Direct to methotrexate 2.5 mg tablets. **2.** Approve if, according to the prescriber, there is a clinical reason the patient is unable to use methotrexate 2.5 mg tablets.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Immunosuppressive Agent	Rezurock	belumosudil tablets	See standard *Graft-Versus-Host Disease – Rezurock Prior Authorization Policy* criteria	See PA duration
Infectious Disease	Impavido	miltefosine capsules	See standard *Infectious Disease – Impavido Prior Authorization Policy* criteria	See PA duration
Inflammatory Agents - Interleukin-36 receptor (IL-36) antagonist	Spevigo Intravenous	spesolimab-sbzo intravenous infusion	See standard *Inflammatory Conditions – Spevigo Intravenous Prior Authorization Policy* criteria	See PA duration
Inflammatory Agents - Interleukin-36 receptor (IL-36) antagonist	Spevigo Subcutaneous	spesolimab-sbzo subcutaneous injection	See standard *Inflammatory Conditions – Spevigo Subcutaneous Prior Authorization Policy* criteria	See PA duration
Inflammatory Bowel Agents	Pentasa 250 mg capsule	mesalamine controlled-release 250 mg capsule	Approve if the patient has tried two other mesalamine products from the following list, if formulary (or one if one is formulary): mesalamine delayed-release tablets (Asacol HD, generics), mesalamine delayed-release tablets (Lialda, generics), mesalamine delayed-release capsule (Delzicol, generics), or mesalamine extended-release capsules (Apriso, generics). If none are formulary, approve.	1 year
Inflammatory Bowel Agents	Dipentum	olsalazine capsule	Approve if the patient has tried two products from the following list (if two are formulary, or one if one is formulary): mesalamine delayed-release tablets (Asacol HD, generics), sulfasalazine (generics), mesalamine delayed-release tablets (Lialda, generics), mesalamine delayed-release capsule (Delzicol, generics), balsalazide (Colazal, generics), mesalamine extended-release capsules (Apriso, generics) or Pentasa. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Inflammatory Bowel Agents	Canasa	mesalamine rectal suppository	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Inflammatory Bowel Agents	Lialda	mesalamine delayed-release tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Inflammatory Conditions	Sovuna	hydroxychloroquine sulfate 200 mg, 300 mg	**1.** Direct to generic hydroxychloroquine tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic hydroxychloroquine tablets.	1 year
Inflammatory Conditions	Plaquenil	hydroxychloroquine sulfate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Inflammatory Conditions – Biologics for CAPS and Other Uses	Arcalyst	rilonacept for SC injection	**1.** Cryopyrin-Associated Periodic Syndromes (CAPS) [including Familial Cold Autoinflammatory Syndrome, Muckle-Wells Syndrome, and Neonatal Onset Multisystem Inflammatory Disease or chronic infantile neurological cutaneous and articular syndrome]: Approve if the patient has tried Ilaris. If Ilaris is non-formulary, approve. **2.** Deficiency of Interleukin-1 Receptor Antagonist: Approve if the patient has tried Kineret. If Kineret is non-formulary, approve. **3.** Pericarditis: Approve if the patient has recurrent disease and meets one of the following criteria (A or B): A) Patient has tried standard therapy (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], colchicine, and/or systemic corticosteroids); OR B) Patient cannot try a standard therapy (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], colchicine, and/or systemic corticosteroids) due to a contraindication. **4.** For indications included in 1-3 above: Patient has been established on Arcalyst for ≥ 90 days: Approve. **5.** For indications included in 1-3 above: Patient has been taking Arcalyst for < 90 days: Refer to appropriate criteria above.	1 year
Inflammatory Conditions – Biologics for CAPS and Other Uses	Ilaris	canakinumab for SC injection	**1.** Cryopyrin-Associated Periodic Syndromes (CAPS) [including Familial Cold Autoinflammatory Syndrome and Muckle-Wells Syndrome, Neonatal Onset Multisystem Inflammatory Disease, and chronic infantile neurological cutaneous and articular syndrome]: Approve if the patient has tried Arcalyst. If Arcalyst is non-formulary, approve. a. If the patient is < 12 years of age: Approve. **2.** Systemic Juvenile Idiopathic Arthritis (SJIA) and Still's Disease (Adult Onset): Approve if the patient has tried one of the following: a tociluzumab product (e.g., Actemra IV or SC, biosimilars) or Kineret. If none are formulary, approve. **3.** Gout, Acute Flare (in a patient ≥ 18 years of age): Approve if the patient has tried non-steroidal anti-inflammatory drugs (NSAIDs) and colchicine OR if, according to the prescriber, NSAIDs and colchicine cannot be used by the patient. **4.** Familial Mediterranean Fever, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, or Tumor Necrosis Factor Receptor Associated Periodic Syndrome: Approve. **5.** For indications included in 1 & 2 above: Patient has been established on Ilaris for ≥ 90 days: Approve. **6.** For indications included in 1 & 2 above: Patient has been started on Ilaris for < 90 days: Refer to the appropriate criteria above.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Infused Non-TNF Biologics	Entyvio IV	vedolizumab for IV infusion	Ulcerative Colitis. Approve if the patient meets one of the following (1 or 2): **1.** Initial therapy in a patient ≥ 18 years of age. Patient has tried two of 1) an ustekinumab intravenous (IV)/subcutaneous (SC) product (Stelara IV/SC, Selarsdi IV/SC, Yesintek IV/SC, Otulfi IV/SC, Wezlana, IV/SC, Pyzchiva IV/SC, ustekinumab-ttwe IV/SC, or Steqeyma IV/SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve; OR Note: All the ustekinumab products counting as one alternative. **2.** Patient has already been started on therapy with Entyvio (IV or SQ). Crohn's disease. Approve if the patient meets one of the following (1 or 2): **1.** Initial therapy in a patient ≥ 18 years of age. Patient has tried one of 1) Skyrizi IV/On body or 2) Tremfya IV/SC, if formulary. If neither are formulary, approve; OR **2.** Patient has already been started on therapy with Entyvio (IV or SQ). Gastrointestinal Toxicity Associated with Checkpoint Inhibitor Therapy; Graft-Versus-Host Disease: approve.	1 year
Inflammatory Conditions – Infused Non-TNF Biologics	Omvoh IV	mirikizumab-mrkz intravenous	Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. **1.** Initial therapy: Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) an ustekinumab product (Stelara IV/SC, biosimilars), 3) Skyrizi IV/SC, or 4) Tremfya IV/SC if two are formulary (or one if one is formulary). If none are formulary, approve. Note: All the ustekinumab products counting as one alternative. **2.** Approve if the patient has already been started on induction therapy with Omvoh IV and requires 1 or 2 more doses to complete induction. Crohn's disease, for an induction regimen in a patient ≥ 18 years of age. **1.** Initial therapy: Approve if the patient has tried one of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) an ustekinumab product (Stelara IV/SC, biosimilars), 3) Skyrizi IV/SC, or 4) Tremfya IV/SC, if formulary. If none are formulary, approve. Note: All the ustekinumab products counting as one alternative. **2.** Approve if the patient has already been started on induction therapy with Omvoh IV and requires 1 or 2 more doses to complete induction.	1 year
Inflammatory Conditions – Infused Non-TNF Biologics	Omvoh SC	mirikizumab-mrkz subcutaneous injection	Ulcerative Colitis- Maintenance therapy (not induction therapy). **1.** Approve if the patient has received Omvoh intravenous (IV) for induction. **2.** Approve if the patient has already been started on therapy with Omvoh IV or subcutaneous (SC). **3.** Patient who has not yet received induction therapy with Omvoh IV: Direct to two of 1) an ustekinumab product (Stelara IV/SC, biosimilars), 2) Entyvio IV/SC, 3) Skyrizi IV/SC, or 4) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, direct to Omvoh IV for Induction. Note: All the ustekinumab products counting as one alternative. Crohn's disease- Maintenance therapy (not induction therapy). **1.** Approve if the patient has received Omvoh intravenous (IV) for induction. **2.** Approve if the patient has already been started on therapy with Omvoh IV or subcutaneous (SC). **3.** Patient who has not yet received induction therapy with Omvoh IV: Direct to one of 1) an ustekinumab product (Stelara IV/SC, biosimilars), 2) Entyvio IV/SC, 3) Skyrizi IV/SC, or 4) Tremfya IV/SC, if formulary. If none are formulary, direct to Omvoh IV for Induction. Note: All the ustekinumab products counting as one alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Infused Non-TNF Biologics	Orencia IV	abatacept injection for intravenous use	Rheumatoid Arthritis: **1.** Patient has tried at least one biologic: Approve. Examples: a tocilizumab product (e.g., Actemra intravenous [IV] or subcutaneous [SC], biosimilars), a sarilumab product (Kevzara), an anakinra product (Kineret), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or SC, biosimilars), an infliximab IV product (e.g., Remicade, biosimilars), or a rituximab product (e.g., Rituxan, biosimilars). If none are formulary, approve. **2.** According to the prescriber, the patient previously experienced a serious infection: Approve. **3.** Patient is currently taking Orencia intravenous or subcutaneous: Approve if the patient has been established on Orencia intravenous or subcutaneous for ≥ 3 months. Juvenile Idiopathic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: a tocilizumab product (e.g., Actemra IV or SC, biosimilars), a sarilumab product (Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), or a golimumab IV product (e.g., Simponi Aria, biosimilars). If none are formulary, approve. **2.** According to the prescriber, the patient previously experienced a serious infection: Approve. **3.** Patient is currently taking Orencia intravenous or subcutaneous: Approve if the patient has been established on Orencia intravenous or subcutaneous for ≥ 3 months. Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or SC, biosimilars), an infliximab IV product (e.g., Remicade, biosimilars), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya), or a ustekinumab product (e.g., Stelara SC, biosimilars). If none are formulary, approve. **2.** According to the prescriber, the patient previously experienced a serious infection: Approve. **3.** Patient is currently taking Orencia intravenous or subcutaneous: Approve if the patient has been established on Orencia intravenous or subcutaneous for ≥ 3 months. Graft-Versus-Host Disease – Prevention: Approve. Chronic Graft-Versus Host Disease – Treatment: Approve	1 year
Inflammatory Conditions – Infused Non-TNF Biologics	Entyvio SC	vedolizumab for subcutabeous injection	See standard *Inflammatory Conditions (**Entyvio SC**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – Infused Non-TNF Biologics – Tocilizumab Intravenous Agents	Actemra IV	tocilizumab intravenous infusion	If any of Avtozma IV, Tyenne IV, or Tofidence IV are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of Avtozma IV, Tyenne IV, and Tofidence IV, if formulary (or two if two are formulary or one if one is formulary); AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of these products are formulary: Avtozma IV, Tyenne IV, AND Tofidence IV: Polyarticular Juvenile Idiopathic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an abatacept product (e.g., Orencia intravenous [IV] or subcutaneous), a sarilumab product (e.g., Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab IV product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars). If none are formulary, approve. **2.** Approve if the patient has been established on a tocilizumab product (e.g., Actemra IV or SC, Avtozma IV or SC, Tyenne IV or SC, or Tofidence IV) for ≥ 90 days. If none of these products are formulary: Avtozma IV, Tyenne IV, and Tofidence IV: Giant Cell Arteritis; Polymyalgia Rheumatica; Systemic Juvenile Idiopathic Arthritis; Castleman Disease; Still's Disease – Adult Onset; Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy; Immune Checkpoint Inhibitor Therapy-Related Toxicities; Cytokine Release Syndrome Associated with Bispecific CD3 T-Cell Engager Therapy; Graft Versus Host Disease; Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic (VEXAS) Syndrome: Approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Infused Non-TNF Biologics – Tocilizumab Intravenous Agents	Avtozma IV	tocilizumab-anoh intravenous infusion	If any of Actemra IV, Tyenne IV or Tofidence IV are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: Actemra IV, Tyenne IV and Tofidence IV, if formulary (or two if two are formulary or one if one is formulary); AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of these products are formulary: Actemra IV, Tyenne IV, AND Tofidence IV: Polyarticular Juvenile Idiopathic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an abatacept product (e.g., Orencia intravenous [IV] or subcutaneous), a sarilumab product (e.g., Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab IV product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars). If none are formulary, approve. **2.** Approve if the patient has been established on a tocilizumab product (e.g., Actemra IV or SC, Avtozma IV or SC, Tyenne IV or SC, or Tofidence IV) for ≥ 90 days. If none of these products are formulary: Actemra IV, Tyenne IV, AND Tofidence IV: Giant Cell Arteritis; Polymyalgia Rheumatica; Systemic Juvenile Idiopathic Arthritis; Castleman Disease; Still's Disease – Adult Onset; Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy; Immune Checkpoint Inhibitor Therapy-Related Toxicities; Cytokine Release Syndrome Associated with Bispecific CD3 T-Cell Engager Therapy; Graft Versus Host Disease; Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic (VEXAS) Syndrome: Approve.	1 year
Inflammatory Conditions – Infused Non-TNF Biologics – Tocilizumab Intravenous Agents	Tofidence IV	tocilizumab-bavi intravenous infusion	If any of Actemra IV, Avtozma IV, or Tyenne IV are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: Actrema IV, Avtozma IV, and Tyenne IV, if formulary (or two if two are formulary or one if one is formulary); AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of these products are formulary: Actemra IV, Avtozma IV, AND Tyenne IV: Polyarticular Juvenile Idiopathic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an abatacept product (e.g., Orencia intravenous [IV] or subcutaneous), a sarilumab product (e.g., Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab IV product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars). If none are formulary, approve. **2.** Approve if the patient has been established on a tocilizumab product (e.g., Actemra IV or SC, Avtozma IV or SC, Tyenne IV or SC, or Tofidence IV) for ≥ 90 days. If none of these products are formulary: Actemra IV, Avtozma IV, and Tyenne IV: Giant Cell Arteritis; Polymyalgia Rheumatica; Systemic Juvenile Idiopathic Arthritis; Castleman Disease; Still's Disease - Adult Onset; Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy; Immune Checkpoint Inhibitor Therapy-Related Toxicities; Cytokine Release Syndrome Associated with Bispecific CD3 T-Cell Engager Therapy; Graft Versus Host Disease; Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic (VEXAS) Syndrome: Approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Infused Non-TNF Biologics – Tocilizumab Intravenous Agents	Tyenne IV	tocilizumab-aazg intravenous infusion	If any of Actemra IV, Avtozma IV, or Tofidence IV are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of Actrema IV, Avtozma IV, and Tofidence IV, if formulary (or two if two are formulary or one if one is formulary); AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of these products are formulary: Actemra IV, Avtozma IV, AND Tofidence IV: Polyarticular Juvenile Idiopathic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an abatacept product (e.g., Orencia intravenous [IV] or subcutaneous), a sarilumab product (e.g., Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab IV product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars). If none are formulary, approve. **2.** Approve if the patient has been established on a tocilizumab product (e.g., Actemra IV or SC, Avtozma IV or SC, Tyenne IV or SC, or Tofidence IV) for ≥ 90 days. If none of these products are formulary: Actemra IV, Avtozma IV, and Tofidence IV: Giant Cell Arteritis; Polymyalgia Rheumatica; Systemic Juvenile Idiopathic Arthritis; Castleman Disease; Still's Disease–Adult Onset; Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy; Immune Checkpoint Inhibitor Therapy-Related Toxicities; Cytokine Release Syndrome Associated with Bispecific CD3 T-Cell Engager Therapy; Graft Versus Host Disease; Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic (VEXAS) Syndrome: Approve.	1 year
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Imuldosa IV	ustekinumab- srlf for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Otulfi IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Starjemza IV, or Yesintek IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Otulfi IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Wezlana IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Yesintek IV, 7) Selarsdi IV and 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Otulfi IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Yesintek IV, Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Otulfi IV	ustekinumab- aauz for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Starjemza IV, or Yesintek IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Wezlana IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Yesintek IV, 7) Selarsdi IV, and 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Yesintek IV, Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Pyzchiva IV	ustekinumab- ttwe for IV infusion	Direct to ustekinumab-ttwe IV, if formulary. If ustekinumab-ttwe IV is non-formulary, If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Yesintek IV, Otulfi IV, or Starjemza IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Wezlana IV, 5) Yesintek IV, 6) Otulfi IV, 7) Selarsdi IV, and 8) Starjemza IV, if formulary; AND Note: Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Yesintek IV, Otulfi IV, Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Selarsdi IV	ustekinumab-aekn IV	If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Otulfi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Starjemza IV, or Yesintek IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Wezlana IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Yesintek IV, 7) Otulif IV, and 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Otulfi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Yesintek IV, Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Starjemza IV	ustekinumab- hmny for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Otulfi IV, Pyzchiva IV or ustekinumab-ttwe IV, or Yesintek IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Wezlana IV, 5) Otulfi IV, 6) Pyzchiva IV or ustekinumab-ttwe IV, 7) Yesintek IV, and 8) Selarsdi IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab IV products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Otulfi IV, Pyzchiva IV or ustekinumab-ttwe IV, Yesintek IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Stelara IV	ustekinumab for IV infusion	Direct to ustekinumab unbranded for intravenous (IV) infusion (Janssen Biotech), if formulary. If ustekinumab unbranded IV infusion (Janssen Biotech) is non-formulary: If any of the following ustekinumab IV products are formulary, Imuldosa IV, Selarsdi IV, Steqeyma IV, Wezlana IV, Yesintek IV, Pyzchiva IV, or ustekinumab-ttwe IV, Starjemza IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Steqeyma IV, 3) Wezlana IV, 4) Yesintek IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Otulfi IV, 7) Selarsdi IV and 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Steqeyma IV, Wezlana IV, Yesintek IV, Pyzchiva IV, or ustekinumab-ttwe IV, Otulfi IV, or Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Steqeyma IV	ustekinumab-stba for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Wezlana IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, Starjemza IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Wezlana IV, 4) Yesintek IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Otulfi IV, 7) Selarsdi IV, and 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Wezlana IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, Otulfi IV, Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	ustekinumab IV (unbranded version of Stelara IV)	ustekinumab IV (unbranded version of Stelara IV)	Direct to Stelara intravenous (IV) [brand], if formulary. If Stelara IV (brand) is non-formulary: If any of the following ustekinumab IV products are formulary, Imuldosa IV, Selarsdi IV, Steqeyma IV, Wezlana IV, Yesintek IV, Pyzchiva IV, or ustekinumab-ttwe IV, Starjemza IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Steqeyma IV, 3) Wezlana IV, 4) Yesintek IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Otulfi IV, 7) Selarsdi IV, and 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Steqeyma IV, Wezlana IV, Yesintek IV, Pyzchiva IV, or ustekinumab-ttwe IV, Otulfi IV, or Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	ustekinumab- ttwe for IV infusion	ustekinumab- ttwe for IV infusion	Direct to Pyzchiva IV, if formulary. If Pyzchiva IV is non-formulary, If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Yesintek IV, Starjemza IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Wezlana IV, 5) Yesintek IV, 6) Otulfi IV, 7) Selarsdi IV, and 8) Starjemza IV, if formulary; AND Note: Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Yesintek IV, Otulfi IV, Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Wezlana IV	ustekinumab for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, Starjemza IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Yesintek IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Otulfi IV, 7) Selarsdi IV, and 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Yesintek IV, Pyzchiva IV, or ustekinumab-ttwe IV, Starjemza IV, or Otulfi IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab IV Agents	Yesintek IV	ustekinumab-kfce for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Starjemza IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Imuldosa IV, 2) Stelara IV or ustekinumab unbranded IV, 3) Steqeyma IV, 4) Wezlana IV, 5) Pyzchiva IV or ustekinumab-ttwe IV, 6) Otulfi IV, 7) Selarsdi IV, 8) Starjemza IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. Stelara IV and ustekinumab unbranded IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Imuldosa IV, Selarsdi IV, Stelara IV or ustekinumab unbranded IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Otulfi IV, Starjemza IV, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve. **3.** Crohn's Disease, for an induction regimen in a patient < 18 years of age. Approve.	1 dose

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions - Infused TNF antagonists	Avsola	Infliximab- axxq for intravenous use	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following, if formulary: Remicade, infliximab (authorized generic of Remicade), Inflectra, and Renflexis; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: if the patient had a trial of Remicade and cannot use due to a formulation difference, an additional trial of infliximab (authorized generic of Remicade) would not be required and vice-versa.	1 year
Inflammatory Conditions - Infused TNF antagonists	infliximab (authorized generic of Remicade)	infliximab injection for intravenous use	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following, if formulary: Avsola, Inflectra, Remicade (brand), and Renflexis; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Inflammatory Conditions - Infused TNF antagonists	Inflectra	infliximab-dyyb for injection, for intravenous use	Patient meets standard *Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy* criteria AND Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following, if formulary: Avsola, infliximab (authorized generic of Remicade), Remicade, and Renflexis; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: if the patient had a trial of Remicade and cannot use due to a formulation difference, an additional trial of infliximab (authorized generic of Remicade) would not be required and vice-versa. Note: An approval will be entered for Avsola and infliximab (the authorized generic of Remicade) if those are the preferred products and the Infliximab Intravenous Products Prior Authorization criteria are met, but the remaining criteria are not met.	See PA duration
Inflammatory Conditions - Infused TNF antagonists	Remicade (brand)	infliximab injection for intravenous use	Patient meets standard *Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy* criteria AND Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following, if formulary: Avsola, Inflectra, infliximab (authorized generic of Remicade), and Renflexis; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: An approval will be entered for Avsola and infliximab (the authorized generic of Remicade) if those are the preferred products and the Infliximab Intravenous Products Prior Authorization criteria are met, but the remaining criteria are not met.	See PA duration
Inflammatory Conditions - Infused TNF antagonists	Renflexis	Infliximab-abda for intravenous use	Patient meets standard *Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy* criteria AND Approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following, if formulary: Avsola, Inflectra, infliximab (authorized generic of Remicade), and Remicade; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: if the patient had a trial of Remicade and cannot use due to a formulation difference, an additional trial of infliximab (authorized generic of Remicade) would not be required and vice-versa. Note: An approval will be entered for Avsola and infliximab (the authorized generic of Remicade) if those are the preferred products and the Infliximab Intravenous Products Prior Authorization criteria are met, but the remaining criteria are not met.	See PA duration
Inflammatory Conditions – Infused TNF Antagonists	Simponi Aria	golimumab injection, for intravenous use	Ankylosing Spondylitis; Juvenile Idiopathic Arthritis; Psoriatic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one other tumor necrosis factor inhibitor**:** Approve. Examples: an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi SC), and infliximab intravenous product (e.g., Remicade, biosimilars). If none are formulary, approve. **2.** Patient is < 18 years of age: Approve. **3.** Patient is currently taking Simponi Aria or SC: Approve if the patient has been established on Simponi (Aria or SC) for ≥ 3 months. **4.** Patient is currently taking Simponi (Aria or SC) for < 3 months: Refer to appropriate criteria above.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Janus Kinase Inhibitors	Rinvoq LQ	upadacitinib oral solution	Psoriatic arthritis. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets ALL of the following (A, B, and C): A. Patient has tried Xeljanz oral solution, if formulary; AND Note: If the patient had tried another form of Xeljanz, this would satisfy criterion A. B. Patient has tried Enbrel, if formulary; AND Note: If the patient had tried another tumor necrosis factor inhibitor, such as adalimumab (e.g., Humira, biosimilars), this would satisfy criterion B. C. Patient meets one of the following (i or ii): i. Patient is < 6 years of age, patient tried one of the following: Cosentyx subcutaneous (SC), Orencia SC, or Simponi Aria. If none are formulary, criterion C is met; OR ii. Patient is ≥ 6 years of age, patient has tried one of the following: Cosentyx SC, Orencia SC, Otezla/XR, Simponi Aria, Tremfya, ustekinumab SC products (Stelara, biosimilars). If none are formulary, criterion C is met; OR **2.** Patient is currently taking Rinvoq LQ or Rinvoq tablets for ≥ 3 months **[documentation required]**, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried Xeljanz oral solution for ≥ 3 months **[documentation required]**, unless intolerant, if formulary; OR Note: If the patient had tried another form of Xeljanz for ≥ 3 months or was intolerant, this would satisfy criterion A. B. Patient had previously tried at least two biologics for the condition; OR Note: Examples of other biologics include: Cosentyx SC, Enbrel, Orencia SC, Otezla/XR, Simponi Aria, Tremfya, ustekinumab SC products (Stelara, biosimilars), Xeljanz. C. Patient has been using Rinvoq concomitantly with one of the following: methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. Juvenile Idiopathic Arthritis. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets ALL of the following (A, B, and C): A. Patient has tried Xeljanz oral solution, if formulary; AND Note: A trial of Xeljanz tablets would also satisfy criteria A. B. Patient has tried one of the following: Enbrel, an adalimumab product (Humira, biosimilars), Cimzia, or Simponi Aria. Note: If none are formulary, criterion B is met; AND C. Patient has tried one of the following: Cosentyx SC, Orencia IV or Orencia SC, Kevzara, or a tocilizumab product (e.g., Actemra IV, Actemra SC, or biosimilars). Note: If none are formulary, criterion C is met; OR **2.** Patient is currently taking Rinvoq LQ or Rinvoq tablets for ≥ 3 months **[documentation required]**, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried Xeljanz oral solution for ≥ 3 months **[documentation required]**, unless intolerant, if formulary; OR Note: If the patient had tried another form of Xeljanz for ≥ 3 months or was intolerant, this would satisfy criterion A. B. Patient had previously tried at least two biologics for the condition; OR Note: Examples of other biologics include: Enbrel, an adalimumab product (Humira, biosimilars), Cimzia, Simponi Aria, Cosentyx SC, Orencia IV or Orencia SC, Kevzara, a tocilizumab product (e.g., Actemra IV, Actemra SC, or biosimilars). C. Patient has been using Rinvoq concomitantly with one of the following: methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.	1 year
Inflammatory Conditions – Janus Kinase Inhibitors	Cibinqo	abrocitinib tablets	Patient ≥ 12 years of age with atopic dermatitis. 1. Approve if patient has tried Rinvoq, if formulary. If Rinvoq is non-formulary, approve if the patient meets (A or B): A. Patient has tried at least one systemic therapy; OR Note: Examples of systemic therapies include Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection, and Adbry (tralokinumab-ldrm subcutaneous injection). Methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil also count towards trial of a systemic therapy. B. Patient has already received at least 90 days of therapy with Cibinqo. 2. If Rinvoq is formulary, approve if the patient weighs < 40 kg.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Janus Kinase Inhibitors	Rinvoq (2 of 2)	upadacitinib extended-release tablets	Ulcerative Colitis. Approve if the patient meets ONE of the following (1 or 2): 1. Patient meets ALL of the following (A, B, and C): A. Patient has tried Xeljanz tablets or Xeljanz XR tablets, if formulary; AND Note: A trial of Xeljanz oral solution would also satisfy criteria A. B. Patient has tried one tumor necrosis factor inhibitor (TNFi), unless, according to the prescriber, a TNFi is clinically inadvisable; AND Note: Examples of TNFis: An adalimumab product (e.g., Humira, biosimilars), Simponi SC, an infliximab product (e.g., Remicade, biosimilars, Zymfentra). Note: If none are formulary, then criterion B is considered met. C. Patient has tried one other biologic other than a TNFi. Note: Examples of other biologics: Entyvio IV or SC, a ustekinumab product (e.g., Stelara IV/SQ, biosimilars), Skyrizi IV or SC, Tremfya IV or SC, or Omvoh IV or SC. Note: If none are formulary, then criterion C is considered met. **2.** Patient is currently taking Rinvoq tablets or Rinvoq LQ for ≥ 3 months **[documentation required]**, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried Xeljanz tablets or Xeljanz XR tablets for ≥ 3 months **[documentation required]**, unless intolerant, if formulary; OR Note: A trial of Xeljanz oral solution would also satisfy criteria A. B. Patient had previously tried at least two biologics for the condition; OR Note: Examples of biologics include: An adalimumab product (e.g., Humira, biosimilars), Simponi SC, an infliximab product (e.g., Remicade, biosimilars, Zymfentra), Entyvio IV or SC, a ustekinumab product (e.g., Stelara IV/SQ, biosimilars), Skyrizi IV or SC, Tremfya IV or SC, or Omvoh IV or SC. C. Patient has been using Rinvoq concomitantly with one of the following: 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus. Patient ≥ 12 years of age with atopic dermatitis. **1.** Approve if the patient has tried Cibinqo, if formulary. If Cibinqo is non-formulary, approve , if the patient meets the following (A or B): A. Patient has tried at least one systemic therapy **[documentation required]**; OR Note: Examples of systemic therapies include Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection), and Adbry (tralokinumab-ldrm subcutaneous injection). Methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil also count towards trial of a systemic therapy. B. Patient is currently taking Rinvoq tablets or Rinvoq LQ for ≥ 3 months **[documentation required]**. **2.** If Cibinqo is formulary, approve, if, according to the prescriber, the patient is on antiplatelet therapy and Cibinqo is not considered clinically appropriate for the patient. Giant Cell Arteritis: Approve.	1 year
Inflammatory Conditions – Janus Kinase Inhibitors	BRAND Xeljanz oral solution	tofacitinib oral solution	See standard Inflammatory Conditions – Tofacitinib Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary policies.	See PSM duration
Inflammatory Conditions – Janus Kinase Inhibitors	Olumiant	baricitinib tablets	See standard *Inflammatory Conditions (**Olumiant**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – Janus Kinase Inhibitors	BRAND Xeljanz tablets	tofacitinib tablets	See standard Inflammatory Conditions – Tofacitinib Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary policies.	See PSM duration
Inflammatory Conditions – Janus Kinase Inhibitors	BRAND Xeljanz XR tablets	tofacitinib extended-release tablets	See standard Inflammatory Conditions – Tofacitinib Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary policies.	See PSM duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Janus Kinase Inhibitors	Rinvoq (1 of 2)	upadacitinib extended-release tablets	Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets ALL of the following (A, B, and C): A. Patient has tried Xeljanz tablets or Xeljanz XR tablets, if formulary; AND Note: A trial of Xeljanz oral solution would also satisfy criteria A. B. Patient has tried one tumor necrosis factor inhibitor (TNFi); AND Note: Examples of TNFis: Enbrel, an adalimumab product (e.g., Humira, biosimilars), Cimzia, Simponi Aria or SC, an infliximab intravenous product (e.g., Remicade, biosimilars). Note: If none are formulary, then criterion B is considered met. C. Patient has tried one other biologic product other than a TNFi; OR Note: Examples of other biologics: A tocilizumab product (e.g., Actemra IV/SC, biosimilars), Kevzara, Orencia IV or SC, rituximab product (e.g., Rituxan intravenous, biosimilars), Bimzelx SC, Cosentyx IV or SC, Taltz, Tremfya, an ustekinumab product (e.g., Stelara IV/SC, biosimilars), or Skyrizi SC. Note: If none are formulary, then criterion C is considered met. **2.** Patient is currently taking Rinvoq tablets or Rinvoq LQ for ≥ 3 months **[documentation required]**, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried Xeljanz tablets or Xeljanz XR tablets for ≥ 3 months **[documentation required]**, unless intolerant, if formulary; OR Note: A trial of Xeljanz oral solution would also satisfy criteria A. B. Patient had previously tried at least two biologics for the condition; OR Note: Examples of biologics include: Enbrel, an adalimumab product (e+D1301.g., Humira, biosimilars), Cimzia, Simponi Aria or SC, an infliximab intravenous product (e.g., Remicade, biosimilars), a tocilizumab product (e.g., Actemra IV/SC, biosimilars), Kevzara, Orencia IV or SC, rituximab product (e.g., Rituxan intravenous, biosimilars), Bimzelx SC, Cosentyx IV or SC, Taltz, Tremfya, an ustekinumab product (e.g., Stelara IV/SC, biosimilars), Skyrizi SC. C. Patient has been using Rinvoq concomitantly with one of the following: methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. Non-radiographic axial spondyloarthritis. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient has tried at least two biologics, one of which was a tumor necrosis factor inhibitor (TNFi) **[documentation required]**. Note: Two TNFis would meet the requirement for approval. Examples of TNFis: Enbrel, an adalimumab product (e.g., Humira, biosimilars), Cimzia. Examples of other biologics: Cosentyx IV or SC, Taltz, Bimzelx SC. Note: If no TNFi are formulary, approve. If no other biologics listed above are formulary, approve. **2.** Patient is currently taking Rinvoq tablets or Rinvoq LQ for ≥ 3 months **[documentation required]**. Crohn's Disease. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried one tumor necrosis factor inhibitor (TNFi) unless, according to the prescriber, a TNFi is clinically inadvisable; AND Note: Examples of TNFis: An adalimumab product (e.g., Humira, biosimilars), Simponi SC, an infliximab product (e.g., Remicade, biosimilars, Zymfentra). Note: If none are formulary, then criterion A is considered met.. B. Patient has tried one other biologic other than a TNFi.	1 year (continued)
Inflammatory Conditions – Janus Kinase Inhibitors - Alopecia Areata	Leqselvi	deuruxolitinib tablets	Alopecia Areata in a patient ≥ 18 years of age. Approve if the patient has tried one of Litfulo or Olumiant, if formulary. If neither are formulary, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried at least ONE of the following for alopecia areata (i or ii): i. Conventional systemic therapy; OR Note: Examples of conventional systemic therapies include corticosteroids, methotrexate, and cyclosporine. ii. Topical corticosteroid; OR B. Patient has already tried Litfulo or Olumiant; OR C. Patient has already been started on therapy with Leqselvi.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Janus Kinase Inhibitors - Alopecia Areata	Litfulo	ritlecitinib capsules	Alopecia Areata in a patient ≥ 12 years of age. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient ≥ 18 years of age: Patient has tried one of Leqselvi or Olumiant, if formulary. If neither are formulary, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried at least ONE of the following for alopecia areata (i or ii): i. Conventional systemic therapy; OR Note: Examples of conventional systemic therapies include corticosteroids, methotrexate, and cyclosporine. ii. Topical corticosteroid; OR B. Patient has already tried Leqselvi or Olumiant; OR C. Patient has already been started on therapy with Litfulo. **2.** Patient is < 18 years of age: Patient meets ONE of the following (A or B A. Patient has tried at least ONE of the following for alopecia areata (i or ii): i. Conventional systemic therapy; OR Note: Examples of conventional systemic therapies include corticosteroids, methotrexate, and cyclosporine. ii. Topical corticosteroid; OR B. Patient has already been started on therapy with Litfulo.	1 year
Inflammatory Conditions – Non-TNF Biologics	Icotyde	icotrokinra tablets	Plaque Psoriasis. **1.** Approve if the patient has tried one of Cosentyx subcutaneous (SC), an ustekinumab SC product (e.g., Stelara SC or any biosimilars), Taltz, Ilumya, or Skyrizi SC (not on-body), Tremfya SC, if formulary. If none are formulary, approve. **2.** Patient is < 18 years of age, approve if the patient tried one of Cosentyx SC, Skyrizi SC (not on-body), Taltz, Tremfya SC, or an ustekinumab SC product (e.g., Stelara SC or any biosimilars), if formulary. If none are formulary, approve. **3.** Approve if the patient has been on Icotyde for at least 3 months.	1 year
Inflammatory Conditions – Non-TNF Biologics	Skyrizi IV	risankizumab-rzaa intravenous infusion	Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. **1.** Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Tremfya IV/SC or 3) an ustekinumab product (Stelara IV/SC, biosimilars), if formulary. If none are formulary, approve. Note: All the ustekinumab products counting as one alternative. **2.** Approve if the patient has already been started on induction therapy with Skyrizi IV and requires 1 or 2 more doses to complete induction. Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. **1.** Approve if the patient has tried one of 1) Entyvio IV/SC or 2) Tremfya IV/SC, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on induction therapy with Skyrizi IV and requires 1 or 2 more doses to complete induction.	3 doses
Inflammatory Conditions – Oral S1P Modulators	Velsipity	etrasimod tablets	Ulcerative Colitis. If Zeposia is formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Zeposia; OR **2.** Patient has been established on Velsipity for greater than or equal to 3 months. If Zeposia is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient meets the following criteria (A and B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one Tumor Necrosis Factor inhibitor (TNFi): an adalimumab product (Humira, biosimilar), Simponi subcutaneous, or an infliximab product (Remicade, biosimilar, Zymfentra), if formulary. If none are formulary, would still need to meet criterion B; AND B. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one of 1) ustekinumab IV or SC (e.g., Stelara, biosimiliars), or 2) Entyvio IV or SC, 3) Skyrizi IV or SC, or 4) Tremfya IV or SC, or 5) Omvoh IV or SC, if formulary. If none are formulary, would still need to try a TNFi inhibitor. Note: If there are no formulary products from criterion A and B, approve. **2.** Patient has been established on Velsipity for greater than or equal to 3 months.	1 year
Inflammatory Conditions – SC Non-TNF Biologics	Skyrizi SC On Body	risankizumab-rzaa subcutaneous injection On Body	Crohn's disease. **1.** Approve if the patient has received Skyrizi intravenous (IV) for induction **[documentation required]**. **2.** Approve if the patient has been established on Skyrizi subcutenaous (SC) for ≥ 3 months **[documentation required]**. **3.** Patient who has not yet received induction therapy with Skyrizi IV: Direct to BOTH of 1) Entyvio IV/SC and 2) Tremfya IV/SC, if formulary. If neither are formulary, direct to Skyrizi IV for induction. Ulcerative Colitis. **1.** Approve if the patient has received Skyrizi IV for induction **[documentation required]**. **2.** Approve if the patient has been established on Skyrizi SC for ≥ 3 months **[documentation required]**. **3.** Patient has not yet received induction therapy with Skyrizi IV: Direct to two of 1) Tremfya IV/SC, 2) Entyvio IV/SC, or 3) an ustekinumab product (Stelara IV/SC. biosimilars). If none are formulary, direct to Skyrizi IV for induction. Note: All the ustekinumab products counting as one alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics	Cosentyx IV	secukinumab for intravenous injection	Approve if the patient has tried Cosentyx subcutaneous, if formulary, AND the patient is unable to continue to use a subcutaneous dosage form. If Cosentyx subcutaneous is non-formulary: Ankylosing Spondylitis; Psoriatic Arthritis. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried Taltz, if formulary; AND Note: If Taltz is non-formulary, would still need to meet criterion B. B. Patient has tried at least one other biologic. Examples of other biologics: an adalimumab product (e.g.,Humira, biosimilars), a bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or subcutaneous), or an abatacept product (e.g., Orencia intravenous or subcutaneous). If none are formulary, criterion B is met. **2.** Patient is currently receiving Cosentyx (intravenous (IV) or subcutaneous (SC): Patient has been established on Cosentyx (IV or SC) for ≥ 90 days, approve. Note: If the patient has been on Cosentyx (IV or SC) for < 90 days, refer to criterion #1. Non-Radiographic Spondyloarthritis. Approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried Taltz, if formulary; OR Note: If Taltz is non-formulary, approve. **2.** Patient is currently receiving Cosentyx (intravenous (IV) or subcutaneous (SC): Patient has been established on Cosentyx (IV or SC) for ≥ 90 days, approve. Note: If the patient has been on Cosentyx (IV or SC) for < 90 days, refer to criterion #1.	1 year
Inflammatory Conditions – SC Non-TNF Biologics	Tremfya IV	guselkumab intravenous	Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. **1.** Initial therapy: Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) an ustekinumab product (Stelara IV/SC, biosimilars) or 3) Skyrizi IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. Note: All the ustekinumab products count as one alternative. **2.** Approve if the patient has already been started on induction therapy with Tremfya IV and requires 1 or 2 more doses to complete induction. Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. **1.** Initial therapy: Approve if the patient has tried one of 1) Entyvio intravenous (IV)/subcutaneous (SC) or 2) Skyrizi IV/SC, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on induction therapy with Tremfya IV and requires 1 or 2 more doses to complete induction.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics	Tremfya SC	guselkumab subcutaneous injection	Plaque Psoriasis. **1.** Approve if the patient has tried one of Cosentyx subcutaneous (SC), Icotyde, an ustekinumab SC product (e.g., Stelara SC or any biosimilars), Taltz, Ilumya, or Skyrizi SC (not on-body), if formulary. If none are formulary, approve. **2.** Patient is < 18 years of age, approve if the patient tried one of Cosentyx SC, Icotyde, Skyrizi SC (not on-body), Taltz, or an ustekinumab SC product (e.g., Stelara SC or any biosimilars), if formulary. If none are formulary, approve. Note: All the ustekinumab products count as one alternative. **3.** Approve if the patient has been on Tremfya for at least 3 months. Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous (IV) product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or subcutaneous [SC]), an abatacept product (e.g., Orencia IV or SC, a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a ustekinumab product (e.g., Stelara SC, biosimilars), a risankizumab product (e.g., Skyrizi subcutaneous), or a bimekizumab SC injection (e.g., Bimzelx). If none are formulary, approve. **2.** Approve if the patient has been on Tremfya for at least 3 months. Ulcerative Colitis- Induction or Maintenance therapy. **1.** Approve if the patient has already received Tremfya intravenous (IV) or subcutaneous (SC) for induction. **2.** Approve if the patient has already been started on therapy with Tremfya IV or SC. **3.** Patient who has not yet received induction therapy with Tremfya IV or SC: Direct to two of 1) an ustekinumab product (Stelara IV/SC or biosimilars), 2) Entyvio IV/SC, or 3) Skyrizi IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. Crohn's Disease- Induction therapy or Maintenance therapy. **1.** Approve if the patient has already received Tremfya intravenous (IV) or (SC) for induction. **2.** Approve if the patient has already been started on therapy with Tremfya IV or subcutaneous (SC). **3.** Patient who has not yet received induction therapy with Tremfya SC or IV: Direct to one of 1) Entyvio IV/SC or 2) Skyrizi IV/SC, if formulary. If neither are formulary, approve.	1 year
Inflammatory Conditions – SC Non-TNF Biologics	Taltz	ixekizumab for SC injection	Plaque Psoriasis. **1.** Approve if the patient has tried one of Cosentyx subcutaneous (SC), Icotyde, an ustekinumab SC product (e.g., Stelara SC, biosimilars), Tremfya SC, Ilumya, or Skyrizi SC (NOT on-body), if formulary. If none are formulary, approve. **2.** Patient is < 18 years of age, approve if the patient has tried one of Cosentyx SC, Icotyde, Skyrizi SC (not on-body), Tremfya SC, or an ustekinumab SC product (e.g., Stelara SC, biosimilars), if formulary. If none are formulary, approve. **3.** Patient is currently receiving Taltz: Approve if the patient has been established on Taltz for ≥ 3 months. **4.** Patient has been started on Taltz for < 3 months: Refer to appropriate criteria above. Ankylosing Spondylitis; Psoriatic Arthritis. **1.** Patient has tried at least one other biologic: Approve. Examples: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous (IV) product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or subcutaneous [SC]), an abatacept product (e.g., Orencia IV or SC), an ustekinumab product (e.g., Stelara SC, biosimilars), a guselkumab product (e.g., Tremfya), a risankizumab SC product (e.g., Skyrizi SC (not On-Body), a bimekizumab product (e.g., Bimzelx SC), or a secukinumab product (e.g., Cosentyx IV or SC). If none are formulary, approve. **2.** Patient is currently receiving Taltz: Approve if the patient has been established on Taltz for ≥ 3 months. **3.** Patient has been started on Taltz for < 3 months: Refer to appropriate criteria above. Non-Radiogaphic Spondyloarthritis. **1.** Approve if the patient has tried one of Cosentyx IV or SC, if formulary. If neither are formulary, approve. **2.** Patient is currently receiving Taltz: Approve if the patient has been established on Taltz for ≥ 3 months. **3.** Patient has been started on Taltz for < 3 months: Refer to appropriate criteria above.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics	Skyrizi SC (NOT on-body)	risankizumab-rzaa subcutaneous injection	Plaque Psoriasis. **1.** Approve if the patient meets ALL of the following (A, B, and C): A. Patient is ≥ 18 years of age; AND B. Patient has tried one of Cosentyx SC or Taltz, if formulary; AND Note: If neither are formulary, criterion B is considered met. C. Patient has tried one of the following: an ustekinumab product (e.g., Stelara SC, biosimilars), Tremfya, Icotyde, or Ilumya, if formulary. Note: If none are formulary criterion C is considered met. **2.** If the patient is < 18 years of age, approve if the patient has tried ONE of Cosentyx, Icotyde, Taltz, an ustekinumab product (e.g., Stelara SC, biosimilars), or Tremfya. If none are formulary, approve. **3.** Patient is currently receiving Skyrizi SC: Approve if the patient has been established on Skyrizi for at least 3 months **[documentation required]**. **4.** Patient has been started on Skyrizi SC for < 3 months: Refer to the appropriate criteria above. Psoriatic Arthritis. **1.** Patient has tried at least TWO biologic: Approve. Note: Examples: an adalimumab product (e.g., Humira, biosimilars), Cimzia, Enbrel, an infliximab intravenous product (e.g., Remicade, biosimilars), Simponi, Simponi Aria, Orencia IV or SC, Cosentyx IV or SC, Taltz, Bimzelx SC, an ustekinumab product (e.g., Stelara SC, biosimilars), or Tremfya. If none are formulary, approve. Note: If only one is formulary, only that product needs to be tried. **2.** Patient is currently receiving Skyrizi SC: Approve if the patient has been established on Skyrizi SC for at least 3 months **[documentation required]**. **3.** Patient has been started on Skyrizi SC for < 3 months: Refer to the appropriate criteria above.	1 year
Inflammatory Conditions – SC Non-TNF Biologics	Cosentyx SC	secukinumab for SC injection	See standard *Inflammatory Conditions (**Cosentyx**) Preferred Specialty Management Policy for High Performance Formulary* policy. OR Plaque Psoriasis. **1.** Approve if the patient meets ALL of the following (A, B, and C): A. Patient is ≥ 18 years of age; AND B. Patient has tried one of Skyrizi SC (not on-body) or Taltz, if formulary; AND Note: If neither are formulary, criterion B is considered met. C. Patient has tried one of the following: an ustekinumab product (e.g., Stelara SC, biosimilars), Tremfya, Icotyde, or Ilumya, if formulary. Note: If none are formulary criterion C is considered met. **2.** If the patient is < 18 years of age, approve if the patient has tried ONE of Icotyde, Skyrizi SC (not on-body), Taltz, an ustekinumab product (e.g., Stelara SC, biosimilars), or Tremfya. If none are formulary, approve. **3.** Approve if the patient has been established on Cosentyx for at least 3 months. Ankylosing Spondylitis. **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried Taltz, if formulary; AND Note: If Taltz is non-formulary, would still need to meet criterion B. B. Patient has tried at least one other biologic. Note: Examples of other biologics: an adalimumab product (e.g.,Humira, biosimilars), a bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or subcutaneous), an abatacept product (e.g., Orencia intravenous or subcutaneous), a ustekinumab product (e.g., Stelara, biosimilars), a guselkumab product (e.g., Tremfya), or a risankizumab product (e.g., Skyrizi). If none are formulary, criterion B is met. **2.** If the patient has been established on Cosentyx for ≥ 90 days, approve. Non-Radiographic Spondyloarthritis. **1.** Approve if the patient has tried Taltz, if formulary. Note: If Taltz is non-formulary, approve. **2.** If the patient has been established on Cosentyx for ≥ 90 days, approve. Psoriatic Arthritis. **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried Taltz, if formulary; AND Note: If Taltz is non-formulary, would still need to meet criterion B. B. Patient has tried at least one other biologic. Note: Examples of other biologics: an adalimumab product (e.g.,Humira, biosimilars), a bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab	See PSM duration or 1 year.

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics	Ilumya	tildrakizumab SC injection	See standard *Inflammatory Conditions (**Ilumya**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics	Kevzara	sarilumab subcutaneous injection	See standard *Inflammatory Conditions (**Kevzara**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics	Siliq	brodalumab for subcutaneous injection	See standard *Inflammatory Conditions (**Siliq**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics	Bimzelx	bimekizumab-bkzx subcutaneous injection	See standard *Inflammatory Conditions (**Bimzelx**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics	Orencia for SC use	abatacept injection for subcutaneous use	See standard *Inflammatory Conditions (**Orencia SC**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics	Kineret	anakinra SC injection	See standard *Inflammatory Conditions (**Kineret**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics - tocilizumab SC	Avtozma SC	tocilizumab-anoh subcutaneous injection	See standard *Inflammatory Conditions (**Avtozma SC**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See SPM duration
Inflammatory Conditions – SC Non-TNF Biologics - tocilizumab SC	Tyenne SC	tocilizumab subcutaneous injecton	If either Actemra SC or Avtozma SC are formulary, [For all indications]: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried BOTH Actemra SC and Avtozma SC (or one if one is formulary); AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If neither Actemra SC nor Avtozma SC are formulary: Rheumatoid Arthritis (RA). **1.** Patient has tried one of Orencia SC or Kevzara: Approve. If neither are formulary, approve. **2.** Approve if the patient has been established on any tocilizumab product (IV or SC) [e.g., Actremra, Tyenne, Avtozma, Tofidence] for at least 90 days. If neither Actemra SC nor Avtozma SC are formulary: Polyarticular Juvenile Idiopathic Arthritis (PJIA). **1.** Patient has tried Orencia SC: Approve. If Orencia SC is non-formulary, approve. **2.** Approve if the patient has been established on any tocilizumab product (IV or SC) [e.g., Actremra, Tyenne, Avtozma, Tofidence] for at least 90 days. If neither Actemra SC nor Avtozma SC are formulary: Giant Cell Arteritis, Interstitial Lung Disease associated with Systemic Sclerosis, Polymyalgia Rheumatica, Still's Disease - Adult-onset; Systemic Juvenile Idiopathic Arthritis; Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic (VEXAS) Syndrome: Approve.	1 year
Inflammatory Conditions – SC Non-TNF Biologics - tocilizumab SC	Actemra SC	tocilizumab subcutaneous injecton	See standard *Inflammatory Conditions (**Actemra SC**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration

Data Class: Confidential

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Imuldosa SC	ustekinumab-srlf SC	**1.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient has tried ALL of the following: 1) Yesintek SC, 2) Wezlana SC, 3) Stelara SC or ustekinumab unbranded SC, 4) Steqeyma SC, 5) Pyzchiva SC or ustekinumab-ttwe SC, 6) Otulfi SC or ustekinumab-aauz SC, 7) Selarsdi SC or ustekinumab-aekn, and 8) Starjemza SC; AND Note: Pyzchiva SC and ustekinumab-ttwe SC count as one alternative. Stelara SC and ustekinumab unbranded count as one alternative. Selarsdi SC and ustekinumab-aekn SC count as one alternative. Otulfi SC and ustekinumab-aauz SC count as one alternative. **B**. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient is < 18 years of age; AND **B.** Patient weighs < 60 kg. If none of the ustekinumab subcutaneous (SC) products are formulary, Yesintek SC, Wezlana SC, Stelara SC or ustekinumab unbranded SC, Steqeyma SC, Pyzchiva SC or ustekinumab-ttwe SC, Otulfi SC or ustekinumab-aauz SC, Starjemza SC, or Selarsdi SC or ustekinumab-aekn SC, approve if the patient meets ONE category below (A, B, C, or D): **A.** Plaque Psoriasis. **1.** Approve if the patient has tried one of Icotyde, Cosentyx subcutaneous (SC), Taltz, Tremfya SC, Ilumya, or Sykyrizi SC, if formulary. If none are formulary, approve. **2.** If the patient is < 18 years of age, approve if the patient has tried one of Cosentyx SC, Icotyde, Skyrizi SC (not on-body), Taltz, or Tremfya SC, if formulary. If none are formulary, approve. **3.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **B.** Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g.,Humira, biosimilars), a bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous (IV) product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or SC), an abatacept product (e.g., Orencia IV or SC), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya SC), or a risankizumab product (e.g., Skyrizi SC). If none are formulary, approve. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **C.** Crohn's disease. **1.** Approve if the patient has received any ustekinumab IV product for induction. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **3.** Patient ≥ 18 years of age who has not yet received induction therapy with any ustekinumab IV product: Direct to one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, direct to an ustekinumab IV product for induction. **4.** Patient < 18 years of age: Approve. **D.** Ulcerative colitis. **1.** Approve if the patient has received any ustekinumab IV product for induction.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Selarsdi SC	ustekinumab-aekn SC	If ustekinumab-aekn SC is non-formulary: If any of the following ustekinumab subcutaneous (SC) products are formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient has tried ALL of the following: 1) Yesintek SC, 2) Wezlana SC, 3) Stelara SC or ustekinumab unbranded SC, 4) Steqeyma SC, 5) Pyzchiva SC or ustekinumab-ttwe SC, 6) Otulfi SC or ustekinumab-aauz SC, 7) Selarsdi SC or ustekinumab-aekn, and 8) Starjemza SC; AND Note: Pyzchiva SC and ustekinumab-ttwe SC count as one alternative. Stelara SC and ustekinumab unbranded count as one alternative. Selarsdi SC and ustekinumab-aekn SC count as one alternative. Otulfi SC and ustekinumab-aauz SC count as one alternative. **B.** Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient is < 18 years of age; AND **B.** Patient weighs < 60 kg. If none of the ustekinumab subcutaneous (SC) products are formulary, Imuldosa SC, Wezlana SC, Stelara SC or ustekinumab unbranded SC, Yesintek SC, Pyzchiva SC or ustekinumab-ttwe SC, Otulfi SC or ustekinumab-aauz SC, Starjemza SC, or Steqeyma SC, approve if the patient meets ONE category below (A, B, C, or D): **A.** Plaque Psoriasis. **1.** Approve if the patient has tried one of Icotyde, Cosentyx subcutaneous (SC), Taltz, Tremfya SC, Ilumya, or Sykyrizi SC, if formulary. If none are formulary, approve. **2.** If the patient is < 18 years of age, approve if the patient has tried one of Cosentyx SC, Icotyde, Skyrizi SC (not on-body), Taltz, or Tremfya SC, if formulary. If none are formulary, approve. **3.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **B.** Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g.,Humira, biosimilars), a bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous (IV) product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or SC), an abatacept product (e.g., Orencia IV or SC), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya SC), or a risankizumab product (e.g., Skyrizi SC). If none are formulary, approve. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **C.** Crohn's disease. **1.** Approve if the patient has received any ustekinumab IV product for induction. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **3.** Patient ≥ 18 years of age who has not yet received induction therapy with any ustekinumab IV product: Direct to one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, direct to an ustekinumab IV product for induction. **4.** Patient < 18 years of age: Approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	ustekinumab- ttwe SC (unbranded version of Pyzchiva SC)	ustekinumab- ttwe SC (unbranded version of Pyzchiva SC)	~~Direct to Pyzchiva subcutaneous (SC), if formulary.~~ If Pyzchiva SC is non-formulary: If any of the following ustekinumab SC products are formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient has tried ALL of the following: 1) Yesintek SC, 2) Wezlana SC, 3) Stelara SC or ustekinumab unbranded SC, 4) Steqeyma SC, 5) Pyzchiva SC or ustekinumab-ttwe SC, 6) Otulfi SC or ustekinumab-aauz SC, 7) Selarsdi SC or ustekinumab-aekn, and 8) Starjemza SC; AND Note: Pyzchiva SC and ustekinumab-ttwe SC count as one alternative. Stelara SC and ustekinumab unbranded count as one alternative. Selarsdi SC and ustekinumab-aekn SC count as one alternative. Otulfi SC and ustekinumab-aauz SC count as one alternative. **B.** Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient is < 18 years of age; AND **B.** Patient weighs < 60 kg. If none of the ustekinumab subcutaneous (SC) products are formulary, Imuldosa SC, Wezlana SC, Stelara SC or ustekinumab unbranded SC, Steqeyma SC, Yesintek SC, Otulfi SC or ustekinumab-aauz SC, Starjemza SC, or Selarsdi SC or ustekinumab-aekn SC are formulary, approve if the patient meets ONE category below (A, B, C, or D): **A.** Plaque Psoriasis. **1.** Approve if the patient has tried one of Icotyde, Cosentyx subcutaneous (SC), Taltz, Tremfya SC, Ilumya, or Sykyrizi SC, if formulary. If none are formulary, approve. **2.** If the patient is < 18 years of age, approve if the patient has tried one of Cosentyx SC, Icotyde, Skyrizi SC (not on-body), Taltz, or Tremfya SC, if formulary. If none are formulary, approve. **3.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **B.** Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g., Humira, biosimilars), a bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous (IV) product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or SC), an abatacept product (e.g., Orencia IV or SC), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya SC), or a risankizumab product (e.g., Skyrizi SC). If none are formulary, approve. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **C.** Crohn's disease. **1.** Approve if the patient has received any ustekinumab IV product for induction. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **3.** Patient ≥ 18 years of age who has not yet received induction therapy with any ustekinumab IV product: Direct to one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, direct to an ustekinumab IV product for induction. **4.** Patient < 18 years of age: Approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Yesintek SC	ustekinumab-kfce SC	If any of the following ustekinumab subcutaneous (SC) products are formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient meets BOTH of the following (A and B): **A**. Patient has tried ALL of the following: 1) Yesintek SC, 2) Wezlana SC, 3) Stelara SC or ustekinumab unbranded SC, 4) Steqeyma SC, 5) Pyzchiva SC or ustekinumab-ttwe SC, 6) Otulfi SC or ustekinumab-aauz SC, 7) Selarsdi SC or ustekinumab-aekn, and 8) Starjemza SC; AND Note: Pyzchiva SC and ustekinumab-ttwe SC count as one alternative. Stelara SC and ustekinumab unbranded count as one alternative. Selarsdi SC and ustekinumab-aekn SC count as one alternative. Otulfi SC and ustekinumab-aauz SC count as one alternative. **B.** Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient is < 18 years of age; AND **B.** Patient weighs < 60 kg. If none of the ustekinumab subcutaneous (SC) products are formulary, Imuldosa SC, Wezlana SC, Stelara SC or ustekinumab unbranded SC, Steqeyma SC, Pyzchiva SC or ustekinumab-ttwe SC, Otulfi SC or ustekinumab-aauz SC, Starjemza SC, or Selarsdi SC or ustekinumab-aekn SC, approve if the patient meets ONE category below (A, B, C, or D): **A.** Plaque Psoriasis. **1.** Approve if the patient has tried one of Icotyde, Cosentyx subcutaneous (SC), Taltz, Tremfya SC, Ilumya, or Sykyrizi SC, if formulary. If none are formulary, approve. 2. If the patient is < 18 years of age, approve if the patient has tried one of Cosentyx SC, Icotyde, Skyrizi SC (not on-body), Taltz, or Tremfya SC, if formulary. If none are formulary, approve. 3. Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **B.** Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g., Humira, biosimilars), a bimekizumab product (e.g., Bimzelx), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous (IV) product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or SC), an abatacept product (e.g., Orencia IV or SC), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya SC), or a risankizumab product (e.g., Skyrizi SC). If none are formulary, approve. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **C.** Crohn's disease. **1.** Approve if the patient has received any ustekinumab IV product for induction. **2.** Approve if the patient has been established on any ustekinumab SC product for ≥ 3 months. **3.** Patient ≥ 18 years of age who has not yet received induction therapy with any ustekinumab IV product: Direct to one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, direct to an ustekinumab IV product for induction. **4.** Patient < 18 years of age: Approve. **D.** Ulcerative colitis. **1.** Approve if the patient has received any ustekinumab IV product for induction.	1 year
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Otulfi SC and ustekinumab-aauz SC	ustekinumab- aauz SC	See standard *Inflammatory Conditions – ustekinumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Pyzchiva SC	ustekinumab- ttwe SC	See standard *Inflammatory Conditions – ustekinumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Starjemza SC	ustekinumab- hmny SC	See standard *Inflammatory Conditions – ustekinumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary, OR 3) FLEX Formulary* policies.	See PSM duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Stelara SC	ustekinumab for SC injection	See standard *Inflammatory Conditions – ustekinumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary, OR 3) FLEX Formulary policies.*	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Steqeyma SC	ustekinumab-stba SC	See standard *Inflammatory Conditions – ustekinumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	ustekinumab SC (unbranded version of Stelara SC)	ustekinumab SC (unbranded version of Stelara SC)	See standard Inflammatory Conditions – ustekinumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	ustekinumab-aekn SC (unbranded version of Selarsdi SC)	ustekinumab-aekn SC (unbranded version of Selarsdi SC)	See standard *Inflammatory Conditions – ustekinumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC Non-TNF Biologics – ustekinumab Agents	Wezlana SC	ustekinumab for SC injection	See standard *Inflammatory Conditions – usteknumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary policies*.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists	Enbrel	etanercept injection	Plaque Psoriasis. Note: If the patient has Plaque Psoriasis and a concomitant rheumatoid condition, should also review under the additional diagnosis. **1.** Patient has tried at least one subcutaneous tumor necrosis factor: Approve. Examples: an adalimumab product (e.g., Humira, biosimilars), or a certolizumab pegol product (e.g., Cimzia). If neither an adalimumab product (Humira, Amjevita) nor Cimzia is formulary, approve. **2.** Patient is < 18 years of age: Approve. Ankylosing Spondylitis; Juvenile Idiopathic Arthritis; Psoriatic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one subcutaneous tumor necrosis factor: Approve. Examples: an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi subcutaneous). If none are formulary, approve. **2.** Psoriatic arthritis, approve if the patient is < 18 years of age. **3.** Patient is currently taking Enbrel: Approve if the patient has been established on Enbrel for ≥ 90 days. **4.** Patient is currently taking Enbrel for < 90 days: Refer to the appropriate criteria above. Graft-Versus-Host Disease (GVHD); Still's Disease; Behcet's Disease; Pyoderma Gangrenosum; Spondyloarthritis, Other Subtypes: Approve.	1 year
Inflammatory Conditions – SC TNF Antagonists	Cimzia	certolizumab powder for injection	See standard *Inflammatory Conditions (**Cimzia**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists	Simponi SC	golimumab subcutaneous injection	See standard *Inflammatory Conditions (**Simponi SC**) Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	adalimumab-adaz	adalimumab-adaz subcutaneous injection (unbranded version of Hyrimoz)	Approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient has tried ALL of the other formulary adalimumab products: Amjevita, Cyltezo/adalimumab-adbm, Hulio/adalimumab-fkjp, Abrilada, Humira, Hadlima/adalimumab-bwwd, Idacio/adalimumab-aacf, Simlandi/adalimumab-ryvk, Yuflyma/adalimumab-aaty, or Yusimry. If none are formulary, approve; AND Note: Hulio/adalimumab-fkip count as one alternative. Hadlima/adalimumab-bwwd count as one alternative. Cyltezo and adalimumab-adbm count as one alternative. Idacio and adalimumab-aacf count as one alternative. Yuflyma and adalimumab-aaty count as one alternative. Simlandi and adalimumab-ryvk count as one alternative. **B.** Patient cannot continue to use all the formulary adalimumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Approve if the patient requires a dose < 20 mg.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	adalimumab-adbm	adalimumab-adbm subcutaneous injection (unbranded version of Cyltezo)	Approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient meets BOTH of the following (A and B): **A.** Patient has tried ALL if the other formulary adalimumab products: Amjevita, Hyrimoz/adalimumab-adaz, Hulio/adalimumab-fkjp, Abrilada, Humira, Hadlima/adalimumab-bwwd, Idacio/adalimumab-aacf, Simlandi/adalimumab-ryvk, Yuflyma/adalimumab-aaty, or Yusimry. If none are formulary, approve; AND Note: Hyrimoz and adalimumab-adaz count as one alternative. Hadlima/adalimumab-bwwd count as one alternative. Hulio/adalimumab-fkip count as one alternative. Idacio and adalimumab-aacf count as one alternative. Simlandi and adalimumab-ryvk count as one alternative. Yuflyma and adalimumab-aaty count as one alternative. **B.** Patient cannot continue to use all the formulary adalimumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Approve if the patient requires a dose < 20 mg.	1 year
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Abrilada	adalimumab-afzb subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Adalimumab-fkjp	adalimumab-fkjp subcutaneous injection (unbranded version of Hulio)	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Amjevita	adalimumab-atto subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary policies.*	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Cyltezo	adalimumab-adbm subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basis Formularies, 2) High Performance Formulary, OR 3) FLEX Formulary policy.*	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Hadlima and adalimumab-bwwd subcutaneous injection	adalimumab-bwwd subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Hulio	adalimumab-fkjp subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Humira	adalimumab injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Hyrimoz	adalimumab-adaz subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Idacio and adalimumab-aacf	adalimumab-aacf subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Simlandi and adalimumab-ryvk	adalimumab-ryvk subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary policies.*	See PSM duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Yuflyma and adalimumab-aaty	adalimumab-aaty subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Yusimry	adalimumab-aqvh subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for 1) National Preferred and Basic Formularies, 2) High Performance Formulary OR 3) FLEX Formulary* policies.	See PSM duration
Inflammatory Conditions – Targeted Synthetic DMARDs (Oral)	Sotyktu	deucravacitinib tablets	Plaque Psoriasis. **1.** Patient has tried at least one biologic or Otezla (apremilast tablets)/Otezla XR (apremilast extended-release tablets): Approve. Examples of biologics: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous product (e.g., Remicade, biosimilars), a secukinumab product (e.g., Cosentyx SC), an ixekizumab product (e.g., Taltz), a brodalumab product (e.g., Siliq), a ustekinumab product (e.g., Stelara subcutaneous), a guselkumab product (e.g., Tremfya), a risankizumab product (e.g., Skyrizi SC), a tildrakizumab product (e.g., Ilumya), or a bimekizumab product (Bimzelx). If none are formulary, approve. **2.** Patient is currently receiving Sotyktu: Approve if the patient has been established on Sotyktu for at least 90 days. **3.** Patient has been started on Sotyktu for < 90 days: Refer to the appropriate criteria above. Psoriatic Arthritis. 1. Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous product (e.g., Remicade, biosimilars), an abatacept product (e.g., Orencia intravenous or subcutaneous), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a ustekinumab product (e.g., Stelara SC, biosimilars), a guselkumab product (e.g., Tremfya SC), a risankizumab product (e.g., Skyrizi subcutaneous), a golimumab product (e.g., Simponi or Simponi Aria), or a bimekizumab product (e.g., Bimzelx). If none are formulary, approve. 2. Patient is currently receiving Sotyktu: Approve if the patient has been established on Sotyktu for at least 90 days. 3. Patient has been started on Sotyktu for < 90 days: Refer to the appropriate criteria above.	1 year
Inflammatory Conditions – Targeted Synthetic DMARDs (Oral)	Otezla	apremilast tablets	Plaque Psoriasis. **1.** Patient has tried at least one biologic, Icotyde (icotrokinra tablets) or Sotyktu (deucravacitinib tablets): Approve. Examples of biologics: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous product (e.g., Remicade, biosimilars), a secukinumab product (e.g., Cosentyx SC), an ixekizumab product (e.g., Taltz), a brodalumab product (e.g., Siliq), a ustekinumab product (e.g., Stelara SC, biosimilars), a guselkumab product (e.g., Tremfya SC), a risankizumab product (e.g., Skyrizi SC), a tildrakizumab product (e.g., Ilumya), or a bimekizumab product (Bimzelx). If none are formulary, approve. **2.** Patient is currently receiving Otezla or Otezla XR: Approve if the patient has been established on Otezla or Otezla XR for at least 120 days. **3.** Patient has been started on Otezla or Otezla XR for < 120 days: Refer to the appropriate criteria above. Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous product (e.g., Remicade, biosimilars), an abatacept product (e.g., Orencia intravenous or subcutaneous), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a ustekinumab product (e.g., Stelara SC, biosimilars), a guselkumab product (e.g., Tremfya SC), a risankizumab product (e.g., Skyrizi subcutaneous), a golimumab product (e.g., Simponi or Simponi Aria), or a bimekizumab product (e.g., Bimzelx). If none are formulary, approve. **2.** Patient is currently receiving Otezla or Otelza XR: Approve if the patient has been established on Otezla or Otezla XR for at least 120 days. **3.** Patient has been started on Otezla or Otezla XR for < 120 days: Refer to the appropriate criteria above. Behcet's Disease: Approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Inflammatory Conditions – Targeted Synthetic DMARDs (Oral)	Otezla XR	apremilast extended-release tablets	Plaque Psoriasis. **1.** Patient has tried at least one biologic, Icotyde (icotrokinra tablets), or Sotyktu (deucravacitinib tablets): Approve. Examples of biologics: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous product (e.g., Remicade, biosimilars), a secukinumab product (e.g., Cosentyx SC), an ixekizumab product (e.g., Taltz), a brodalumab product (e.g., Siliq), a ustekinumab product (e.g., Stelara SC, biosimilars), a guselkumab product (e.g., Tremfya SC), a risankizumab product (e.g., Skyrizi SC), a tildrakizumab product (e.g., Ilumya), or a bimekizumab product (Bimzelx). If none are formulary, approve. **2.** Patient is currently receiving Otezla or Otezla XR: Approve if the patient has been established on Otezla or Otezla XR for at least 120 days. **3.** Patient has been started on Otezla or Otezla XR for < 120 days: Refer to the appropriate criteria above. Psoriatic Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab intravenous product (e.g., Remicade, biosimilars), an abatacept product (e.g., Orencia intravenous or subcutaneous), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a ustekinumab product (e.g., Stelara SC, biosimilars), a guselkumab product (e.g., Tremfya SC), a risankizumab product (e.g., Skyrizi subcutaneous), a golimumab product (e.g., Simponi or Simponi Aria), or a bimekizumab product (e.g., Bimzelx). If none are formulary, approve. **2.** Patient is currently receiving Otezla or Otelza XR: Approve if the patient has been established on Otezla or Otelza XR for at least 120 days. **3.** Patient has been started on Otezla or Otelza XR for < 120 days: Refer to the appropriate criteria above. Behcet's Disease: Approve.	1 year
Inflammatory Conditions -Infliximab-containing Agents - Subcutaneous	Zymfentra	infliximab subcutaneous injection	For maintenance therapy (NOT for induction therapy) of Crohn's disease or ulcerative colitis. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has received induction with an infliximab intravenous product; AND **2.** Patient is unable to continue to use an infliximab intravenous product for maintenance therapy. Note: Examples of infliximab intravenous products include Avsola, Remicade, Renflexis, Inflectra.	1 year
Insulin-like growth factor-1 receptor (IGF-1R) antagonist antibody	Lumvoa	veligrotug-vvze intravenous infusion	**1.** Approve if the patient has tried Tepezza. If Tepezza is non-formulary, approve. **2.** Approve if the patient has already received at least one infusion of Lumvoa (in order to complete the course of therapy).	1 year
Insulin-like growth factor-1 receptor (IGF-1R) antagonist antibody	Tepezza	teprotumumab injection for intravenous use	**1.** Approve if the patient has tried Lumvoa. If Lumvoa is non-formulary, approve. **2.** Approve if the patient has already received at least one infusion of Tepezza (in order to complete the course of therapy).	1 year
Interferons	Besremi	ropeginterferon alfa-2b-njft subcutaneous injection	See *Oncology (Injectable) – Besremi Prior Authorization Policy* criteria.	See PA duration
Iron Replacement (Injectable)	INFeD	iron dextran injection	**1.** Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Injectafer, Venofer, sodium ferric gluconate complex (Ferrlecit, generics), or Monoferric. If none are formulary, approve. **2.** Patient does NOT have chronic kidney disease, approve if the patient has tried one of Injectafer or Monoferric, if formulary. If neither are formulary, approve. a. Patient is ≤ 18 years of age, approve if the patient has tried Injectafer, if formulary. If Injectafer is non-formulary, approve. **3.** Patients < 2 and ≥ 1 year of age, approve if the patient has tried Injectafer, if formulary. If Injectafer is non-formulary, approve. **4.** Patients ≥ 2 years of age and < 6 years of age: approve if the patient has tried Venofer or Injectafer, if formulary. If neither are formulary, approve. **5.** Patients ≥ 6 years and < 18 years of age: approve if the patient has tried one of the following, if one is formulary: Venofer, Injectafer, or sodium ferric gluconate complex (Ferrlecit, generics). If none are formulary, approve. **6.** Patients < 1 years of age: approve. **7.** Approve if the patient has been started on a course of therapy with INFeD (to complete the course).	1 year
Iron Replacement (Injectable)	Injectafer	ferric carboxymaltose injection	**1.** Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Venofer, sodium ferric gluconate complex (Ferrlecit, generics), or Monoferric. If none are formulary, approve. **2.** Patient does NOT have chronic kidney disease, approve if the patient has tried Monoferric, if formulary. If Monoferric is non-formulary, approve. a. Patient is ≤ 18 years of age, approve. **3.** Patients ≥ 6 years and < 18 years of age: approve if the patient has tried one of the following, if one is formulary: Venofer or sodium ferric gluconate complex (Ferrlecit, generics). If none are formulary, approve. **4.** Patients ≥ 2 years of age and < 6 years of age: approve if the patient has tried Venofer, if formulary. If Venofer is non-formulary, approve. **5.** Patients < 2 years of age: approve. **6.** Approve if the patient has been started on a course of therapy with Injectafer (to complete the course).	1 year
Iron Replacement (Injectable)	Monoferric	ferric derisomaltose injection for intravenous use	**1.** Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Venofer, sodium ferric gluconate complex (Ferrlecit, generics), or Injectafer. If none are formulary, approve. **2.** Patient does NOT have chronic kidney disease, approve if the patient has tried Injectafer. If Injectafer is non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Iron Replacement (Injectable)	Venofer	iron sucrose injection	**1.** Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Injectafer, sodium ferric gluconate complex (Ferrlecit, generics), or Monoferric. If none are formulary, approve. **2.** Patients with hemodialysis dependent chronic kidney disease: approve if the patient has tried sodium ferric gluconate complex (Ferrlecit, generics), if formulary. If sodium ferric gluconate complex (Ferrlecit, generics) is non-formulary, approve. a. Patients < 6 years of age with hemodialysis dependent chronic kidney disease: approve. **3.** Patients receiving peritoneal dialysis: approve. **4.** Patients ≥ 6 years and < 18 years of age approve if the patient has tried sodium ferric gluconate complex (Ferrlecit, generics) or Injectafer, if formulary. If neither are formulary, approve. a. If the patient has chronic kidney disease and is non-dialysis dependent, approve. **5.** Patients < 6 years of age: approve if the patient has tried Injectafer, if formulary. If Injectafer is non-formulary, approve. a. If the patient has chronic kidney disease, approve. **6.** Approve if the patient has been started on a course of therapy with Venofer (to complete the course).	1 year
Iron Replacement (Injectable)	Feraheme	ferumoxytol injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Iron Replacement (oral)	Accrufer	ferric maltol capsules	Approve if the patient has tried one other iron replacement product (e.g., OTC ferrous fumarate, OTC ferrous gluconate, Auryxia).	1 year
Irritable Bowel Syndrome Agents	Viberzi	eluxadoline tablets	**1.** Approve if the patient meets ALL of the following (A, B, and C): A. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried a loperamide-containing product; OR Note: An over-the-counter product would satisfy the requirement. ii. Patient has already tried Xifaxan (any strength); OR iii. Patient has already tried alosetron (Lotronex, generics); AND B. Patient has tried Xifaxan 550 mg; AND Note: If Xifaxan 550 mg is non-formulary, criterion B is met. Note: If another strength of Xifaxan was tried, criterion B is met. C. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried alosetron tablets (Lotronex, generics); OR Note: If alosetron tablets (Lotronex, generic) are non-formulary, criterion C is met. ii. Patient is male; OR Note: Males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression. iii. Patient has altered gut anatomy. Note: An example of altered gut anatomy is a history of bowel resection. **2.** Approve if the patient has already been started on therapy with Viberzi.	1 year
Irritable Bowel Syndrome Agents	Lotronex	alosetron tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Isotretinoin Products	Absorica LD	isotretinoin capsules low dose	Approve if the patient has tried three of the following: isotretinoin capsules (Absorica [not LD]), Accutane, Amnesteem, Claravis, or Zenatane, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve.	1 year
Keratoconus Agents	Epioxa and Epioxa HD	riboflavin 5'-phosphate ophthalmic solution	See standard *Ophthalmology – Epioxa and Epioxa HD Prior Authorization Policy* criteria.	See PA duration
Kinase inhibitor –Cholangiocarcinoma Agent	Lytgobi	futibatinib tablets	Cholangiocarcinoma with fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. **1.** Approve if the patient has tried Pemazyre. If Pemazyre is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Lytgobi.	1 year
Kinase inhibitor –Cholangiocarcinoma Agent	Pemazyre	pemigatinib tablets	Cholangiocarcinoma with fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. **1.** Approve if the patient has tried Lytgobi. If Lytgobi is non-formulary, approve. **2.** Patient has extrahepatic disease, approve. **3.** Approve if the patient has already been started on therapy with Pemazyre. Myeloid/lymphoid neoplasms: Approve.	1 year
Lambert-Eaton Myasthenic Syndrome Agents	Firdapse	amifampridine 10 mg tablets	See standard *Firdapse Prior Authorization Policy* criteria	See PA duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Leucovorin-type Agents	Khapzory	levoleucovorin injection for intravenous use	**1.** Approve if the patient has tried one levoleucovorin calcium injection (e.g., Fusilev, generics) or leucovorin injection, if one is formulary. If neither are formulary, approve. **2.** If the patient has already been started on therapy with Khapzory, approve if the patient has tried levoleucovorin calcium injection (e.g., Fusilev, generics). If levoleucovorin calcium injections (e.g., Fusilev, generics) are non-formulary, approve.	1 year
Leukotriene Pathway Inhibitors	zileuton extended-release tablets	zileuton extended-release tablets	**1.** Approve if the patient has tried one of the following, if one is formulary: montelukast (Singulair, generics) or zafirlukast (Accolate, generics). If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with a zileuton-containing product (e.g., zileuton ER tablets, Zyflo).	1 year
Leukotriene Pathway Inhibitors	Zyflo	zileuton tablets	**1.** Approve if the patient has tried one of the following, if one is formulary: montelukast (Singulair, generics) or zafirlukast (Accolate, generics). If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with a zileuton-containing product (e.g., zileuton ER tablets, Zyflo).	1 year
Leukotriene Pathway Inhibitors	Singulair tablets	montelukast sodium tablets, chewable tablets, granules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Long-Acting Beta-Agonists (Inhalers)	Serevent Diskus	salmeterol xinafoate inhalation powder	**1.** Approve if the patient has tried Striverdi Respimat, if formulary. If Striverdi is non-formulary, approve. **2.** Patient who is unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve. **3.** Patient with asthma: Approve if the patient is using Serevent Diskus concomitantly with an inhaled corticosteroid or an inhaled corticosteroid-containing product. **4.** Patient with exercise induced bronchospasm without asthma: approve. Note: A patient with exercise-induced bronchospasm and asthma should be referred to criterion #3.	1 year
Long-Acting Beta-Agonists (Inhalers)	Striverdi Respimat	olodaterol inhalation spray	**1.** Approve if the patient has tried Serevent Diskus, if formulary. If Serevent Diskus is non-formulary, approve. **2.** Patients who have a low inspiratory flow rate and are unable to use a dry-powder inhaler (DPI): approve.	1 year
Long-Acting Beta-Agonists (nebulized)	Perforomist	formoterol fumarate inhalation solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	Anoro Ellipta	umeclidinium and vilanterol inhalation powder	Direct to umeclidinium-vilanterol inhalation powder (authorized generic of Anoro Ellipta), if formulary. If umeclidinium-vilanterol inhalation powder is non-formulary: **1.** Approve if the patient has tried three of Bevespi Aerosphere, Duaklir Pressair, Stiolto Respimat, if three are formulary, or two if two are formulary, or one if one is formulary. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a metered-dose inhaler (MDI), approve if the patient has tried Duaklir Pressair, if formulary. If Duaklir Pressair is non-formulary, approve.	1 year
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	Bevespi Aerosphere	glycopyrrolate and formoterol fumarate inhalation aerosol	**1.** Approve if the patient has tried three of 1) Anoro Ellipta or umeclidinium and vilanterol inhalation powder (authorized generic of Anoro Ellipta), 2) Duaklir Pressair, or 3) Stiolto Respimat, if three are formulary, or two if two are formulary, or one if one is formulary. If none are formulary, approve. Note: Anoro Ellipta and umeclidinium and vilanterol inhalation powder (authorized generic of Anoro Ellipta) would count as one alternative. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried Stiolto Respimat, if formulary. If Stiolto Respimat is non-formulary, approve.	1 year
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	Duaklir Pressair	aclidinium bromide and formoterol fumarate inhalation powder	**1.** Approve if the patient has tried three of 1) Anoro Ellipta or umeclidinium and vilanterol inhalation powder (authorized generic of Anoro Ellipta), 2) Bevespi Aerosphere, or 3) Stiolto Respimat, if three are formulary, or two if two are formulary or one if one is formulary. If none are formulary, approve. Note: Anoro Ellipta and umeclidinium and vilanterol inhalation powder (authorized generic of Anoro Ellipta) would count as one alternative. **2.** If the patient is unable to coordinate breath and actuation with a metered-dose inhaler (MDI), approve if the patient has tried one of Anoro Ellipta or umeclidinium and vilanterol inhalation powder (authorized generic of Anoro Ellipta), if formulary. If neither are formulary, approve.	1 year
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	Stiolto Respimat	tiotropium bromide and olodaterol inhalation spray	**1.** Approve if the patient has tried three of 1) Anoro Ellipta or umeclidinium and vilanterol inhalation powder (authorized generic of Anoro Ellipta), 2) Bevespi Aerosphere, or 3) Duaklir Pressair if three are formulary, or two if two are formulary, or one if one is formulary. If none are formulary, approve. Note: Anoro Ellipta and umeclidinium and vilanterol inhalation powder (authorized generic of Anoro Ellipta) would count as one alternative. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried Bevespi Aerosphere, if formulary. If Bevespi Aerosphere is non-formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	umeclidinium and vilanterol inhalation powder	umeclidinium and vilanterol inhalation powder	Direct to Anoro Ellipta (brand), if formulary. If Anoro Ellipta (brand) is non-formulary: **1.** Approve if the patient has tried three of Bevespi Aerosphere, Duaklir Pressair, Stiolto Respimat, if three are formulary, or two if two are formulary, or one if one is formulary. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a metered-dose inhaler (MDI), approve if the patient has tried Duaklir Pressair, if formulary. If Duaklir Pressair is non-formulary, approve.	1 year
Long-Acting Opioids (Oral)	Belbuca	buprenorphine buccal film	**1.** Approve if the patient has tried buprenorphine transdermal system (Butrans, generics), if formulary. If buprenorphine transdermal system (Butrans, generics) are non-formulary, approve. **2.** Approve if the patient has tried two other oral long-acting opioid products. For example: OxyContin, oxycodone ER tablets (generics), Xtampza ER, morphine sulfate controlled-release/extended-release capsules or tablets (MS Contin, Kadian ER, generics), Nucynta ER, oxymorphone extended-release tablets, hydrocodone ER (Zohydro ER, Hysingla ER, generics),hydromorphone extended-release tablets (Exalgo ER, generics). **3.** Approve if the patient is currently receiving Belbuca AND is using the requested medication for chronic pain (cancer or non-cancer pain).	1 year
Long-Acting Opioids (Oral)	Nucynta ER and authorized generic	tapentadol extended-release tablets	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets (MS Contin, Kadian ER, generics), OxyContin, oxycodone ER tablets (generics), Xtampza ER, hydromorphone extended-release tablets (Exalgo ER, generics), oxymorphone extended-release tablets, or hydrocodone ER (Zohydro ER, Hysingla ER, generics). **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), OxyContin, or Xtampza ER. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), OxyContin, or Xtampza ER. If none are formulary, approve. **4.** Approve if the patient is currently receiving Nucynta ER AND is using the requested medication for chronic pain (cancer or non-cancer pain).	1 year
Long-Acting Opioids (Oral)	oxycodone ER	oxycodone extended-release tablets	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets (MS Contin, Kadian ER, generics), hydromorphone extended-release tablets (Exalgo ER, generics), oxymorphone extended-release, Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, or Xtampza ER. **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **4.** Patients ≥ 11 years and < 18 years of age: approve if the patient has tried OxyContin, if formulary. If Oxycontin is non-formulary, approve. **5.** If the patient is currently receiving oxycodone ER AND is using the requested medication for chronic pain (cancer or non-cancer pain), approve if the patient has tried one of Oxycontin or Xtampza ER, if formulary. If neither are formulary, approve.	1 year
Long-Acting Opioids (Oral)	Oxycontin	oxycodone controlled-release tablets	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets (MS Contin, Kadian ER, generics), hydromorphone extended-release tablets (Exalgo ER, generics), oxycodone ER tablets (generics), Xtampza ER, oxymorphone extended-release, Nucynta ER, or hydrocodone ER (Zohydro ER, Hysingla ER, generics). **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), or Xtampza ER. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), or Xtampza ER. If none are formulary, approve. **4.** Patients ≥ 11 years and < 18 years of age: approve. **5.** If the patient is currently receiving Oxycontin or oxycodone ER AND is using the requested medication for chronic pain (cancer or non-cancer pain), approve if the patient has tried Xtampza ER, if formulary. If Xtampza is non-formulary, approve.	1 year
Long-Acting Opioids (Oral)	Xtampza ER	oxycodone extended-release capsules (with DETERx)	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets (MS Contin, Kadian ER, generics), hydromorphone extended-release tablets (Exalgo ER, generics), oxymorphone extended-release, Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, or oxycodone ER tablets (generics). **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER tablets or capsules (Zohydro ER, Hysingla ER, generics), or OxyContin. If none are formulary, approve. **4.** If the patient is currently receiving Xtampza ER AND is using the requested medication for chronic pain (cancer or non-cancer pain), approve if the patient has tried Oxycontin, if formulary. If Oxycontin is non-formulary, approve.	1 year
Long-Acting Opioids (Transdermal)	Butrans	buprenorphine transdermal system	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Loop diuretics	Furoscix	furosemide subcutaneous injection by on-body infusor/autoinjector	Approve if the patient has tried at least one loop diuretic **[documentation required]** or the patient is currently taking a loop diuretic. Note: Examples of loop diuretics include furosemide, bumetanide, torsemide, ethacrynic acid.	30 days

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Formulary Exception Criteria

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Loop diuretics	Lasix Onyu	furosemide subcutaneous infusion	Approve if the patient has tried at least one loop diuretic **[documentation required]** or the patient is currently taking a loop diuretic. Note: Examples of loop diuretics include furosemide, bumetanide, torsemide, ethacrynic acid.	30 days
Loop diuretics	Enbumyst	bumetanide nasal spray	Approve if the patient has tried **[documentation required]** and cannot take at least one oral loop diuretic. Note: Examples of loop diuretics include furosemide, bumetanide, torsemide, ethacrynic acid.	1 year
Loop diuretics	Soaanz	torsemide tablets	Approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): torsemide tablets, bumetanide (Bumex, generics), furosemide (Lasix, generics), or ethacrynic acid (Edecrin, generics). If none are formulary, approve. Note: A brand product and its generic count as one alternative. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Low Molecular Weight Heparins and Related Agents	Fragmin	dalteparin sodium injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): enoxaparin (Lovenox, generics) or fondaparinux (Arixtra, generics). If neither are formulary, approve. **2.** If the patient is less than 18 years of age, approve. **2.** Approve if the patient has been started on Fragmin to complete the course of therapy.	1 year
Low Molecular Weight Heparins and Related Agents	Lovenox	enoxaparin sodium injection (syringe/vial)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Lupus Agents - Immunosuppressant Agents	Benlysta IV	belimumab injection for intravenous (IV) use	**1.** Approve if the patient has tried subcutaneous (SC) Benlysta, if formulary. If SC Benlysta is non-formulary, approve.	1 year
Lupus Agents - Immunosuppressant Agents	Benlysta SC	belimumab injection for subcutaneous (SC) use	**1.** Approve if the patient has tried intravenous(IV) Benlysta, if formulary. If IV Benlysta is non-formulary, approve. **2.** Approve if according to the prescriber, the patient cannot receive intravenous (IV) Benlysta due to an inability to obtain and/or to maintain peripheral IV access.	1 year
Lupus Agents - Immunosuppressant Agents	Lupkynis	voclosporin capsules	Lupus nephritis. **1.** Approve if the patient has tried ONE of Benlysta intravenous or subcutaneous, if formulary. If neither are formulary, approve. **2.** Approve if, according to the prescriber, the patient has severe proteinuria. **3.** Approve if the patient has already been started on therapy with Lupkynis.	1 year
Lupus Agents - Immunosuppressant Agents for SLE	Saphnelo IV and SC	anifrolumab-fnia intravenous infusion and subcutaneous injection	Systemic Lupus Erythematosus. **1.** Approve if the patient has tried at least ONE of Benlysta intravenous or subcutaneous, if formulary. If neither are formulary, approve. **2.** Approve if, per the prescriber, the patient has depression or suicidality. **3.** Approve if the patient has already been started on therapy with Saphnelo.	1 year
Melanocortin 4 (MC4) receptor agonist	Imcivree	setmelanotide subcutaneous injection	See standard *Metabolic Disorders – Imcivree Prior Authorization Policy* criteria	See PA duration
Menkes Disease Agents	Zycubo	copper histidinate subcutaneous injection	See standard *Menkes Disease – Zycubo Prior Authorization Policy* criteria.	See PA duration
Metabolic Agents	Carbaglu	carglumic acid tablets	See standard *Metabolic Disorders – Carbaglu Prior Authorization Policy* criteria	See PA duration
Metabolic Agents	Dojolvi	triheptanoin oral liquid	See standard *Metabolic Disorders – Dojolvi Prior Authorization Policy* criteria.	See PA duration
Metabolic Agents	Cystadane	betaine trimethylglycine powder for solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Metabolic Agents - Phenylbutyrate Agents	Olpruva	sodium phenylbutyrate oral suspension	Urea Cycle Disorders. Approve if the patient meets ONE of the following (1, 2, or 3): **1.** Patient has tried BOTH of the following, if both are formulary (or one if only one is formulary): 1) Pheburane oral pellets and 2) glycerol phenylbutyrate oral liquid (Ravicti, generics). If neither are formulary, approve; OR **2.** Patient has a feeding tube: Approve if the patient has tried one of 1) sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) or 2) glycerol phenylbutyrate oral liquid (Ravicti, generics), if formulary. If neither are formulary, approve. **3.** Patient is NOT eating solid food AND does NOT have a feeding tube (e.g., young infant): Approve if the patient has tried glycerol phenylbutyrate oral liquid (Ravicti, generics), if formulary. If glycerol phenylbutyrate oral liquid (Ravicti, generics) are non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. Note: The brand and its generic would count as one alternative.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Metabolic Agents - Phenylbutyrate Agents	Pheburane	sodium phenylbutyrate oral pellets	Urea Cycle Disorders. Approve if the patient meets ONE of the following (1, 2, 3, or 4): **1.** Patient has tried BOTH of the following, if both are formulary (or one if only one is formulary): 1) Olpruva and 2) glycerol phenylbutyrate oral liquid (Ravicti, generics). If neither are formulary, approve; OR **2.** Patient has a feeding tube: Approve if the patient has tried one of 1) sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) or 2) glycerol phenylbutyrate oral liquid (Ravicti, generics), if formulary. If neither are formulary, approve; OR **3.** Patient is < 7 kg or < 1 year of age: Approve if the patient has tried glycerol phenylbutyrate oral liquid (Ravicti, generics), if formulary. If glycerol phenylbutyrate oral liquid (Ravicti, generics) are non-formulary, approve. **4.** Patient is NOT eating solid food AND does NOT have a feeding tube (e.g., young infant): Approve if the patient has tried glycerol phenylbutyrate oral liquid (Ravicti, generics), if formulary. If glycerol phenylbutyrate oral liquid (Ravicti, generics) are non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. Note: The brand and its generic would count as one alternative.	1 year
Metabolic Agents - Phenylbutyrate Agents	Ravicti and generic glycerol phenylbutyrate oral liquid	glycerol phenylbutyrate oral liquid	Patient meets the following: *Metabolic Disorders – Phenylbutyrate Products Prior Authorization Policy* criteria AND Patient meets one of the following (1, 2, 3, 4, or 5): **1.** Approve if the patient has tried BOTH of the following, if both are formulary (or one if only one is formulary): 1) Olpruva and 2) Pheburane **[documentation required]**. If neither are formulary, approve; OR **2.** Patient has a feeding tube: Approve if the patient has tried sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) **[documentation required]**, if formulary. If sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) is non-formulary, approve; OR **3.** Patient is < 7 kg or < 1 year of age: Approve; OR **4.** Patient is NOT eating solid food AND does NOT have a feeding tube (e.g., young infant): Approve; OR **5.** Patient is on a sodium-restricted diet OR, according to the prescriber, a high sodium diet is contraindicated **[documentation required]**: Approve.	See PA duration
Metabolic Agents - Nitisinone	Orfadin oral suspension	nitisinone oral suspension	Hereditary Tyrosinemia Type 1. Approve if the patient meets the following criteria (A, B, C, D, and E): A. According to the prescriber, diagnosis is supported by one of the following (i or ii): i. Genetic testing confirms biallelic pathogenic or likely pathogenic variants in the FAH gene; OR ii. Patient has elevated levels of succinylacetone in the serum or urine; AND B. The medication is prescribed in conjunction with a tyrosine- and phenylalanine-restricted diet; AND C. Patient will not be taking the requested agent concurrently with another nitisinone product; AND Note: Examples of nitisinone products include Orfadin, generic nitisinone capsules, and Nityr. Concurrent use of these agents is not allowed. D. The medication is prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases); AND E. Approve if the patient has tried one of Nityr tablets or nitisinone capsules (Orfadin capsules, generics), if one is formulary. If neither are formulary, approve. Alkaptonuria. Approve if the patient meets ALL of the following (A, B, and C): A. According to the prescriber, diagnosis is supported by ONE of the following (i or ii): i. Genetic testing confirms biallelic pathogenic or likely pathogenic variants in the homogentisate 1,2 dioxygenase (HGD) gene; OR ii. Patient has elevated levels of homogentisic acid (HGA) in the urine; AND B. The medication is prescribed by or in consultation with a rheumatologist or metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases); AND C. Approve if the patient has tried one of Nityr tablets or nitisinone capsules (Orfadin capsules, generics), if one is formulary. If neither are formulary, approve.	1 year
Metabolic Agents - Nitisinone	Harliku	nitisinone tablets	For the reduction of urine homogentisic acid in a patient with alkaptonuria. Approve if the patient has tried one of nitisinone 2 mg capsules (Orfadin 2mg capsules, generics), Orfadin oral suspension, or Nityr 2 mg tablets, if formulary. If none are formulary, approve. Note: If the patient has tried another strength of any of the product above, this would satisfy for an approval.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Metabolic Agents - Nitisinone	Nityr tablets	nitisinone tablets	Hereditary Tyrosinemia Type 1. Approve if the patient meets the following criteria (A, B, C, D, and E): A. According to the prescriber, diagnosis is supported by one of the following (i or ii): i. Genetic testing confirms biallelic pathogenic or likely pathogenic variants in the FAH gene; OR ii. Patient has elevated levels of succinylacetone in the serum or urine; AND B. The medication is prescribed in conjunction with a tyrosine- and phenylalanine-restricted diet; AND C. Patient will not be taking the requested agent concurrently with another nitisinone product; AND Note: Examples of nitisinone products include Orfadin, generic nitisinone capsules, and Nityr. Concurrent use of these agents is not allowed. D. The medication is prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases); AND E. Approve if the patient has tried one of nitisinone capsules (Orfadin capsules, generics) or Orfadin oral suspension, if one is formulary. If neither are formulary, approve. Alkaptonuria. Approve if the patient meets ALL of the following (A, B, and C): A. According to the prescriber, diagnosis is supported by ONE of the following (i or ii): i. Genetic testing confirms biallelic pathogenic or likely pathogenic variants in the homogentisate 1,2 dioxygenase (HGD) gene; OR ii. Patient has elevated levels of homogentisic acid (HGA) in the urine; AND B. The medication is prescribed by or in consultation with a rheumatologist or metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases); AND C. Approve if the patient has tried one of Orfadin oral suspension or nitisinone capsules (Orfadin capsules, generics), if one is formulary. If neither are formulary, approve.	1 year
Metabolic Disorder Agent	Oxlumo	lumasiran injection for subcutaneous use	See standard *Metabolic Disorders – Primary Hyperoxaluria – Oxlumo Prior Authorization Policy* criteria	See PA duration
Metabolic Disorder Agent	Rivfloza	nedosiran subcutaneous injection	Primary Hyperoxaluria Type 1 in a patient ≥ 2 years of age. **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Oxlumo, if formulary. If Oxlumo is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Rivfloza.	1 year
Metabolic Disorders – Cysteamine Ophthalmic Products	Cystadrops	cysteamine ophthalmic solution	Cystinosis with Corneal Cysteine Crystal Deposits: Approve, if the patient has tried Cystaran, if formulary. If Cystaran is non-formulary, approve.	1 year
Metabolic Disorders – Cysteamine Ophthalmic Products	Cystaran	cysteamine ophthalmic solution	Cystinosis with Corneal Cysteine Crystal Deposits: Approve if the patient has tried Cystadrops, if formulary. If Cystadrops is non-formulary, approve.	1 year
Metastatic Castration-Resistant Prostate Cancer Agents	Pluvicto	lutetium Lu 177 vipivotide tetraxetan intravenous infusion	Prostate Cancer - Metastatic Castration Resistant (mCRPC). Approve if the patient meets all of the following (A, B, C, D, and E): A) Patient is ≥ 18 years of age; AND B) Patient has prostate-specific membrane antigen (PSMA)-positive disease; AND C) Patient meets both of the following criteria (i and ii): i.Patient has tried at least one androgen receptor pathway inhibitor; AND Note: Examples of androgen receptor pathway inhibitor include: abiraterone, Yonsa (abiraterone acetate tablets), Xtandi (enzalutamine tablets or capsules), Erleada (apalutamide tablets), or Nubeqa (darolutamide tablet). ii. Patient meets one of the following (a or b): a) Patient has tried at least one taxane-based chemotherapy regimen; OR b) It is considered appropriate to delay taxane-based chemotherapy; ; AND Note: Examples of taxane-based chemotherapy regimen include: docetaxel or Jevtana (cabazitaxel intravenous infusion). D) Patient meets one of the following (i or ii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog; OR Note: Examples of GnRH analog include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Firmagon (degarelix acetate subcutaneous injection), or Orgovyx (relugolix tablet). ii. Patient has had a bilateral orchiectomy; AND E) The medication is prescribed by or in consultation with an oncologist.	1 year
Methenamine Agents	Methenamine mandelate oral solution	methenamine mandelate solution	**1.** Approve if the patient has tried and cannot take methenamine mandelate tablets. If methenamine mandelate tablets are non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets. **3.** Approve if the prescribed dose cannot be obtained with whole methenamine mandelate tablets.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Migraine – Ergotamine Agents	Brekiya	dihydroergotamine mesylate subcutaneous injection	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried one of the following: dihydroergotamine nasal spray (Migranal, generics) or Trudhesa; AND Note: If neither of the dihydroergotamine nasal spray products are formulary, criterion 1 is considered to be met. **2.** Patient meets ONE of the following (A or B): A. Patient has tried TWO chemically unique triptans; OR Note: Examples of triptans: almotriptan (Axert, generics), eletriptan (Relpax, generics), frovatriptan (Frova, generics), naratriptan (Amerge, generics), rizatriptan (Maxalt, generics), sumatriptan (Imitrex, generics), zolmitriptan (Zomig, generics). Note: A trial of two formulations of the same chemical (e.g., sumatriptan injection and sumatriptan tablet) counts as ONE trial. B. If, per the prescriber, the patient has a contraindication to triptans.	1 year
Migraine – Ergotamine Agents	Trudhesa	dihydroergotamine mesylate nasal spray	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried dihydroergotamine nasal spray (Migranal, generics), if formulary. If dihydroergotamine nasal spray (Migranal, generics) are non-formulary, criterion 1 is considered to be met; AND **2.** Patient meets one of the following (A or B): A. Patient has tried TWO chemically unique triptans; OR Note: Examples of triptans: almotriptan (Axert, generics), eletriptan (Relpax, generics), frovatriptan (Frova, generics), naratriptan (Amerge, generics), rizatriptan (Maxalt, generics), sumatriptan (Imitrex, generics), zolmitriptan (Zomig, generics). Note: A trial of two formulations of the same chemical (e.g., sumatriptan injection and sumatriptan tablet) counts as ONE trial. B. If, per the prescriber, the patient has a contraindication to triptans.	1 year
Migraine Agent – Serotonin (5-HT) 1F receptor agonist	Reyvow	lasmiditan tablets	Approve if the patient meets the following (A, B, C, and D): A. Patient has tried Nurtec ODT, if formulary; AND Note: If Nurtec ODT is non-formulary, would still need to meet criteria B, C, and D. B. Patient has tried Ubrelvy, if formulary; AND Note: If Ubrelvy is non-formulary, would still need to meet criteria A, C, and D. C. Patient has tried Zavzpret, if formulary; AND Note: If Zavzpret is non-formulary, would still need to meet criteria A, B, and D. D. Patient meets one of the following (i or ii): i. Patient meets one of the following (1 or 2): 1. Patient has tried two triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR 2. Patient has tried one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product (e.g., Treximet or Symbravo) OR the patient has tried a triptan taken concomitantly with an NSAID; OR ii. Patient meets one of the following (1 or 2): 1. Per the prescriber, the patient has a contraindication to triptans; OR 2. Per the prescriber, the patient has had a significant intolerance to one or more triptans.	1 year
Migraine Agent – Treatment Medications - Calcitonin gene-related peptide (CGRP) receptor antagonist	Zavzpret	zavegepant nasal spray	Approve if the patient meets the following (A and B): A. Patient meets one of the following (i or ii): i. Patient has tried both Nurtec ODT AND Ubrelvy, if both are formulary (or only one if one is formulary); OR ii. If the patient is unable to swallow or has difficulty swallowing tablets, the patient has tried Nurtec ODT, if formulary. If Nurtec ODT is non-formulary, criteria A is met; AND Note: The patient would still need to meet criteria B even if criteria A is met. B. Patient meets one of the following (i or ii): i. Patient meets one of the following (1 or 2): 1. Patient has tried two triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR 2. Patient has tried one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product (e.g., Treximet or Symbravo) OR the patient has tried a triptan taken concomitantly with an NSAID; OR ii. Patient meets one of the following (1 or 2): 1. Per the prescriber, the patient has a contraindication to triptans; OR 2. Per the prescriber, the patient has had a significant intolerance to one or more triptans.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Migraine Agent – Treatment Medications - Calcitonin gene-related peptide (CGRP) receptor antagonist	Nurtec ODT	rimegepant orally disintegrating tablets	**1.** Approve if the patient meets the following (A and B): A. Patient meets one of the following (i or ii): i. Patient has tried both Zavzpret and Ubrelvy, if both are formulary (or one if one is formulary); OR ii. If the patient is unable to swallow or has difficulty swallowing tablets, the patient has tried Zavzpret, if formulary. If Zavzpret is non-formulary, criteria A is met; AND Note: The patient would still need to meet criteria B even if criteria A is met. B. Patient meets one of the following (i or ii): i. Patient meets one of the following (1 or 2): 1. Patient has tried two triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR 2. Patient has tried one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product (e.g., Treximet or Symbravo) OR the patient has tried a triptan taken concomitantly with an NSAID; OR ii. Patient meets one of the following (1 or 2): 1. Per the prescriber, the patient has a contraindication to triptans; OR 2. Per the prescriber, the patient has had a significant intolerance to one or more triptans. **2.** For the prevention of episodic migraine, approve if the patient has tried four of the following products, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Aimovig, Ajovy, Emgality, and Qulipta. If none are formulary, approve.	1 year
Migraine Agent – Treatment Medications - Calcitonin gene-related peptide (CGRP) receptor antagonist	Ubrelvy	ubrogepant tablets	Approve if the patient meets the following (A and B): A. Patient has tried both Nurtec ODT and Zayzpret, if both are formulary (or one if one is formulary). Note: If neither are formulary, would still need to meet criteria B. B. Patient meets one of the following (i or ii): i. Patient meets one of the following (1 or 2): 1. Patient has tried two triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR 2. Patient has tried one triptan/non-steroidal anti-inflammatory drug (NSAID) combination product (e.g., Treximet or Symbravo) OR the patient has tried a triptan taken concomitantly with an NSAID; OR ii. Patient meets one of the following (1 or 2): 1. Per the prescriber, the patient has a contraindication to triptans; OR 2. Per the prescriber, the patient has had a significant intolerance to one or more triptans.	1 year
Migraine Agents - Calcitonin Gene-Related Peptide (CGRP) Inhibitors	Ajovy	fremanezumab-vfrm injection for subcutaneous use	**1.** Approve if the patient has tried three of the following products, if formulary (or two if two are formulary or one if one is formulary): Aimovig, Emgality, and Qulipta. If none are formulary, approve. **2.** Patient is ≥ 6 years of age and < 18 years of age and is using Ajovy for the preventive treatment of episodic migraine.	1 year
Migraine Agents - Calcitonin Gene-Related Peptide (CGRP) Inhibitors	Aimovig	erenumab injection for subcutaneous use	Approve if the patient has tried three of the following products, if formulary (or two if two are formulary or one if one is formulary): Ajovy, Emgality, and Qulipta. If none are formulary, approve.	1 year
Migraine Agents - Calcitonin Gene-Related Peptide (CGRP) Inhibitors	Qulipta	atogepant tablets	Approve if the patient has tried three of the following products, if formulary (or two if two are formulary or one if one is formulary): Aimovig, Emgality, and Ajovy. If none are formulary, approve.	1 year
Migraine Agents - Calcitonin Gene-Related Peptide (CGRP) Inhibitors	Vyepti	eptinezumab-jjmr injection for intravenous use	Approve if the patient has tried four of the following products, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Aimovig, Emgality, Ajovy, and Qulipta. If none are formulary, approve.	1 year
Migraine Agents – Triptan Combination Products	Symbravo	meloxicam and rizatriptan tablets	Approve if the patient meets BOTH of the following (A and B): A. Patient has used concurrently any oral non-steroidal anti-inflammatory drug (NSAID) with an oral triptan AND, according to the prescriber experienced inadequate efficacy or significant intolerance; AND B. Patient has used concurrently any oral NSAID with another oral triptan (NOT the same triptan that was used in criterion A) AND, according to the prescriber experienced inadequate efficacy or significant intolerance. Note: Examples of oral NSAIDs include etodolac, flurbiprofen, ibuprofen, ketoprofen, meloxicam, nabumetone, naproxen, oxaprozin. Note: Examples of oral triptans include rizatriptan, almotriptan, eletriptan, frovatriptan, naratriptan, sumatriptan, zolmitriptan.	1 year
Migraine Agents – Triptan Combination Products	Treximet and generic sumatriptan-naproxen sodium tablets	sumatriptan/ naproxen sodium tablets	Approve if the patient meets BOTH of the following (A and B): A. Patient has used concurrently any oral non-steroidal anti-inflammatory drug (NSAID) with an oral triptan AND, according to the prescriber experienced inadequate efficacy or significant intolerance; AND B. Patient has used concurrently any oral NSAID with another oral triptan (NOT the same triptan that was used in criterion A) AND, according to the prescriber experienced inadequate efficacy or significant intolerance. Note: Examples of oral NSAIDs include etodolac, flurbiprofen, ibuprofen, ketoprofen, meloxicam, nabumetone, naproxen, oxaprozin. Note: Examples of oral triptans include rizatriptan, almotriptan, eletriptan, frovatriptan, naratriptan, sumatriptan, zolmitriptan.	1 year
Migraine Agents - Triptans	Zembrace SymTouch	sumatriptan 3 mg injection	Approve if the patient has tried one product from the following list (if one is formulary): sumatriptan injection (Imitrex, generics). If none are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Migraine Agents - Triptans	Onzetra Xsail	sumatriptan nasal powder	Approve if the patient meets both of the following (a and b): a. Patient has tried one of sumatriptan nasal spray (Imitrex Nasal Spray, generics) or Tosymra, if formulary; AND b. Patient has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary. Note: If no products from a. or b. are formulary, approve.	1 year
Migraine Agents - Triptans	Tosymra Nasal Spray	sumatriptan nasal spray	Approve if the patient meets both of the following (a and b): a. Patient has tried one of sumatriptan nasal spray (Imitrex Nasal Spray, generics) or Onzetra Xsail, if formulary; AND b. Patient has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary. Note: If no products from a. or b. are formulary, approve.	1 year
Migraine Agents - Triptans	Imitrex injection	sumatriptan succinate solution for injection (injectable pen/cartridges)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Migraine Agents - Triptans	Imitrex nasal spray	sumatriptan nasal spray	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Migraine Agents - Triptans	Imitrex tablets	sumatriptan succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Migraine Agents - Triptans	Maxalt	rizatriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Migraine Agents - Triptans	Maxalt MLT	rizatriptan orally disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Migraine Agents - Triptans	Relpax	eletriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Migraine Agents - Triptans	Zomig tablets	zolmitriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Migraine Agents - Calcitonin Gene-Related Peptide (CGRP) Inhibitors	Emgality	galcanezumab-gnlm injection for subcutaneous use	**1.** Approve if the patient has tried three of the following products, if formulary (or two if two are formulary or one if one is formulary): Ajovy, Aimovig, and Qulipta. If none are formulary, approve. **2.** Episodic Cluster Headache Treatment, approve.	1 year
Miscellaneous - Rare Disease	Crysvita	burosumab-twza injection for subcutaneous use	See standard *Crysvita Prior Authorization Policy* criteria.	See PA duration
Miscellaneous - Rare Disease	Gamifant	emapalumab-lzsg injection for intravenous infusion	See standard *Gamifant Prior Authorization Policy* criteria.	See PA duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Miscellaneous anticholinergic	Sofdra	sofpironium topical gel, 12.45%	Hyperhidrosis, Primary Axillary in a patient ≥ 9 years of age. Note: Sofdra is not intended for application to areas other than the axillae. Approve if the patient meets BOTH of the following (1 and 2): **1.** Approve if the patient meets ONE of the following (A or B): A. Patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one of Drysol, Xerac AC, or Bromi-lotion **[documentation required]**; OR B. According to the prescriber, the patient has experienced a significant intolerance with one of these products **[documentation required]**; AND **2.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Qbrexza, if formulary. Note: If Qbrexa is non-formulary, criterion 2 is met.	1 year
Miscellaneous anticholinergic	Qbrexza	glycopyrronium cloth 2.4%, for topical use	Hyperhidrosis, Primary Axillary in a patient ≥ 9 years of age. Note: Qbrexza is not intended for application to areas other than the axillae. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient meets ONE of the following (A or B): A. Patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one of Drysol, Xerac AC, or Bromi-lotion **[documentation required]**; OR B. According to the prescriber, the patient has experienced a significant intolerance with one of these products **[documentation required]**. **2.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Sofdra, if formulary. Note: If Sofdra is non-formulary, criterion 2 is met.	1 year
Miscellaneous anticholinergic	Mestinon	pyridostigmine tablet, solution, exteneded-release tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Miscellaneous Drugs	Xiaflex	collagenase clostridium histolyticum for injection, for intralesional use	See standard *Xiaflex Prior Authorization Policy* criteria.	See PA duration
Miscellaneous Drugs	Thalomid	thalidomide oral capsules	See standard *Oncology (Oral – Immunomodulator) – Thalomid Prior Authorization Policy* criteria	See PA duration
Miscellaneous Urologicals	Urimar-T	methenamine 120 mg, sodium phosphate monobasic 40.8 mg, phenyl salicylate 36.2 mg, methylene blue 10.8 mg, hyoscyamine sulfate 0.12 mg capsule	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH Uro-MP capsules and MB capsules, if formulary. If neither are formulary, approve.	1 year
Miscellaneous Urologicals	Urneva	methenamine 120 mg, sodium phosphate monobasic 40.8 mg, phenyl salicylate 36.2 mg, methylene blue 10.8 mg, hyoscyamine sulfate 0.12 mg capsule	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH Uro-MP capsules and MB capsules, if formulary. If neither are formulary, approve.	1 year
Molluscum Contagiosum Agents	Ycanth	cantharidin 0.7% topical solution	Molluscum contagiosum in a patient ≥ 2 years of age. Approve if the patient has tried one other therapy for the condition (i.e., cryotherapy, curettage, compounded cantharadin, Zelsuvmi).	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Molluscum Contagiosum Agents	Zelsuvmi	berdazimer 10.3% topical gel	Molluscum contagiosum in a patient ≥ 1 years of age. Patient has tried one other therapy for the condition (i.e., cryotherapy, curettage, compounded cantharadin, Ycanth).	1 year
Molybdenum cofactor deficiency Type A Agents	Nulibry	fosdenopterin intravenous infusion	See standard *Metabolic Disorders – Nulibry Prior Authorization Policy* criteria	See PA duration
Monoamine Oxidase Inhibitors	Emsam	selegiline transdermal system	**1.** Approve if the patient has tried one monoamine oxidase inhibitor (MAOI) from the following list (if one is formulary): phenelzine (Nardil, generics), tranylcypromine (Parnate, generics) or Marplan). If none are formulary, approve. **2.** Approve if the patient is currently taking Emsam or has taken Emsam at any time in the past. **3.** Approve if the patient has difficulty swallowing or cannot swallow.	1 year
Monoamine Oxidase Inhibitors	Marplan	isocarboxazid tablets	**1.** Approve if the patient has tried one monoamine oxidase inhibitor (MAOI) from the following list (if one is formulary): phenelzine (Nardil, generics) or tranylcypromine (Parnate, generics). If none are formulary, approve. **2.** Approve if the patient is currently taking Marplan or has taken Marplan at any time in the past.	1 year
Monoclonal Antibodies	Sylvant	siltuximab injection for intravenous infusion	See standard *Oncology (Injectable) – Sylvant Prior Authorization Policy* criteria	See PA duration
Monoclonal antibody	Zinplava	bezlotoxumab injection for intravenous use	Approve Zinplava if the patient meets the following criteria (a, b, and c): **a.** The patient currently has *Clostridioides difficile* infection; AND **b.** Zinplava is being administered concomitantly with an antibiotic for treatment of *Clostridioides difficile* infection (e.g., oral or IV metronidazole, oral vancomycin [Vancocin® {vancomycin capsules, generics} or Firvanq™ compounded oral solution], or Dificid® [fidaxomicin tablets]); AND **c.** According to the prescriber, the patient is at high-risk for*Clostridioides difficile* infection recurrence.	1 year
mTOR Inhibitor	Fyarro	sirolimus protein-bound particles intravenous infusion	See standard *Oncology (Injectable) - Fyarro PA Policy* criteria.	See PA duration
Multiple Sclerosis Drugs -Injectable Beta Interferons	Avonex	interferon beta-1a, intramuscular injection	Relapsing form of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets one of the following (A or B): A. Patient has tried three formulary products from the following list: 1) Betaseron, 2) Rebif, or 3) Plegridy, if three are formulary (or two if two are formulary or one if one is formulary); OR B. If no beta-interferons (above) are formulary, patient meets BOTH of the following (i and ii): i. Patient has tried one oral fumarate product: Bafiertam, Vumerity, or dimethyl fumarate (Tecfidera, generics), if formulary; AND Note: If no oral fumarate products are formulary, approve. ii. Patient has tried one other agent for multiple sclerosis. Note: Examples of other agents for multiple sclerosis include Mayzent, Ponvory, Zeposia, fingolimod (Gilenya, generics), Tascenso ODT, teriflunomide (Aubagio, generics), glatiramer, Glatopa (Copaxone, generics). **2.** Patient has been established on Avonex for greater than or equal to 120 days.	1 year
Multiple Sclerosis Drugs -Injectable Beta Interferons	Betaseron	interferon beta-1b injection	Relapsing form of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets one of the following (A or B): A. Patient has tried three formulary products from the following list: Rebif, Avonex, or Plegridy, if three are formulary (or two if two are formulary or one if one is formulary); OR B. If no beta-interferon products (above) are formulary, patient meets BOTH of the following (i and ii): i. Patient has tried one oral fumarate product: Bafiertam, Vumerity, or dimethyl fumarate (Tecfidera, generics), if formulary; AND Note: If no oral fumarate products are formulary, approve. ii. Patient has tried one other agent for multiple sclerosis. Note: Examples of other agents for multiple sclerosis include Mayzent, Ponvory, Zeposia, fingolimod (Gilenya, generics), Tascenso ODT, teriflunomide (Aubagio, generics), glatiramer, Glatopa (Copaxone, generics). **2.** Patient has been established on Betaseron for greater than or equal to 120 days, approve.	1 year
Multiple Sclerosis Drugs -Injectable Beta Interferons	Plegridy	peginterferon beta-1a injection for subcutaneous or intramuscular use	Relapsing form of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets one of the following (A or B): A. Patient has tried three formulary products from the following list: 1) Betaseron, 2) Rebif, or 3) Avonex, if three are formulary (or two if two are formulary, or one if one is formulary); OR B. If no beta-interferon products (above) are formulary, patient meets BOTH of the following (i and ii): i. Patient has tried one oral fumarate product: Bafiertam, Vumerity, or dimethyl fumarate (Tecfidera, generics), if formulary; AND Note: If no oral fumarate products are formulary, approve. ii. Patient has tried one other agent for multiple sclerosis. Note: Examples of other agents for multiple sclerosis include Mayzent, Ponvory, Zeposia, fingolimod (Gilenya, generics), Tascenso ODT, teriflunomide (Aubagio, generics), glatiramer, Glatopa (Copaxone, generics). **2.** Patient has been established on Plegridy for greater than or equal to 120 days.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Multiple Sclerosis Drugs -Injectable Beta Interferons	Rebif	interferon beta-1a injection [subcutaneous]	Relapsing form of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets one of the following (A or B): A. Patient has tried three formulary products from the following list: 1) Avonex, 2) Betaseron, or 3) Plegridy, if three are formulary (or two if two are formulary or one if one is formulary); OR B. If no beta-interferon products (above) are formulary, patient meets BOTH of the following (i and ii): i. Patient has tried one oral fumarate product: Bafiertam, Vumerity, or dimethyl fumarate (Tecfidera, generics), if formulary; AND Note: If no oral fumarate products are formulary, approve. ii. Patient has tried one other agent for multiple sclerosis. Note: Examples of other agents for multiple sclerosis include Mayzent, Ponvory, Zeposia, fingolimod (Gilenya, generics), Tascenso ODT, teriflunomide (Aubagio, generics), glatiramer, Glatopa (Copaxone, generics). **2.** Patient has been established on Rebif for greater than or equal to 120 days.	1 year
Multiple Sclerosis Drugs -Injectable glatiramer	Copaxone	glatiramer acetate injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Multiple Sclerosis Drugs (Injectable)	Lemtrada	alemtuzumab intravenous infusion	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include relapsing remitting disease and active secondary progressive disease. Approve if the patient meets one of the following (1, 2, 3, or 4): **1.** Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with at least TWO other disease-modifying agents used for multiple sclerosis. Note: Examples of disease-modifying agents for multiple sclerosis include: a beta interferon product (Avonex, Betaseron, Rebif, Plegridy), a glatiramer product (Copaxone, generics, Glatopa), a fingolimod product (Gilenya, generics, Tascenso ODT), teriflunomide tablets (Aubagio, generics), natalizumab product (Tysabri, biosimilar), cladribine (Mavenclad, generics), Mayzent, Zeposia, Ponvory, Kesimpta, Ocrevus, Ocrevus Zunovo, Briumvi, or a dimethyl fumarate product (Tecfidera, generics, Vumerity, Bafiertam). **2.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE of Briumvi, Kesimpta, cladribine (Mavenclad, generics), Ocrevus, Ocrevus Zunovo, or a natalizumab product (Tysabri, biosimilar). **3.** If, according to the prescriber, the patient has highly-active or aggressive multiple sclerosis. **4.** Patient is currently receiving Lemtrada or has received it in the past.	1 year
Multiple Sclerosis Drugs (Injectable) - CD20-directed cytolytic antibodies	Kesimpta	ofatumumab subcutaneous injection	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. **1.** Approve if the patient has tried and, according to the prescriber, has had inadequate efficacy or significant intolerance with ONE of 1) Briumvi or 2) Ocrevus intravenous or Ocrevus Zunovo, if formulary. If none are formulary, approve. **2.** If the patient is unable to obtain and/or maintain intravenous access, approve if the patient has tried Ocrevus Zunovo, if formulary. If Ocrevus Zunovo is non-formulary, approve. **3.** Approve if the patient has been established on Kesimpta for greater than or equal to 120 days.	1 year
Multiple Sclerosis Drugs (Injectable) - CD20-directed cytolytic antibodies	Ocrevus Zunovo	ocrelizumab and hyaluronidase-ocsp subcutaneous injection	Primary progressive multiple sclerosis. **1.** Approve if the patient has tried and cannot use Ocrevus intravenous (IV), if formulary. If Ocrevus IV is non-formulary, approve. **2.** Approve if the patient is unable to obtain IV access. Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following if Ocrevus intravenous is formulary (1 or 2): **1.** Patient has tried and cannot use Ocrevus intravenous, if formulary; OR **2.** Patient is unable to obtain IV access. If Ocrevus intravenous is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy or significant intolerance with ONE of Briumvi or Kesimpta, if formulary; OR i. If the patient is unable to obtain IV access, approve if the patient has tried and, according to the prescriber, has had inadequate efficacy or significant intolerance with Kesimpta, if formulary. If Kesimpta is non-formulary, approve. Note: If neither are formulary, criterion A is met. B. Patient has already been started on Ocrevus Zunovo or Ocrevus intravenous.	1 year
Multiple Sclerosis Drugs (Injectable) - CD20-directed cytolytic antibodies	Briumvi	ublituximab-xiiy intravenous infusion	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. **1.** Approve if the patient has tried and, according to the prescriber, has had inadequate efficacy or significant intolerance with ONE of 1) Ocrevus intravenous or Ocrevus Zunovo or 2) Kesimpta, if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on Briumvi therapy.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Multiple Sclerosis Drugs (Injectable) - CD20-directed cytolytic antibodies	Ocrevus intravneous	ocrelizumab intravenous infusion	Primary progressive multiple sclerosis: Approve if the patient has tried and cannot use Ocrevus Zunovo, if formulary. If Ocrevus Zunovo is non-formulary, approve. Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. **1.** Approve if the patient has tried Ocrevus Zunovo, if formulary. If Ocrevus Zunovo is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy or significant intolerance with ONE of Briumvi or Kesimpta, if formulary. If neither are formulary, approve. B. Patient has already been started on Ocrevus intravenous or Ocrevus Zunovo. **2.** Approve if the patient is ≥ 10 years of age and < 18 years of age.	1 year
Multiple Sclerosis Drugs (Oral)	Zeposia	ozanimod capsules	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets the following (A and B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one fumarate-based product, if formulary: Bafiertam, dimethyl fumarate (Tecfidera, generics), or Vumerity. If none are formulary, approve; AND	1 year
Multiple Sclerosis Drugs (Oral)	Aubagio and teriflunomide tablets	teriflunomide tablets	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. If brand Aubagio is being requested: Approve if the brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent generic products, generic teriflunomide tablets, if the generic is formulary. If teriflunomide tablets are non-formulary or generic teriflunomide is being requested: Approve if the patient meets one of the following (1, 2, or 3): **1.** Patient meets the following (A and B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one fumarate-based product, if formulary: Bafiertam, dimethyl fumarate (Tecfidera, generics), or Vumerity. If none are formulary, approve; AND B. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one of the following: fingolimod (Gilenya, generics), Zeposia, Mayzent, or Ponvory, if formulary. If none are formulary, would still need to try a fumarate-based product, if one is formulary. **2.** For patients with an underlying cardiovascular condition (e.g., heart failure, myocardial infarction, stroke, transient ischemic attack, unstable angina, atrioventricular [AV] block, cardiac arrhythmias, bradyarrhythmias), patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one other oral disease-modifying therapy (e.g., dimethyl fumarate, Vumerity). Note: Any oral disease modifying agent would satisfy this requirement, including dimethyl fumarate, Tecfidera, Vumerity, Bafiertam, cladribine (Mavenclad, generics), Zeposia, Mayzent, Ponvory, fingolimod, Gilenya, Tascenso ODT. **3.** Patient has been established on teriflunomide (Aubagio) for greater than or equal to 120 days.	1 year
Multiple Sclerosis Drugs (Oral)	Mavenclad	cladribine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Multiple Sclerosis Drugs (Oral)	Mayzent	siponimod tablets	Relapsing form of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1, 2, or 3): **1.** Patient meets the following (A and B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one fumarate-based product, if formulary: Bafiertam, dimethyl fumarate (Tecfidera, generics), or Vumerity. If none are formulary, approve; AND B. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one of the following: Zeposia, fingolimod (Gilenya, generics) or Ponvory, if formulary. If none are formulary, would still need to try a fumarate-based product, if one is formulary. **2.** Patient has active secondary progressive multiple sclerosis. **3.** Patient has been established on Mayzent for greater than or equal to 120 days.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Multiple Sclerosis Drugs (Oral)	Ponvory	ponesimod capsules	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets the following (A and B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one fumarate-based product, if formulary: Bafiertam, dimethyl fumarate (Tecfidera, generics), or Vumerity. If none are formulary, approve; AND B. Patient has tried and, according to the prescriber, has had inadequate efficacy ORor significant intolerance with one of the following: fingolimod (Gilenya, generics), Mayzent, or Zeposia, if formulary. If none are formulary, would still need to try a fumarate-based product, if one is formulary. **2.** Patient has been established on Ponvory for greater than or equal to 120 days.	1 year
Multiple Sclerosis Drugs (Oral)	Tascenso ODT 0.5 mg	fingolimod orally disintegrating tablets	Patient with relapsing form of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. **1.** Approve if the patient is unable to swallow or has difficulty swallowing fingolimod 0.5 mg capsules or Gilenya 0.5 mg capsules **[documentation required]**. **2.** Approve if neither fingolimod 0.5 mg capsule nor Gilenya 0.5 mg capsules are formulary.	1 year
Multiple Sclerosis Drugs (Oral)	Tascenso ODT 0.25 mg	fingolimod orally disintegrating tablets	1. Patient meets all of the following (A, B, and C): A. Patient with relapsing form of multiple sclerosis; AND Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. B. Patients ≥ 10 years of age; AND	1 year
Multiple Sclerosis Drugs (Oral)	Gilenya 0.25 mg	fingolimod capsule	Patient meets all of the following (A, B, C and D): A. Patient with relapsing form of multiple sclerosis; AND Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. B. Patients ≥ 10 years of age; AND C. Patient weighs less than or equal to 40 kg **[documentation required]**; AND D. Patient has tried Tascenso 0.25 mg orally disintegrating tablets (ODT), if formulary. If Tascenso 0.25 ODT are non-formulary, approve.	1 year
Multiple Sclerosis Drugs (Oral)	Ampyra	dalfampridine extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Multiple Sclerosis Drugs (Oral)	Gilenya 0.5 mg	fingolimod capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Multiple Sclerosis Drugs (Oral) – Fumarate-based Agents	Bafiertam	monomethyl fumarate delayed-release capsules	Approve if the patient has tried one of Vumerity or dimethyl fumarate (Tecfidera, generics), if formulary. If none are formulary, approve.	1 year
Multiple Sclerosis Drugs (Oral) – Fumarate-based Agents	Vumerity	diroximel fumarate delayed-release capsules	Approve if the patient has tried one of dimethyl fumarate (Tecfidera, generics), or Bafiertam, if formulary. If none are formulary, approve.	1 year
Multiple Sclerosis Drugs (Oral) – Fumarate-based Agents	Tecfidera	dimethyl fumarate delayed-release capsules	See standard *Multiple Sclerosis (Tecfidera) Preferred Specialty Management Policy* criteria.	See PSM duration
Multiple Sclerosis/Crohn's Disease Medications (Injectable)	Tyruko	natalizumab-sztn intravenous infusion	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried Tysabri, if formulary; AND Note: If Tysabri is non-formulary, approve. **2.** Patient cannot continue to use Tysabri due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Multiple Sclerosis/Crohn's Disease Medications (Injectable)	Tysabri	natalizumab intravenous infusion	Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried Tyruko, if formulary; AND Note: If Tyruko is non-formulary, approve. **2.** Patient cannot continue to use Tyruko due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Muscle Relaxants	Zanaflex 8 mg capsule; tizanidine 8 mg capsule (brand)	tizanidine 8 mg capsule	Approve if the patient tried and cannot take generic tizanidine tablets or capsules. If neither generic tizanidine tablets or capsules are formulary, approve.	1 year
Muscle Relaxants	Soma (carisoprodol tablets), Soma Compound (carisoprodol/aspirin), and Parafon Forte (carisoprodol/aspirin/codeine phosphate)	carisoprodol tablets, carisoprodol-aspirin, and carisoprodol/aspirin/codeine phosphate	Approve if the patient has tried both baclofen AND tizanidine.	14 days
Muscle Relaxants	Methocarbamol 1,000 mg tablets (brand)	methocarbamol 1,000 mg tablets	**1.** Direct the patient to methocarbamol 500 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the methocarbamol 500 mg tablets.	1 year
Muscle Relaxants	Amrix and generic	cyclobenzaprine extended-release 15 mg and 30 mg capsule	Approve if the patient has tried and cannot take cyclobenzaprine 5 mg or 10 mg tablets (generics), if formulary. If cyclobenzaprine 5 mg or 10 mg tablets (generics) are non-formulary, approve.	1 year
Muscle Relaxants	Fexmid	cyclobenzaprine tablet	Approve if the patient has tried and cannot take cyclobenzaprine tablets (generics), if formulary. If cyclobenzaprine tablets (generics) are non-formulary, approve.	1 year
Muscle Relaxants	Lorzone	chlorzoxazone tablets	Approve if the patient has tried and cannot take generic chlorzoxazone tablets, if formulary. If generic chlorzoxazone tablets are non-formulary, approve.	1 year
Muscle Relaxants	Ontralfy	tizanidine oral solution	**1.** Approve if the patient has tried one of tizanidine tablets or tizanidine capsules, if formulary. If neither are formulary, approve. **2.** Approve if the patient has difficulty swallowing oral dosage forms (tablets or capsules) or the patient cannot swallow oral dosage forms (tablets or capsules).	1 year
Muscle Relaxants	Atmeksi	methocarbamol oral suspension	**1.** Approve if the patient has tried and cannot take methocarbamol tablets, if formulary. If methocarbamol tablets are non-formulary, approve. **2.** Approve if the patient cannot swallow tablets or has difficulty swallowing tablets.	1 year
Muscle Relaxants	metaxalone 640 mg tablet	metaxalone 640 mg tablet	**1.** Approve if the patient has tried and cannot take one of metaxolone 400 mg or 800 mg tablets. **2.** According to the prescriber, there is a significant clinical concern such that the patient is unable to use metaxolone 400 mg or 800 mg tablets.	1 year
Muscle Relaxants – Baclofen Agents	Fleqsuvy and baclofen oral suspension, concentrated formulation 25 mg/5 mL	baclofen oral suspension, concentrated formulation 25 mg/5mL	If requesting brand Fleqsuvy oral suspension: Approve if the patient has tried and cannot take generic baclofen oral suspension 25 mg/5 ml (generic of Fleqsuvy) due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic baclofen oral suspension 25 mg/5 ml (generic of Fleqsuvy) or baclofen oral suspension 25 mg/5 ml (generic of Fleqsuvy) is non-formulary: **1.** Direct to oral baclofen tablets. **2.** Patient is unable to swallow oral tablets or has difficulty swallowing oral tablets, approve if the patient has tried baclofen oral solution (Ozobax or Ozobax DS oral solution, generics), if formulary. If baclofen oral solution (Ozobax or Ozobax DS oral solution, generics) are non-formulary, approve.	1 year
Muscle Relaxants – Baclofen Agents	Lyvispah	baclofen oral granules	**1.** Direct the patient to oral baclofen tablets. **2.** If Lyvispah will be administered via a feeding tube, approve. **3.** Patient is unable to swallow oral tablets or has difficulty swallowing oral tablets, approve if the patient has tried one of 1) baclofen oral solution (Ozobax or Ozobax DS oral solution, generics) or 2) baclofen 25mg/5ml oral suspension (Fleqsuvy suspension, generics), if formulary. If neither are formulary, approve.	1 year
Muscle Relaxants – Baclofen Agents	Ozobax, Ozobax DS, and generics	baclofen oral solution	If requesting brand Ozobax 5 mg/5 ml or brand Ozobax DS 10 mg/5ml: Approve if the patient has tried and cannot take one of the respective generic products, baclofen 5 mg/ 5 ml oral solution or baclofen 10 mg/ 5ml oral solution, due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic baclofen 5 mg/ 5ml oral solution or generic baclofen 10 mg/ 5 ml oral solution OR BOTH of those products are non-formulary: **1.** Direct to oral baclofen tablets. **2.** Patient is unable to swallow oral tablets or has difficulty swallowing oral tablets, approve if the patient has tried one of 1) baclofen 25 mg/5ml oral suspension (Fleqsuvy suspension, generics), if formulary. If baclofen 25 mg/5ml oral suspension (Fleqsuvy suspension, generics) are non-formulary, approve.	1 year
Muscle Relaxants – Baclofen Agents	baclofen 15 mg	baclofen 15 mg tablets	**1.** Direct the patient to generic baclofen 5mg, 10mg, or 20 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic baclofen 5 mg, 10 mg, or 20 mg tablets.	1 year
Muscle Relaxants (intrathecal injections)	Gablofen	baclofen intrathecal injection (pre-filled syringe)	Approve if the patient has tried Lioresal, if formulary. If Lioresal is non-formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Muscle Relaxants (intrathecal injections)	Lioresal	baclofen intrathecal injection	Approve if the patient has tried baclofen intrathecal injection (Gablofen, genercis), if formulary. If baclofen intrathecal injection (Gablofen, generics) are non-formulary, approve.	1 year
Myelodysplastic syndrome Agent	Inqovi	decitabine and cedazuridine tablets	Acute Myeloid Leukemia; Chronic Myelomonocytic Leukemia; Myelodysplastic Syndrome with Myeloproliferative Neoplasm Overlap Syndrome; Myelodysplastic Syndromes (Note: Examples of myelodysplastic syndromes include: refractory anemia, refractory anemia with ringed sideroblasts, and refractory anemia with excess blasts.). **1.** Approve if the patient has tried decitabine injection (Dacogen, generics), if formulary. If decitabine injection (Dacogen, generics) is non-formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** Approve if the patient has already started therapy with Inqovi.	1 year
Myelofibrosis Agents	Vonjo	pacritinib capsules	See standard *Oncology – Vonjo Prior Authorization Policy* criteria.	See PA duration
Myelofibrosis Agents	Jakafi XR	ruxolitinib extended-release tablets	Approve if the patient has tried Jakafi (not XR), if formulary. If Jakafi (not XR) is non-formulary, approve.	1 year
Myelofibrosis Agents	Jakafi [not XR]	ruxolitinib tablets	**1.** Approve if the patient has tried Jakafi XR, if formulary. If Jakafi XR is non-formulary, approve. **2.** Approve if the patient is unable to or has difficulty swallowing oral tablets whole. **3.** Approve if the requested product is being administered through a nasogastric or other feeding tube. **4.** According to the prescriber, Jakafi XR is not clinically appropriate for the patient due to dose modifications for drug-drug interactions OR dose modifications for renal impairment OR dose modifications for hepatic impairment.	1 year
Myelofibrosis Agents	Inrebic	febratinib capsules	Myelofibrosis. Note: Myelofibrosis includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. **1.** Approve if the patient has tried one of Jakafi or Jakafi XR, if formulary. If neither are formulary, approve. Note: If the patient has tried Vonjo, this would satisfy requirement for approval. **2.** If the patient is unable to or has difficulty swallowing oral tablets/capsules whole OR the requested product is being administered through a nasogastric or other feeding tube, approve if the patient has tried Jakafi (not XR), if formulary. If Jakafi (not XR) is non-formulary, approve. **3.** Approve if the patient has already been started on Inrebic. Accelerated or Blast Phase Myeloproliferative Neoplasm: approve. Myeloid/Lymphoid Neoplasms: approve.	1 year
Myelofibrosis Agents – JAK Inhibitors	Ojjaara	momelotinib tablets	Myelofibrosis. Note: This includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. **1.** Approve if the patient has tried one of Jakafi or Jakafi XR, if formulary. If neither are formulary, approve. Note: If the patient has tried Vonjo, this would satisfy requirement for approval. **2.** If the patient has myelofibrosis anemia, approve. **3.** Approve if the patient has already started on therapy with Ojjaara. Accelerated or Blast Phase Myeloproliferative Neoplasm: approve. Myeloid or Lymphoid Neoplasms: approve.	1 year
Naloxone Products for Opioid Overdose	Zimhi	naloxone hydrochloride intramuscular or subcutaneous injection 5 mg/0.5 ml	**1.** Approve if the patient has tried naloxone syringes, if formulary. If naloxone syringes are non-formulary, approve. **2.** Approve, if according to the prescriber, a higher-strength naloxone product is needed.	1 year
Nasal Antihistamines and Combination Products	Dymista and generic azelastine-fluticasone propionate nasal spray	azelastine and fluticasone propionate nasal spray	Approve if the patient has tried AND USED CONCOMITANTLY one formulary nasal steroid spray, if one is formulary AND azelastine nasal spray (Astelin, generics), if formulary. If azelastine nasal spray is non-formulary, approve if the patient has tried one nasal steroid spray. Note: Nasal steroids are flunisolide nasal spray, fluticasone propionate nasal spray, mometasone furoate nasal spray, Omnaris, Qnasl, Ryaltris, Xhance. Note: A trial of Astepro or generic Astepro, would also count toward a trial of azelastine. Note: A trial of an over-the-counter (OTC) nasal spray would count toward either trial above. Note: If there are no formulary nasal steroid sprays, approve.	1 year
Nasal Combination Agents (Nasal Steroid and Anti-histamine)	Ryaltris	olopatadine hydrochloride and mometasone furoate nasal spray	Approve if the patient has tried 1) both of the following antihistamine nasal sprays: azelastine nasal spray and olopatadine nasal spray, if formulary (or one if one is formulary) AND the patient has tried 2) four nasal steroids from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Qnasl, or Omnaris. Note: A brand and its generic would count as one alternative. Note: Over-the-counter (OTC) nasal steroids and nasal antihistamines would count as a trial of an alternative.	1 year
Nasal Steroids	Omnaris	ciclesonide nasal spary	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Qnasl, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Nasal Steroids	Qnasl	beclomethasone dipropionate nasal aersol	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year
Nasal Steroids	Xhance	fluticasone propionate nasal spray	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year
Nasal Steroids	Zetonna	ciclesonide nasal aerosol	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Qnasl. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year
Nephropathic Cystinosis Medications	Cystagon	cysteamine capsules	Nephropathic cystinosis. Approve if the patient has tried Procysbi, if formulary. If Procysbi is non-formulary, approve .	1 year
Nephropathic Cystinosis Medications	Procysbi	cysteamine bitartrate dealyed-release capsules and granule packets	Nephropathic cystinosis. Approve if the patient has tried **[documentation required]** and, according to the prescriber, experienced inadequate efficacy or significant intolerance with Cystagon, if formulary. If Cystagon is non-formulary, approve.	1 year
Neprilisin Inhibitor and Angiotensin 2 Receptor Blocker	Entresto Sprinkle	sacubitril and valsartan oral pellets	Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year
Neprilisin Inhibitor and Angiotensin 2 Receptor Blocker	Entresto tablets	sacubitril and valsartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Neuroblastoma Agents	Danyelza	naxitamab-gqgk injection for intravenous use	Neuroblastoma: **1.** Approve if the patient has tried Unituxin injection. If Unituxin injection is non-formulary, approve. **2.** If the prescriber has safety concerns regarding Unituxin therapy (e.g., capillary leak syndrome, atypical hemolytic uremic syndrome), approve. **3.** If the patient has already started therapy with Danyelza, approve.	1 year
Neurofibromatosis Agents	Gomekli	mirdametinib capsules and tablets for oral suspension	Neurofibromatosis Type 1. **1.** Approve if the patient has tried Koselugo. If Koselugo is non-formulary, approve. **2.** Approve if the prescriber has concerns using Koselugo due to any of the following: gastrointestinal toxicity, increased creatine phosphokinase, or risk of bleeding. **3.** Approve if the patient has already been started on therapy with Gomekli.	1 year
Neurofibromatosis Agents	Koselugo	selumetinib capsules and sprinkle capsules	See standard *Oncology – Koselugo Prior Authorization Policy* criteria.	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Neurokinin1 and 3 Antagonists	Lynkuet	elinzanetant capsules	Approve if the patient meets ALL of the following (1, 2, and 3): **1.** Patient meets ONE of the following (A, B, C, or D): A. Patient has tried Veozah, if formulary; OR Note: If Veozah is non-formulary, then criterion 1 is met. B. According to the prescriber, the patient is at risk of hepatotoxicity, OR C. Patient has cirrhosis, severe renal impairment, or end-stage renal disease; OR D. Patient is using the requested medication for symptoms associated with endocrine therapy for hormone receptor-positive breast cancer or its prevention; AND **2.** Patient meets ONE of the following (A or B): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with at least one oral or topical estrogen-containing product: estradiol tablets (Estrace, generics), Premarin, Menest, estradiol patches (Alora, Climara, Menostar, Vivelle-Dot, Minivelle, generics), estradiol gel (Divigel, Estrogel, generics), Elestrin, Evamist; OR Note: If the patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with an oral or topical estrogen product in combination with a progestin agent, this would satisfy the requirement. B. According to the prescriber, the patient has a contraindication to hormone therapy **[documentation required]**; AND Note: Examples of contraindications to hormone therapy may include: Current or history of an estrogen-dependent cancer; current or history of deep vein thrombosis or pulmonary embolism; current or history of thrombophilic disorders; cardiovascular disorders. Note: Hormone therapy includes any oral or topical estrogen or estrogen/progestin combination products. **3.** Patient meets ONE of the following (A, B, C, or D): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with paroxetine 7.5 mg (formerly Brisdelle); OR Note: If the patient has already tried paroxetine 10 mg or any other strength of paroxetine, this would satisfy criterion A. B. Paroxetine 7.5 mg is non-formulary; OR C. Patient is already taking 1) a selective serotonin reuptake inhibitor, OR 2) a serotonin and norepinephrine reuptake inhibitor; OR D. According to the prescriber, the patient has a contraindication to a selective serotonin reuptake inhibitor.	1 year
Neurokinin-3 Antagonists	Veozah	fezolinetant tablets	Approve if the patient meets ALL of the following (1, 2, AND 3): **1.** Patient meets ONE of the following (A or B): A. Patient has tried Lynkuet, if formulary; OR Note: If Lynkuet is non-formulary, then criterion 1 is met. B. If, according to the prescriber, the patient has a seizure disorder or is at risk for seizures; AND **2.** Patient meets ONE of the following (A or B): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with at least one oral or topical estrogen-containing product: estradiol tablets (Estrace, generics), Premarin, Menest, estradiol patches (Alora, Climara, Menostar, Vivelle-Dot, Minivelle, generics), estradiol gel (Divigel, Estrogel, generics), Elestrin, Evamist; OR Note: If the patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with an oral or topical estrogen product in combination with a progestin agent, this would satisfy the requirement. B. According to the prescriber, the patient has a contraindication to hormone therapy **[documentation required]**; AND Note: Examples of contraindications to hormone therapy may include: Current or history of an estrogen-dependent cancer; current or history of deep vein thrombosis or pulmonary embolism; current or history of thrombophilic disorders; cardiovascular disorders. Note: Hormone therapy includes any oral or topical estrogen or estrogen/progestin combination products. **3.** Patient meets ONE of the following (A, B, C, or D): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with paroxetine 7.5 mg (formerly Brisdelle); OR Note: If the patient has already tried paroxetine 10 mg or any other strength of paroxetine, this would satisfy criterion A. B. Paroxetine 7.5 mg is non-formulary; OR C. Patient is already taking 1) a selective serotonin reuptake inhibitor, OR 2) a serotonin and norepinephrine reuptake inhibitor; OR D. According to the prescriber, the patient has a contraindication to a selective serotonin reuptake inhibitor.	1 year
Neurology - Amyotrophic Lateral Sclerosis (ALS) Agents	Qalsody	tofersen intrathecal injection	See standard *Neurology – Qalsody Prior Authorization Policy* criteria.	See PA duration
Neurology - Amyotrophic Lateral Sclerosis (ALS) Agents.	Radicava intravenous and edaravone intravenous	edaravone intravenous infusion	Patient meets the following: *Neurology – Edaravone Products Prior Authorization Policy* criteria AND Patient meets ONE of the following (1 or 2): **1.** Patient is unable to swallow oral medication and is NOT on a feeding tube, approve. **2.** Approve if the patient has tried Radicava ORS, if formulary. If Radicava ORS is non-formulary, approve.	See PA duration

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Neurology - Amyotrophic Lateral Sclerosis (ALS) Agents.	Radicava ORS	edaravone oral suspension	Patient meets the following: *Neurology – Edaravone Products Prior Authorization Policy* criteria AND Patient meets ONE of the following (1, 2, 3 or 4): **1.** Patient has the ability to swallow oral medication, approve. **2.** Patient has a feeding tube, approve. **3.** Approve if the patient has tried one of Radicava intravenous or edaravone intravenous, if formulary. If neither are formulary, approve. **4.** Patient is unable to obtain and/or maintain intravenous (IV) access, approve.	See PA duration
Neurology - Enzyme Replacement Therapy	Brineura	cerliponase alfa injection for intraventricular use	See standard *Neurology – Brineura Prior Authorization Policy* criteria	See PA duration
Neurology- Gene Therapy	Lenmeldy	atidarsagene autotemcel intravenous infusion	See standard *Neurology – Gene Therapy – Lenmeldy Prior Authorization Policy* criteria.	See PA duration
Neuromyelitis optica spectrum disorder (NMOSD) Agents	Enspryng	satralizumab-mwge for subcutaneous injection	Anti-aquaporin (AQ4P) antibody-positive Neuromyelitis Optica Spectrum Disorder in a patient ≥ 18 years of age. **1.** Approve if the patient has tried and, according to the prescriber, has inadequate efficacy or significant intolerance to Uplizna, if formulary. If Uplizna is non-formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** Approve if the patient has already started on therapy with Enspryng.	1 year
Nicotinamide Modified Allogeneic Hematopoietic Progenitor cell therapy (derived from cord blood)	Omisirge	omidubicel-onlv intravenous infusion	Umbilical Cord Blood Transplantation. Approve if the patient meets ALL of the following (A, B, and C): A. Patient is ≥ 12 years of age; AND B. Patient has a hematologic malignancy; AND Note: Examples of hematologic malignancies are acute myelogenous leukemia, acute lymphoblastic leukemia, and chronic myeloid leukemia. C. Omisirge is prescribed by or in consultation with a hematologist, oncologist, transplant specialist physician, or a physician associated with a transplant center. Aplastic Anemia. Approve if the patient meets ALL of the following (A, B, C, and D): A. Patient is ≥ 6 years of age; AND B. Patient has undergone reduced intensity conditioning treatment; AND C. Patient meets ONE of the following (i or ii): i. Patient has tried at least one immunosuppressant therapy; OR Note: Examples of immunosuppressant therapies include cyclosporine, Atgam (lymphocyte immune globulin, anti-thymocyte globulin [equine] sterile solution for intravenous use only), mycophenolate mofetil, or sirolimus. ii. Patient has an intolerance to immunosuppressant therapy; AND D. Omisirge is prescribed by or in consultation with a hematologist.	30 days
Nicotinic Parasympathetic Ganglionic Blocker	Vecamyl	mecamylamine hydrochloride tablets	See standard *Vecamyl Prior Authorization Policy* criteria.	See PA duration
Niemann-Pick disease type C Agents	Aqneursa	levacetylleucine granules	See standard *Niemann-Pick disease type C – Aqneursa Prior Authorization Policy* criteria.	See PA duration
Niemann-Pick disease type C Agents	Miplyffa	arimoclomol capsules	Patient meets the following *Niemann-Pick Disease Type C – Miplyffa Prior Authorization Policy* AND Patient meets ONE of the following (1, 2, or 3): **1.** Patient has tried Aqneursa, if formulary. If Aqneursa is non-formulary, criterion A is met; OR **2.** Patient is < 4 years of age. **3.** Patient has already been started on therapy with Miplyffa.	1 year
Nitrogrlycerin Sublingual (SL) Products	GoNitro	nitroglycerin sublingual powder	Approve if the patient has tried both nitroglycerin sublingual (SL) tablets (Nitroquick, generics) and nitroglycerin translingual spray (Nitrolingual, Nitromist, generics), if formulary. If neither are formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
N-methyl D-aspartate (NMDA) receptor antagonists	Spravato	esketamine nasal spray	**1.** Treatment-Resistant Depression: approve if the patient meets the following criteria (A, B, C, D, and E): A. Patient is ≥ 18 years of age; AND B. Patient meets both of the following (i and ii): i. Patient has demonstrated nonresponse (≤ 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic class, according to the prescriber; AND Note: Different pharmacologic classes of antidepressants include selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, bupropion, mirtazapine, etc. ii. Each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber; AND C. Patient has one of the following (i or ii): i. No history of psychosis; OR ii. History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks; AND D. The patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program, according to the prescriber; AND E. The medication is prescribed by or in consultation with a psychiatrist or a mental health provider. **2.** Major Depressive Disorder with Acute Suicidal Ideation or Behavior: approve if the patient meets the following criteria (A, B, C, D, and E): A. Patient is ≥ 18 years of age; AND B. Patient has major depressive disorder that is considered to be severe, according to the prescriber; AND C. Patient is concomitantly receiving at least one oral antidepressant; AND Note: Antidepressants may include, but are not limited to, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, mirtazapine, and bupropion. D. Patient has one of the following (i or ii): i. No history of psychosis; OR ii. History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks; AND E. The medication is prescribed by or in consultation with a psychiatrist or a mental health provider. **3.** For the diagnosis of Treatment-Resistant Depression OR Major Depressive Disorder with acute suicidal ideation or behavior: approve if the patient has already started therapy with Spravato.	1 year
Nocturnal Polyuria Agents	Nocdurna	desmopressin acetate sublingual tablets	See standard *Desmopressin Products – Nocdurna Prior Authorization Policy* criteria.	See PA duration
Non-alcoholic Steatohepatitis (NASH) Agents	Rezdiffra	resmetirom tablets	Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH) in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Wegovy injection, if formulary. If Wegovy injection is non-formulary, approve. Note: If the patient tried Wegovy injection HD or Wegovy tablet, this would satisfy the criteria. **2.** Approve If the patient is currently taking a glucagon-like peptide-1 (GLP-1) agonist or a GLP-1/glucose-dependent insulinotropic polypeptide (GIP) agonist for another indication (e.g., type 2 diabetes, sleep apnea, weight loss). Note: Examples of GLP-1 agonist products are exenatide, Ozempic, Rybelsus, Trulicity, liraglutide (Victoza, Saxenda), Foundayo, Wegovy. Note: Examples of GLP-1/GIP agonist products are Zepbound, Mounjaro. **3.** Approve if, according to the prescriber, the patient has a contraindication to a GLP-1 or GIP product. **4.** Approve if, according to the prescriber, the patient has a history of significant intolerance to a semaglutide-containing product. Note: Examples of semaglutide-containing products are Rybelsus, Wegovy, Ozempic. **5.** Approve if the patient has already been started on therapy with Rezdiffra.	1 year
Non-Cystic Fibrosis Bronchiectasis	Brinsupri	brensocatib tablets	See standard *Pulmonary – Brinsupri Prior Authorization Policy* criteria.	See PA duration
Nonsteroidal mineralocorticoid receptor antagonist	Kerendia	finerenone tablets	Chronic kidney disease in a patient ≥ 18 years of age with type 2 diabetes. Approve if the patient meets ONE of the following (A or B): A. Patient has tried, or is currently taking, ONE of Farxiga or dapagliflozin, Jardiance, or Invokana. If BOTH 1) a dapagliflozin product (dapagliflozin or Farxiga) and 2) Jardiance are non-formulary, approve; OR Note: A trial of, or if the patient is currently taking, another SGLT-2 inhibitor or SGLT-2 inhibitor-containing combination product also satisfies this requirement. Note: Examples of SGLT-2 inhibitors include Jardiance, Steglatro, Farxiga or dapagliflozin, Invokana. Examples of SGLT-2 combination products include Invokamet XR, Invokamet, Xigduo XR or dapagliflozin-metformin ER, Synjardy XR, Synjardy, Segluromet. B. According to the prescriber, the patient has a contraindication or has experienced significant intolerance to SGLT-2 inhibitor therapy. Heart failure with left ventricular ejection fraction (LVEF) ≥ 40% in a patient ≥ 18 years of age. Approve if the patient meets ONE of the following (A or B): A. Patient has tried, or is currently taking, ONE of Farxiga or dapagliflozin, Jardiance, or Inpefa. If none are formulary approve; OR Note: If the patient has tried or is currently receiving a dapagliflozin-containing product or an empagliflozin-containing product, this would satisfy the requirement. B. According to the prescriber, the patient has a contraindication or has experienced significant intolerance to SGLT-2 inhibitor therapy.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
NSAID and Acid Reducing Agent Combination Products	Duexis and generic ibuprofen-famotidine tablets	ibuprofen and famotidine tablets	Approve if the patient has tried and cannot take famotidine AND has concurrently tried ibuprofen (brand or generic).	1 year
NSAID and Acid Reducing Agent Combination Products	Vimovo and generic naproxen-esomeprazole magnesium delayed-release tablets	naproxen and esomeprazole magnesium delayed-release tablets	Approve if the patient has tried and cannot take esomeprazole AND has concurrently tried naproxen (e.g., Naprosyn, Naprelan, generics).	1 year
NSAIDS (Cox2)	Vyscoxa	celecoxib oral suspension	**1.** Approve if the patient is unable to ingest the prescribed dosage when using celecoxib capsule that can be opened and sprinkled on food. **2.** Approve if the prescribed dose cannot be obtained with celecoxib capsules. **3.** If celecoxib capsules are non-formulary, approve.	1 year
NSAIDS (Cox2)	Elyxyb	celecoxib oral solution	Acute treatment of migraine. **1.** Direct the patient to celecoxib capsules. If celecoxib capsules (Celebrex, generics) are non-formulary, approve. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use celecoxib capsules.	1 year
NSAIDS (Cox2)	Celebrex	celecoxib capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
NSAIDs (Oral)	Indocin Suspension	indomethacin oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
NSAIDs (Oral)	Fenoprofen capsules [brand] and Fenopron	fenoprofen capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: For example: fenoprofen (tablets/generic), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	ketoprofen 25mg	ketoprofen 25mg capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	Lofena and authorized generic diclofenac potassium	diclofenac potassium tablets	Approve if the patient has tried five prescription-strength, oral NSAIDS. **Note**: Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	Relafen DS	nabumetone 1,000 mg tablets	Approve if the patient has tried five prescription-strength oral NSAIDs. **Note**: : For example: nabumetone (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	Tivorbex and authorized generic	indomethacin, submicronized capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: indomethacin (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	Zorvolex and authorized generic	diclofenac capsules	Approve if the patient has tried five prescription-strength, oral NSAIDS. **Note**: Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
NSAIDs (Oral)	Meloxicam suspension and Zybic	meloxicam suspension	Approve if the patient has tried one of ibuprofen suspension (e.g., Motrin, generics) or naproxen suspension (e.g., Naprosyn, generics), if formulary. If neither are formulary, approve. **Note**: Over-the-counter ibuprofen suspension would count as an alternative, regardless of formulary status.	1 year
NSAIDs (Oral)	Vivlodex	meloxicam capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: meloxicam (Mobic, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	Dolobid	diflunisal tablets	Approve if the patient has tried five prescription-strength oral NSAIDs. Note: For example: nabumetone (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. Note: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	Coxanto and oxaprozin 300 mg (brand)	oxaprozin capsule	Approve if the patient has tried five prescription-strength, oral NSAIDs. Note: Examples include: oxaprozin (Daypro, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. Note: Five unique NSAIDs should be tried.	1 year
NSAIDs (Oral)	Sprix	ketorolac tromethamine nasal spray	**1.** Approve if the patient has tried five prescription-strength, oral NSAIDs **[documentation required]**. **Note**: Examples include: etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried. **2.** Approve for patients with difficulty swallowing or for patients who cannot swallow.	1 year
NSAIDs (Oral)	Nalfon	fenoprofen capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
NSAIDs (Oral)	Zipsor	diclofenac potassium capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
NSAIDs (Suppository)	Indocin Suppositories	indomethacin suppositories	No exceptions are recommended. There are multiple therapeutic alternatives available. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There are multiple therapeutic alternatives available.)	N/A
NSAIDs (Topical)	diclofenac epolamine 1.3% topical patch (authorized generic of Flector Patch)	diclofenac epolamine 1.3% topical patch	Direct the patient to use Flector patch (brand), if formulary. If Flector patch (brand) is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Licart 1.3% topical system, diclofenac 2% solution pump (generic of Pennsaid 2.0%), diclofenac sodium 1.5% topical solution (generics), or prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics), if one is formulary. If none are formulary, approve if the patient has tried over-the-counter Voltaren 1% gel; OR B. Patient is < 18 years of age, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Licart 1.3% topical system, if formulary. If Licart 1.3% topical system is non-formulary, approve.	1 year
NSAIDs (Topical)	Flector Patch (brand)	diclofenac epolamine 1.3% topical patch	Direct the patient to use diclofenac epolamine topical patch (authorized generic of Flector), if formulary. If diclofenac epolamine topical patch (authorized generic of Flector) is non-formulary, approve if the patient meets ONE of the following (A or B): A. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Licart 1.3% topical system, diclofenac 2% solution pump (generic of Pennsaid 2.0%), diclofenac sodium 1.5% topical solution (generics), or prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics), if one is formulary. If none are formulary, approve if the patient has tried over-the-counter Voltaren 1% gel; OR B. Patient is < 18 years of age, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Licart 1.3% topical system, if formulary. If Licart 1.3% topical system is non-formulary, approve.	1 year
NSAIDs (Topical)	Licart	diclofenac epolamine 1.3% topical system	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): diclofenac epolamine 1.3% topical patch (authorized generic to Flector patch), diclofenac 2% solution pump (generic of Pennsaid 2.0%), diclofenac sodium 1.5% topical solution (generics), or prescription diclofenac 1% gel (Voltaren 1% gel, generics). If none are formulary, approve if the patient has tried over-the-counter Voltaren 1% gel. **2.** Patient < 18 years of age, approve if the patient tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE of diclofenac eoplamine topical patch (authorized generic of Flector) or Flector patch (brand), if formulary. If neither are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Nuclear Factor (erythroid-derived 2)-like 2 (Nrf2) Activator	Skyclarys	omaveloxolone capsules	See standard *Neurology – Skyclarys Prior Authorization Policy* criteria.	See PA duration
Obstructive Hypertrophic Cardiomyopathy – Cardiac Myosin Inhibitors	Camzyos	mavacamten capsules	**1.** Approve if the patient has tried Myqorzo, if formulary. If Myqorzo is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Camzyos.	1 year
Obstructive Hypertrophic Cardiomyopathy – Cardiac Myosin Inhibitors	Myqorzo	aficamten tablets	**1.** Approve if the patient has tried Camzyos, if formulary. If Camzyos is non-formulary, approve. **2.** Approve if the patient is pregnant or planning to become pregnant. **3.** Approve if the patient has already been started on therapy with Myqorzo.	1 year
Omega-3 Fatty Acid Products	Lovaza	omega-3 acid ethyl esters capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Oncology (Injectable – Programmed Death Receptor-1	Opdualag	nivolumab and relatlimab-rmbw intravenous infusion	See standard *Oncology (Injectable – Programmed Death Receptor-1) – Opdualag Prior Authorization Policy* criteria	See PA duration
Oncolytic Viral Therapy	Imlygic	talimogene laherparepvec suspension for intralesional injection	Melanoma. **1.** Approve if the patient has tried at least ONE systemic agent for melanoma (e.g., Yervoy, Opdivo, Keytruda, Mekinist, Tafinlar, Zelboraf, Cotellic, Mektovi, Braftovi). **2.** Approve if in the opinion of the prescriber, localized therapy with Imlygic is more appropriate for this patient over systemic therapeutic alternatives (e.g., Yervoy, Opdivo, Keytruda, Mekinist, Tafinlar, Zelboraf, Cotellic, Mektovi, Braftovi). **3.** Approve if the patient has already started therapy with Imlygic. Merkel Cell Carcinoma in a patient ≥ 18 years of age, approve.	1 year
Onychomycosis Agents	Ciclodan & ciclopirox 8% treatment kit	ciclopirox 8% treatment kit	Approve if the patient has tried ONE of the following, if formulary: ciclopirox 8% solution or tavaborole 5% topical solution. If neither are formulary, approve.	1 year
Ophthalmic – Antibiotic/Corticosteroid Combination Products	TobraDex ST	tobramycin 0.3%/dexamethasone 0.05% ophthalmic suspension	**1.** Approve if the patient has tried tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics), if formulary. If tobramycin-dexamthasone ophthalmic suspension (Tobradex, generics) are non-formulary, approve. **2.** For the treatment of currently active eye infections: approve in patients already receiving TobraDex ST to complete the course of therapy.	1 year
Ophthalmic – Antibiotic/Corticosteroid Combination Products	Zylet	tobramycin 0.3%/loteprednol etabonate 0.5% ophthalmic suspension	**1.** Approve if the patient has tried one of tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics) or TobraDex ST, if formulary. If neither are non-formulary, approve. **2.** Patients < 2 years of age, approve. **3.** For the treatment of currently active eye infections: approve in patients already receiving Zylet to complete the course of therapy.	1 year
Ophthalmic - Calcineurin Inhibitor Immunosuppressant	Verkazia	cyclosporine 0.1% ophthalmic emulsion	Moderate to Severe Vernal Keratoconjunctivitis. **1.** Approve if the patient meets one of the following (A or B): A. Patient has tried two single-action ophthalmic medications (i.e., ophthalmic mast-cell stabilizers or ophthalmic antihistamines) for the maintenance treatment of vernal keratoconjunctivitis; OR Note: Examples of single-action ophthalmic medications for the maintenance treatment of vernal keratoconjunctivitis include ophthalmic mast-cell stabilizers (e.g., cromolyn ophthalmic solution, Alomide ophthalmic solution) and ophthalmic antihistamines (e.g., Zerviate [cetirizine solution]). B. Patient has tried one dual-action ophthalmic mast-cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis. Note: Examples of dual-action ophthalmic mast-cell stabilizer/antihistamine products include azelastine ophthalmic solution, beoptastine ophthalmic solution, epinastine ophthalmic solution, ketotifen ophthalmic solution, Lastacaft, olopatadine ophthalmic solution. Note: An exception to the requirement for a trial of two single-action ophthalmic medications (i.e., ophthalmic mast-cell stabilizers or ophthalmic antihistamines) or one dual-action ophthalmic mast-cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis can be made if the patient has already tried at least one ophthalmic cyclosporine product. Note: If the patient has tried an over-the-counter product in one of the categories above, this would count toward a trial.	1 year
Ophthalmic - Presbyopia Agents	Vizz	aceclidine ophthalmic solution	No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: Formulary coverage is not provided for this medication.)	N/A
Ophthalmic - Presbyopia Agents	Vuity and pilocarpine 1.25%	pilocarpine 1.25% ophthalmic solution	No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: Formulary coverage is not provided for this medication.)	N/A

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic - Presbyopia Agents	Qlosi	pilocarpine hydrochloride ophthalmic solution, 0.4%	No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: Formulary coverage is not provided for this medication.)	N/A
Ophthalmic - Presbyopia Agents	Yuvezzi	carbachol and brimonidine tartrate ophthalmic solution	No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: Formulary coverage is not provided for this medication.)	N/A
Ophthalmic Agent – Mydriatics/ Cycloplegics	Atropine sulfate 1% ophthalmic solution (preservative free) [brand]	atropine sulfate 1% ophthalmic solution	**1.** Direct the patient to generic atropine sulfate 1% ophthalmic solution. **2.** Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]), approve.	1 year
Ophthalmic Agents - Complement Protein C3 Inhibitor	Syfovre	pegcetacoplan injection, intravitreal use	Patient meets the following: *Ophthalmology – Syfovre Prior Authorization Policy* criteria AND **1.** Approve if the patient has tried Izervay, if formulary. If Izervay is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Syfovre.	1 year
Ophthalmic Agents - Complement Protein C5 Inhibitor	Izervay	avacincaptad pegol intravitreal injection	See standard *Ophthalmology – Izervay Prior Authorization Policy* criteria.	See PA duration
Ophthalmic Agents - For Dry Eye	Eysuvis	loteprednol etabonate 0.25% ophthalmic suspension	Short term treatment of dry eye disease: Approve if the patient has tried one artificial tear substitute AND one other ophthalmic loteprednol etabonate-containing product. Note: If no generic loteprednol products are formulary (loteprednol 0.5% drops/gel drops, loteprednol 0.2% drops), patient would still need to try one artificial tear substitute.	14 days
Ophthalmic Agents - For Dry Eye	Tyrvaya	varenicline 0.03 mg/spray nasal solution	Approve if the patient meets both of the following (A and B): A. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: cyclosporine ophthalmic 0.05% emulsion (Restasis, generics), Cequa, or Vevye; AND Note: If none are formulary would still need to meet criteria B. B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Xiidra, if formulary. Note: If Xiidra is non-formulary, would still need to meet criteria A. Note: If none in criteria A or B are formulary, approve.	1 year
Ophthalmic Agents - For Dry Eye	Xiidra	lifitegrast 5% ophthalmic solution	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of cyclosporine ophthalmic 0.05% emulsion (Restasis, generics), Cequa, or Vevye, if formulary. If none are formulary, approve. **2.** Approve if the patient is currently receiving therapy with Xiidra.	1 year
Ophthalmic Agents - For Dry Eye	Miebo	perfluorohexyloctane ophthalmic solution	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products from the following list, if formulary (or one if one is formulary): Cequa, cyclosporine ophthalmic 0.05% emulsion (Restasis, generics), Vevye, Tyrvaya, or Xiidra, if formulary. If none are formulary, approve. **2.** If the patient has diagnosed Meibomian gland disease, approve.	1 year
Ophthalmic Agents - For Dry Eye - Cyclosporine Products	Cequa	cyclosporine ophthalmic solution 0.09%	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two of cyclosporine ophthalmic 0.05% emulsion (Restasis, generics), Vevye, or Xiidra, if formulary (or one if one is formulary). If none are formulary, approve. **2.** If the patient is currently receiving therapy with Cequa, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of cyclosporine ophthalmic 0.05% emulsion (Restasis, generics) or Vevye, if formulary. If neither are formulary, approve.	1 year
Ophthalmic Agents - For Dry Eye - Cyclosporine Products	Restasis Multidose (brand)	cyclosporine ophthalmic emulsion 0.05%	Direct the patient to generic cyclosporine 0.05% ophthalmic emulsion (Restasis, generics). If the patient is unable to use generic cyclosporine 0.05% ophthalmic emulsion (Restasis, generics), approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two of the following products: Xiidra,Cequa, or Vevye, if formulary (or one if one is formulary). If none are formulary, approve. **2.** If the patient is currently receiving therapy with Restasis, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Cequa or Vevye, if formulary. If neither are formulary, approve.	1 year
Ophthalmic Agents - For Dry Eye - Cyclosporine Products	Vevye	cyclosporine ophthalmic solution, 0.1%	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two of the following products: cyclosporine ophthalmic 0.05% emulsion (Restasis, generics), Cequa, or Xiidra, if formulary (or one if one is formulary). If none are formulary, approve. **2.** If the patient is currently receiving therapy with Vevye, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of cyclosporine ophthalmic 0.05% emulsion (Restasis, generics) or Cequa, if formulary. If neither are formulary, approve.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic Agents - For Dry Eye - Transient Receptor Potential Melastatin 8 (TRPM8) Thermoreceptor Agonist	Tryptyr	acoltremon 0.003% ophthalmic solution	Approve if the patient meets both of the following (A and B): A. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: cyclosporine ophthalmic 0.05% emulsion (Restasis, generics), Cequa, or Vevye; AND Note: If none are formulary would still need to meet criteria B. B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Xiidra, if formulary. Note: If Xiidra is non-formulary, would still need to meet criteria A. Note: If none in criteria A or B are formulary, approve.	1 year
Ophthalmic Agents - Other	Natacyn	natamycin ophthalmic suspension	**1.** Fungal blepharitis, conjunctivitis, or keratitis: Approve. **2.** Patients already receiving Natacyn (to complete the course of therapy): Approve.	30 days
Ophthalmic Agents - Other	Oxervate	cenegermin-bkbj ophthalmic solution	See standard *Ophthalmology – Oxervate Prior Authorization Policy* criteria.	See PA duration
Ophthalmic Agents - VEGF Inhibitors	Susvimo	ranibizumab intravitreal injection via ocular implant and implant/insert tool	No exceptions are recommended. Due to safety concerns, an exception is not recommended for Susvimo. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to safety concerns, an exception is not recommended for Susvimo.)	N/A
Ophthalmic Agents - VEGF Inhibitors	Vabysmo	faricimab-svoa intravitreal injection	Neovascular (Wet) Age-Related Macular Degeneration; Diabetic Macular Edema; Macular Edema following Retinal Vein Occlusion; Other Neovascular Diseases of the Eye. Note: Examples of other neovascular diseases of the eye include angioid streaks, iris neovascularization, neovascular glaucoma, pachychoroid neovasculopathy, polypoidal choroidal vasculopathy, and presumed ocular histoplasmosis syndrome. **1.** Approve if the patient has tried at least ONE aflibercept product: Eylea, Pavblu, Yesafili, or Eylea HD. If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Vabysmo.	1 year
Ophthalmic Agents - VEGF Inhibitors	Beovu	brolucizumab-dbll intravitreal injection	Neovascular (Wet) Age-Related Macular Degeneration; Diabetic Macular Edema; Other Neovascular Diseases of the Eye. Note: Examples of other neovascular diseases of the eye include angioid streaks, iris neovascularization, neovascular glaucoma, pachychoroid neovasculopathy, polypoidal choroidal vasculopathy, and presumed ocular histoplasmosis syndrome. 1. Approve if the patient has tried at least ONE aflibercept product: Eylea, Eylea HD, Pavblu, or Yesafili. If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Beovu.	1 year
Ophthalmic Agents - VEGF Inhibitors – Aflibercept Products	Eylea	aflibercept intravitreal injection	If either Pavblu or Yesafili are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried BOTH Pavblu and Yesafili, if formulary; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If neither Pavblu nor Yesafili are formulary: Approve if the patient meets ONE of the following (A or B): A. Patient has tried Eylea HD, if formulary. If Eylea HD is non-formulary, approve; OR B. For the diagnosis of retinopathy of prematurity.	1 year
Ophthalmic Agents - VEGF Inhibitors – Aflibercept Products	Pavblu (biosimilar to Eylea)	aflibercept-ayyh intravitreal injection	If either Eylea (not HD) or Yesafili are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried BOTH Eylea (not HD) and Yesafili, if formulary; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If neither Eylea (not HD) nor Yesafili are formulary: Approve if the patient meets ONE of the following (A or B): A. Patient has tried Eylea HD, if formulary. If Eylea HD is non-formulary, approve; OR B. For the diagnosis of retinopathy of prematurity.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic Agents - VEGF Inhibitors – Aflibercept Products	Yesafili	aflibercept-jbvf intravitreal injection (biosimilar to Eylea)	If either Eylea (not HD) or Pavblu are formulary: Approve if the patient meets BOTH of the following (A and B): A. Patient has tried BOTH Eylea (not HD) and Pavblu, if formulary; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If neither Eylea (not HD) nor Pavblu are formulary: Approve if the patient meets ONE of the following (A or B): A. Patient has tried Eylea HD, if formulary. If Eylea HD is non-formulary, approve; OR B. For the diagnosis of retinopathy of prematurity.	1 year
Ophthalmic Agents - VEGF Inhibitors – Aflibercept Products	Eylea HD	aflibercept intravitreal injection	Diabetic macular edema; Diabetic retinopathy; Macular Edema Following Retinal Vein Occlusion; Neovascular (wet) age-related macular degeneration; Other neovascular diseases of the eye. Note: Examples of other neovascular diseases of the eye include angioid streaks, iris neovascularization, neovascular glaucoma, pachychoroid neovasculopathy, polypoidal choroidal vasculopathy, and presumed ocular histoplasmosis syndrome. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried at least ONE aflibercept product: Eylea (not HD), Pavblu, or Yesafili **[documentation required]**; AND **2.** Patient cannot continue to use an aflibercept (not HD) product due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: If none of the aflibercept (not HD) products are formulary (Eylea [not HD], Pavblu, and Yesafili), approve.	1 year
Ophthalmic Agents - VEGF Inhibitors – Ranibizumab Products	Byooviz	ranibizumab-nuna (biosimilar to Lucentis)	If any of Lucentis, Cimerli, Nufymco are formulary, approve if the patient meets both of the following (A and B): A. Patient has tried ALL of the following products: Lucentis, Cimerli, and Nufymco, if formulary; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of Cimerli, Lucentis, and Nufymco are formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried at least ONE aflibercept product: Eylea, Eylea HD, Pavblu, or Yesafili. If none are formulary, approve; OR B. Patient has myopic choroidal neovascularization (mCNV); OR C. Patient has already been started on therapy with Byooviz.	1 year
Ophthalmic Agents - VEGF Inhibitors – Ranibizumab Products	Cimerli	ranibizumab-eqrn intravitreal injection (biosimilar to Lucentis)	If any of Byooviz, Lucentis, and Nufymco are formulary, approve if the patient meets both of the following (A and B): A. Patient has tried ALL of the following products: Byooviz, Lucentis, and Nufymco, if formulary; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of Byooviz, Lucentis, and Nufymco are formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried at least ONE aflibercept product: Eylea, Eylea HD, Pavblu, or Yesafili. If none are formulary, approve; OR B. Patient has myopic choroidal neovascularization (mCNV); OR C. Patient has already been started on therapy with Cimerli.	1 year
Ophthalmic Agents - VEGF Inhibitors – Ranibizumab Products	Lucentis	ranibizumab intravitreal injection	If any of Byooviz, Cimerli, and Nufymco are formulary, approve if the patient meets both of the following (A and B): A. Patient has tried ALL of the following products: Byooviz, Cimerli, and Nufymco, if formulary; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of Byooviz, Cimerli, and Nufymco are formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried at least ONE aflibercept product: Eylea, Eylea HD, Pavblu, or Yesafili. If none are formulary, approve; OR B. Patient has myopic choroidal neovascularization (mCNV); OR C. Patient has already been started on therapy with Lucentis.	1 year
Ophthalmic Agents - VEGF Inhibitors – Ranibizumab Products	Nufymco	ranibizumab-leyk intravitreal injection (biosimilar to Lucentis)	If any of Lucentis, Byooviz, and Cimerli are formulary, approve if the patient meets both of the following (A and B): A. Patient has tried ALL of the following products: Lucentis, Byooviz, and Cimerli, if formulary; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of Byooviz, Cimerli, and Lucentis are formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried at least ONE aflibercept product: Eylea, Eylea HD, Pavblu, or Yesafili. If none are formulary, approve; OR B. Patient has myopic choroidal neovascularization (mCNV); OR C. Patient has already been started on therapy with Nufymco.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic alpha adrenoceptor agonist	Upneeq	oxymetazoline hydrochloride 0.1% ophthalmic solution	No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Upneeq. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)	N/A
Ophthalmic Anti-Allergics	Alrex	loteprednol etabonate 0.2% ophthalmic suspension	**1.** Approve if the patient has tried three products from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): bepotastine ophthalmic drops (Bepreve, generics), cromolyn ophthalmic drops (generics), epinastine 0.05% solution (generics), Lastacaft, azelastine 0.05% solution (generics), olopatadine ophthalmic solution (generics), Zerviate. If none are formulary, approve. **2.** Patients who require concurrent use of Alrex with an H1 antagonist or an H1 antagonist/mast cell stabilizer (e.g. azelastine [generics], bepotastine, epinastine solution [generics], Lastacaft, olopatadine ophthalmic solution [generics], Zerviate): approve.	1 year
Ophthalmic Anti-Allergics	Zerviate	cetirizine 0.24% ophthalmic solution	Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, or olopatadine solution (generics). Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Anti-Allergics	Bepreve	bepotastine besilate ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Ophthalmic Antibiotics - Quinolones	Besivance and besifloxacin 0.6% eye drop	besifloxacin ophthalmic suspension 0.6%	**1.** Approve if the patient has tried two products from the following list, (if two are formulary, or one if one is formulary): 1) gatifloxacin ophthalmic solution (generics), 2) moxifloxacin ophthalmic solution (Vigamox, Moxeza, generics), or 3) levofloxacin ophthalmic solution (generics). If none are formulary, approve. **2.** Approve if there is laboratory data that the patient has an eye infection due to pathogens resistant to ciprofloxacin and one other ophthalmic quinolone. **3.** For the treatment of currently active eye infections: approve in patients already receiving Besivance therapy to complete the course of therapy.	1 year
Ophthalmic Antibiotics - Quinolones	Ciloxan ointment	ciprofloxacin ophthalmic ointment 0.3%	**1.** Approve if the patient has tried four products from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): ciprofloxacin ophthalmic solution (Ciloxan, generics), gatifloxacin ophthalmic solution (generics), moxifloxacin ophthalmic solution (Vigamox, Moxeza, generics), levofloxacin ophthalmic solution (generics), or ofloxacin 0.3% ophthalmic solution (Ocuflox, generics). If none are formulary, approve. **2.** If the patient is allergic to benzalkonium chloride, approve if the patient has tried moxifloxacin (Vigamox, Moxeza, generics), if formulary. If moxifloxacin (Vigamox, Moxeza, generics) are non-formulary, approve. **3.** For the treatment of currently active eye infections: approve in patients already receiving Ciloxan ointment to complete the course of therapy.	1 year
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Prolensa	bromfenac ophthalmic solution 0.7%	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Acuvail	ketorolac tromethamine 0.45% preservative-free solution	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), a bromfenac product (0.09% ophthalmic solution [generics], bromfenac ophthalmic solution 0.07% [Prolensa, generics], or bromfenac 0.075% [BromSite, generics]), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): bromfenac 0.075% (BromSite, generics), diclofenac ophthalmic solution (generics), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **3.** Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]): approve if the patient has tried diclofenac ophthalmic solution (generics), if formulary. If diclofenac ophthalmic solution is non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Ilevro	nepafenac ophthalmic suspension 0.3%	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), ketorolac ophthalmic solution (Acular, Acular LS, generics), Acuvail, Nevanac, or a bromfenac product (0.09% ophthalmic solution [generics], bromfenac ophthalmic solution 0.07% [Prolensa, generics], or bromfenac 0.075% [BromSite, generics]). If none of the agents are formulary, then approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): bromfenac 0.075% (BromSite, generics), diclofenac ophthalmic solution (generics), Nevanac, ketorolac ophthalmic solution (Acular, Acular LS, generics), or Acuvail. If none are formulary, approve. **3.** Patients < 18 years of age: approve if the patient has tried one of ketorolac ophthalmic solution (Acular, Acular LS, generics) or Nevanac, if one is formulary. If neither are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Nevanac	nepafenac ophthalmic suspension 0.1%	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), ketorolac ophthalmic solution (Acular, Acular LS, generics), Acuvail, Ilevro, or a bromfenac product (0.09% ophthalmic solution [generics], bromfenac ophthalmic solution 0.07% [Prolensa, generics], or bromfenac 0.075% [BromSite, generics]). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): bromfenac 0.075% (BromSite, generics), diclofenac ophthalmic solution (generics), Ilevro, ketorolac ophthalmic solution (Acular, Acular LS, generics), or Acuvail. If none are formulary, approve. **3.** Patients < 18 years of age: approve if the patient has tried ketorolac ophthalmic solution (Acular, Acular LS, generics) or Ilevro, if one is formulary. If neither are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Anti-Inflammatory Agents - NSAIDs	BromSite	bromfenac 0.075% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic Antivirals	Zirgan	ganciclovir ophthalmic gel 0.15%	**1.** Approve if the patient had tried trifluridine 1% ophthalmic solution, if formulary. If trifluridine 1% ophthalmic solution is non-formulary, approve. **2.** Approve if the patient is < 6 years of age. **3.** Approve if the patient has a cytomegalovirus (CMV)-related ophthalmic infection (e.g., CMV uveitis, CMV retinitis). **4.** Approve if the patient has been started on a course of therapy with Zirgan (this is to allow for completion of a course of treatment).	1 year
Ophthalmic Corticosteroid Implant	Ozurdex	dexamethasone intravitreal implant	**1.** Macular edema following retinal vein occlusion: Approve. **2.** Non-infectious uveitis: Approve. **3.** Diabetic macular edema: Approve.	30 days
Ophthalmic Corticosteroid Implant	Iluvien	fluocinolone acetonide 0.19 mg intravitreal implant	Diabetic macular edema; Non-infectious uveitis. Approve if the patient has previously used Ozurdex, if formulary. If Ozurdex is non-formulary, approve.	30 days
Ophthalmic Corticosteroid Implant	Retisert	fluocinolone acetonide intravitreal implant	Non-infectious uveitis. Approve if the patient has previously used Ozurdex, if formulary. If Ozurdex is non-formulary, approve.	30 days
Ophthalmic Corticosteroid Implant	Yutiq	fluocinolone acetonide intravitreal implant	Diabetic macular edema; Non-infectious uveitis. Approve if the patient has previously used Ozurdex, if formulary. If Ozurdex is non-formulary, approve.	30 days
Ophthalmic Corticosteroid Injection	Xipere	triamcinolone acetonide suprachoroidal injection, 40 mg/mL	**1.** Approve if the patient has tried Triesence ophthalmic injectable suspension, if formulary. If Triesence ophthalmic injectable suspension is non-formulary, approve. **2.** Approve if the patient has already started on Xipere and requires Xipere to complete the course of treatment.	1 year
Ophthalmic Corticosteroids	Lotemax	0.5% ophthalmic ointment	**1.** Approve if patient has tried two formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) difluprednate (Durezol, generics), 3) a fluorometholone product (FML Liquifilm, generics; FML Forte, Flarex), 4) a loteprednol product (Lotemax, generics; Lotemax SM, Inveltys), 5) a prednisolone product (Pred Forte, generics; Pred Mild), or 6) clobetasol propionate ophthalmic suspension, if two are formulary or one if one is formulary. If none are formulary, approve. **2.** Patient with a known sensitivity to benzalkonium chloride [BAK]), approve if the patient has tried difluprednate (Durezol, generics), if formulary. If difluprednate (Durezol, generics) are non-formulary, approve. **3.** If patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a fluorometholone product (FML Liquifilm, generics; FML Forte, Flarex), or 2) a loteprednol product (Lotemax, generics; Lotemax SM), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Corticosteroids	Byqlovi 0.05% ophthalmic suspension and Clobetasol propionate 0.05% ophthalmic suspension	clobetasol propionate 0.05% ophthalmic suspension	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; FML Forte, Flarex), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild), if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a fluorometholone product (FML Liquifilm, generics; FML Forte, Flarex), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve.	1 year
Ophthalmic Corticosteroids	Flarex	fluorometholone acetate ophthalmic suspension 0.1%	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; FML Forte), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild), or 6) clobetasol propionate ophthalmic suspension, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a fluorometholone product (FML Liquifilm, generics; FML Forte), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Corticosteroids	FML Forte	fluorometholone 0.25% ophthalmic suspension	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; Flarex), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 5) prednisolone (Pred Forte, Omnipred, generics; Pred Mild), or 6) clobetasol propionate ophthalmic suspension, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 2) a fluorometholone product (FML Liquifilm, generics; Flarex), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Corticosteroids	Inveltys	loteprednol etabonate ophthalmic suspension 1%	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone (generics or Maxidex), 2) difluprednate (Durezol, generics), 3) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 4) a loteprednol product (Lotemax, generics; Lotemax SM), 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild), or 6) clobetasol propionate ophthalmic suspension, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a fluorometholone product (FML Liquifilm, generics; Flarex; FML Forte), 2) a loteprednol product (Lotemax, generics; Lotemax SM), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic Corticosteroids	Lotemax SM	loteprednol etabonate ophthalmic gel, 0.38%	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary, or one if one is formulary): 1) a dexamethasone product (generics or Maxidex), 2) difluprednate (Durezol, generics), 3) a loteprednol product (Lotemax, generics; Inveltys), 4) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild), or 6) clobetasol propionate ophthalmic suspension. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): 1) a fluorometholone product (FML Liquifilm, generics; Flarex; FML Forte), 2) a loteprednol product (Lotemax, generics; Inveltys), or 3) difluprednate (Durezol, generics). Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Corticosteroids	Maxidex	dexamethasone 0.1% ophthalmic suspension	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary or one if one is formulary): 1) dexamethasone (generics), 2) difluprednate (Durezol, generics), 3) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 4) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild) or 6) clobetasol propionate ophthalmic suspension. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): 1) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Corticosteroids	Pred Mild	prednisolone acetate 0.12% ophthalmic suspension	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary; or one if one is formulary): 1) a dexamethasone (generics or Maxidex), 2) difluprednate (Durezol, generics), 3) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 4) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 5) a prednisolone product (Pred Forte, Omnipred, generics), or 6) clobetasol propionate ophthalmic suspension. If none are fomualry, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): 1) a fluorometholone product (FML Liquifilm, generics; Flarex; FML Forte), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Corticosteroids	Durezol	difluprednate 0.05% ophthalmic emulsion	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Ophthalmic Drugs for Glaucoma - Alpha-Adrenergic Agonist	Iopidine	apraclonidine 1% ophthalmic solution	**1.** Approve if the patient has tried one product from the following list (if one is formulary): brimonidine 0.1%, brimonidine 0.15% (Alphagan P, generics) or brimonidine 0.2% ophthalmic solution. If none are formulary, approve. **2.** Patients undergoing argon laser trabeculoplasty, argon laser iridotomy or Nd:YAG posterior capsulotomy: approve.	1 year
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Betimol	timolol hemihydrates 0.25% and 0.5% ophthalmic solution	Approve if the patient has tried four of the following, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): 1) levobunolol ophthalmic solution, 2) a timolol product (Istalol, Timoptic/XE, generics), 3) a betaxolol ophthalmic solution (generics or Betoptic S), or 4) carteolol opthalmic solution (generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Betoptic S	betaxolol 0.25% ophthalmic suspension	Approve if the patient has tried four of the following, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): 1) levobunolol ophthalmic solution (generics), 2) a betaxolol ophthalmic solution (generics), 3) a timolol product (Istalol, Timoptic/XE, generics), or 4) carteolol opthalmic solution (generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Timoptic in Ocudose	timolol maleate 0.25% and 0.5% ophthalmic solution	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list: 1) a timolol product (Istalol, Timoptic/XE, generics), 2) levobunolol ophthalmic solution (generics), 3) betaxolol ophthalmic solution (generics or Betoptic S), or 4) carteolol opthalmic solution (generics), if four are formulary (or three if three are formulary or two if two are formulary or one if one is formulary). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Approve if the patient has a known sensitivity to a preservative or when use of a preservative-free topical medication is advisable.	1 year
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Istalol	timolol maleate 0.5% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Ophthalmic Drugs for Glaucoma - Carbonic Anhydrase Inhibitor	Azopt	brinzolamide 1% ophthalmic suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Ophthalmic Drugs for Glaucoma - Carbonic Anhydrase Inhibitor/Beta-Adrenergic Blocker	Cosopt/Cosopt PF	dorzolamide 2%/timolol 0.5% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic Drugs for Glaucoma – Combination Agents	Rocklatan	netarsudil/latanoprost ophthalmic solution	**1.** Approve if the patient has tried latanoprost ophthalmic solution (Xalatan, generics) AND Rhopressa, if Rhopressa is formulary. **2.** If Rhopressa is non-formulary, approve if the patient meets the following criteria (A, B, and C): A. Patient has tried one ophthalmic prostaglandin product; AND Note: Examples of ophthalmic prostaglandin products include: latanoprost ophthalmic solution (Xalatan, generics), travoprost ophthalmic solution (Travatan Z, generics), bimatoprost 0.03% ophthalmic solution (generics), tafluprost ophthalmic solution (Zioptan, generics), Lumigan, Vyzulta, Xelpros, or Omlonti. B. Patient has tried one ophthalmic beta-blocker product; AND Note: Examples of ophthalmic beta-blockers products include: levobunolol solution, timolol maleate solution (Istalol, generics), betaxolol ophthalmic solution, Betopic S, carteolol opthalmic solution, timolol (Timoptic, Timoptic in Ocudose, generics), timolol gel-forming solution. C. Patient has tried either one ophthalmic alpha-adrenergic agonists or an ophthalmic carbonic anhydrase inhibitor. Note: Examples of ophthalmic alpha-adrenergic agonists include: brimonidine solution (Alphagan, Alphagan P, generics), apraclonidine solution. Note: Examples of ophthalmic carbonic anhydrase inhibitors include: brinzolamide eye drops (Azopt, generics), dorzolamide 2% eye drops. Note: A combination ophthalmic agent containing the requested drug products, would count as a trial of the respective alternatives.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Omlonti	omidenepag isopropyl 0.002% ophthalmic solution	Approve if the patient has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): 1) latanoprost ophthalmic solution (Xalatan, generics), 2) travoprost ophthalmic solution (Travatan Z, generics), 3) bimatoprost 0.03% ophthalmic solution (generics) or Lumigan, 4) tafluprost ophthalmic solution (Zioptan, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Travatan Z and travoprost	travoprost 0.004% ophthalmic solution (benzalkonium chloride-free)	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE of the following, if formulary: 1) latanoprost ophthalmic solution (Xalatan, generics) OR 2) bimatoprost 0.03% ophthalmic solution (generics). If neither are formulary, approve. Note: If the patient has tried a brand version of a generic product, then this would satisfy the requirement. **2.** Patient has a known sensitivity to benzalkonium chloride (BAK), approve.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Zioptan and tafluprost	tafluprost 0.0015% ophthalmic solution	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE of the following, if formulary: 1) latanoprost ophthalmic solution (Xalatan, generics) OR 2) bimatoprost 0.03% ophthalmic solution (generics). If neither are formulary, approve. Note: If the patient has tried a brand version of a generic product, then this would satisfy the requirement. **2.** Patient has a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]), approve.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Iyuzeh	latanoprost ophthalmic solution, 0.005%; preservative-free	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of 1) latanoprost ophthalmic solution (Xalatan, generics) or 2) Xelpros, if formulary. If none are formulary, approve. **2.** If according to the prescriber, the patient has a significant benzalkonium chloride allergy/sensitivity: approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Xelpros, if formulary. If Xelpros is non-formulary, approve. **3.** If, according to the prescriber, the patient has a significant allergy/sensitivity to other preservatives (OTHER than benzalkonium chloride), approve.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Xelpros	latanoprost 0.005% ophthalmic emulsion	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of 1) latanoprost ophthalmic solution (Xalatan, generics) or 2) Iyuzeh, if formulary. If none are formulary, approve. **2.** If, according to the prescriber, the patient has a significant benzalkonium chloride allergy/sensitivity: approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Iyuzeh, if formulary. If Iyuzeh is non-formulary, approve.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Vyzulta	latanoprostene bunod ophthalmic solution 0.024%	Approve if the patient has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): 1) latanoprost ophthalmic solution (Xalatan, generics), 2) travoprost ophthalmic solution (Travatan Z, generics), 3) bimatoprost 0.03% ophthalmic solution (generics) or Lumigan, 4) tafluprost ophthalmic solution (Zioptan, generics) or 5) Omlonti. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Lumigan	bimatoprost 0.01% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Zolymbus	bimatoprost 0.01% ophthalmic gel	**1.** Approve if the patient has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): 1) a latanoprost product (latanoprost ophthalmic solution [Xalatan, generics], Iyuzeh, Xelpros), 2) a bimatoprost product (bimatoprost 0.03% ophthalmic solution [generics], bimotoprost 0.01% ophthalmic solution [Lumigan, generics]), 3) travoprost ophthalmic solution (Travatan Z, generics), or 4) tafluprost ophthalmic solution (Zioptan, generics). If none are formulary, approve. Note: Latanoprost products would count as one alternative. Bimatoprost products would count as one alternative. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patient has a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]), approve if the patient has tried one of Iyuzeh or tafluprost ophthalmic solution (Zioptan, generic), if formulary. If neither are formulary, approve.	1 year
Ophthalmic Drugs for Glaucoma - Prostaglandins	Xalatan	latanoprost 0.005% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Ophthalmic Drugs for Glaucoma – Prostaglandins – Implants	Durysta	bimatoprost implant	Approve if the patient meets the following (A, B and C): A. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy); AND Note: Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan (bimatoprost 0.01% ophthalmic solution), Vyzulta (latanoprostene bunod 0.024% ophthalmic solution), Xelpros (latanoprost 0.005% ophthalmic emulsion), tafluprost 0.0015% ophthalmic solution, Iyuzeh (latanoprost 0.005% opthalmic solution), and Omlonti (omidenepag isopropyl 0.002% ophthalmic solution). B. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two other ophthalmic products from two different pharmacological classes (either as monotherapy or as concomitant therapy); AND Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil). C. The product is NOT being used for re-treatment of an eye previously treated with Durysta. Note: Durysta is approved for a one-time use in each eye. Repeat administration in previously treated eye(s) is not approvable.	90 days
Ophthalmic Drugs for Glaucoma – Prostaglandins – Implants	iDose TR	travoprost intracameral implant	Approve if the patient meets the following (A, B and C): A. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy); AND Note: Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan (bimatoprost 0.01% ophthalmic solution), Vyzulta (latanoprostene bunod 0.024% ophthalmic solution), Xelpros (latanoprost 0.005% ophthalmic emulsion), tafluprost 0.0015% ophthalmic solution, Iyuzeh (latanoprost 0.005% opthalmic solution), and Omlonti (omidenepag isopropyl 0.002% ophthalmic solution). B. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two other ophthalmic products from two different pharmacological classes (either as monotherapy or as concomitant therapy); AND Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil). C. The product is NOT being used for re-treatment of an eye previously treated with iDose TR more than once per year. Note: It is not recommended to readminister iDose TR more than once per year. Each eye can be treated once per year.	90 days
Ophthalmic Drugs for Glaucoma - Rho Kinase	Rhopressa	netarsudil ophthalmic solution 0.02%	Approve if the patient meets the following criteria (A, B, and C): A. Patient has tried one ophthalmic prostaglandin product; AND Note: Examples of ophthalmic prostaglandin products include: latanoprost ophthalmic solution (Xalatan, generics), travoprost ophthalmic solution (Travatan Z, generics), bimatoprost 0.03% ophthalmic solution (generics), tafluprost ophthalmic solution (Zioptan, generics), Lumigan, Vyzulta, Xelpros, or Omlonti. B. Patient has tried one ophthalmic beta-blocker product; AND Note: Examples of ophthalmic beta-blockers products include: levobunolol solution, timolol maleate solution (Istalol, generics), betaxolol ophthalmic solution, Betopic S, carteolol opthalmic solution, timolol (Timoptic, Timoptic in Ocudose, generics), timolol gel-forming solution. C. Patient has tried either one ophthalmic alpha-adrenergic agonists or an ophthalmic carbonic anhydrase inhibitor. Note: Examples of ophthalmic alpha-adrenergic agonists include: brimonidine solution (Alphagan, Alphagan P, generics), apraclonidine solution. Note: Examples of ophthalmic carbonic anhydrase inhibitors include: brinzolamide eye drops (Azopt, generics), dorzolamide 2% eye drops. Note: A combination ophthalmic agent containing the requested drug products, would count as a trial of the respective alternatives.	1 year
Ophthalmology – Specialized	Luxturna	voretigene neparvovec-rzyl intraocular suspension for subretinal injection	See standard *Ophthalmology – Gene Therapy – Luxturna Prior Authorization* Policy	See PA duration
Opiate Agonists/Antagonists	Zubsolv	buprenorphine and naloxone sublingual tablets	**1.** Approve if the patients has tried one product from the following list (if one is formulary): buprenorphine and naloxone sublingual tablets or buprenorphine and naloxone sublingual film (Suboxone sublingual film, generics). If none are formulary, approve.	1 year
Opiate Agonists/Antagonists	Suboxone	buprenorphine/naloxone sublingual film	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Opioids (Oral) - Other	Prolate solution	oxycodone and acetaminophen 10-300 mg/5 oral solution	**1.** Approve if the patient has tried and cannot take oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if the patient is unable to swallow or has difficulty swallowing tablets.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Opioids (Oral) - Other	Qdolo and authorized generic	tramadol hydrochloride oral solution	Approve if the patient is unable to swallow or has difficulty swallowing tramadol tablets.	1 year
Opioids (Oral) - Other	Roxybond and authorized generic	oxycodone hydrochloride tablet, coated	Approve if the patient has tried and cannot take one of the following formulary products: oxycodone hydrochloride tablets (Roxicodone, generics). If oxycodone hydrochloride tablets (Roxicodone, generics) are non-formulary, approve.	1 year
Opioids (Oral) - Other	tramadol 25 mg tablets (brand)	tramadol 25 mg tablets	Approve if the prescribed dose cannot be obtained with tramadol 50 mg. Note: The patient is NOT required to split the 50 mg tablets in half.	1 year
Opioids (Oral) - Other	tramadol 75 mg tablets (brand)	tramadol 75 mg tablets	Approve if the prescribed dose cannot be obtained with tramadol 50 mg. Note: The patient is NOT required to split the 50 mg tablets in half.	1 year
Opioids (Oral) - Other	oxycodone-acetaminophen 10-	oxycodone-acetaminophen 10-	**1.** Direct to oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 10-325 mg tablets.	1 year
Opioids (Oral) - Other	oxycodone-acetaminophen 2.5-	oxycodone-acetaminophen 2.5-	**1.** Direct to oxycodone-acetaminophen 2.5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the oxycodone-acetaminophen 2.5-325 mg tablets.	1 year
Opioids (Oral) - Other	oxycodone-acetaminophen 5-300 tablets (includes Primlev, Prolate)	oxycodone-acetaminophen 5-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 5-325 mg tablets.	1 year
Opioids (Oral) - Other	oxycodone-acetaminophen 7.5-300 tablets (includes Primlev and Prolate)	oxycocodne-acetaminophen 7.5-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 7.5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 7.5-325 mg tablets.	1 year
Opioids (Oral) - Other	Conzip and tramadol ER capsule	tramadol ER capsule	Approve, if per the prescriber, the patient is unable to use generic tramadol ER tablets.	1 year
Opioids (Oral) - Other	tramadol 100 mg tablets (brand)	tramadol 100 mg tablets	Approve, if per the prescriber, the patient is unable to use generic tramadol 50 mg tablets.	1 year
Opioids (Oral) - Other	Xyvona and levorphanol 2mg and 3mg	levorphanol 2mg and 3mg tablets	**1.** Approve if the patient has tried three medications (each from a different group) of the following: a morphine-containing product, a hydrocodone-containing product, a hydromorphone-containing product, an oxycodone-containing product, an oxymorphone-containing product, a fentanyl-containing product, a methadone-containing product, or a tapentadol-containing product. **2.** Approve if the patient is currently receiving levorphanol or Xyvona AND is using the requested medication for chronic pain (cancer or non-cancer pain).	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Opioids (Oral) - Other	Nucynta and tapentadol immediate-release tablets	tapentadol immediate-release tablets	<u>If requesting brand Nucynta tablets</u>: Approve if the patient has tried and cannot take generic tapentadol immediate-release tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. <u>If requesting generic tapentadol immediate-release tablets or tapentadol immediate-release tablets are non-formulary</u>: **1.** Approve if the patient has tried three other oral immediate-release (NOT long-acting) centrally acting/opioid analgesics. Examples of oral immediate-release (NOT long-acting) centrally acting/opioid analgesics include, but are not limited to: hydromorphone (Dilaudid, generics), oxycodone hydrochloride tablets (Roxicodone, generics), oxymorphone (generics), morphine (generics), hydrocodone/acetaminophen (Vicodin, Vicodin ES, Norco, Lortab, Lorcet, multiple generics), oxycodone/acetaminophen (Percocet, Endocet, Roxicet, multiple generics), tramadol (Ultram, generics), tramadol/acetaminophen (Ultracet, generics). **NOTE:** A trial of the requested product does not count toward this requirement. **2.** Patients ≥ 6 years of age to < 18 years of age, approve if the patient meets ONE of the following (A, B, <u>or</u> C): A. Patient has tried one of morphine sulfate immediate-release tablets or morphine sulfate immediate-release oral solution. If neither are formulary, approve; OR B. Patient has renal insufficiency; OR C. Patient is intolerant or allergic to morphine.	1 year
Opioids (Oral) - Other	Tapentadol Hydrochloride Oral Solution	tapentadol hydrochloride oral solution	**1.** Approve if the patient has tried tapentadol immediate-release tablets (Nucynta tablets, generics). If tapentadol immediate-release tablets (Nucynta tablets, generics) are non-formulary, approve. **2.** Approve if the patient is unable to swallow solid oral dosage formulary or has difficulty swallowing solid oral dosage forms. **3.** Approve if the prescribed dose cannot be obtained with whole immediate-release tapentadol tablets (Nucynta tablets, generics).	1 year
Opioids (Oral) - Other	Percocet	oxycodone/acetaminophen tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Opioids (Oral) – Other/NSAID	Seglentis	celecoxib and tramadol hydrochloride tablets	**1.** Direct the patient to tramadol tablets and celecoxib capsules as separate agents. If celecoxib capsules (Celebrex, generics) are non-formulary, approve. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use tramadol and celecoxib as separate agents.	1 year
Otic Antibiotics	Cetraxal	ciprofloxacin 0.2% otic solution	Approve if the patient has tried one of the following, if one is formulary: ofloxacin otic solution (generics) or ciprofloxacin 0.2% otic solution (generic). If none are formulary, approve.	1 year
Otic Antibiotics	Xtoro	finafloxacin 0.3% otic suspension	**1.** Approve if the patient has tried one of the following: ofloxacin otic solution OR an otic ciprofloxacin-containing product (e.g., ciprofloxacin 0.2% otic solution, Cetraxal 0.2% otic solution). If none are formulary, approve. **2.** Approve if the patient has already started on Xtoro in order to complete the course of therapy.	1 year
Otic Antibiotics and Combination Products	ciprofloxacin/ fluocinolone otic solution (authorized generic to Otovel)	ciprofloxacin and fluocinolone acetonide otic solution, 0.3%/0.025%	**1.** Direct the patient to Otovel (brand), if formulary. **2.** If Otovel (brand) is non-formulary, approve if the patient has tried both 1) ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and 2) ciprofloxacin-hydrocortisone otic suspension (Cipro HC otic suspension, generics) [or one if one is formulary]. If neither are formulary, approve. **3.** If Otovel (brand) is non-formulary, patients treating acute otitis media through tympanostomy tubes (AOMT), patients with a perforated ear drum (tympanic membrane), or patients < 1 year of age: approve if the patient has tried ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics), if formulary. If ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics) are non-formulary, approve. **4.** If Otovel (brand) is non-formulary, patient has a known hypersensitity to a preservative (e.g., benzalkonium chloride [BAK], benzyl alcohol), approve.	1 year
Otic Antibiotics and Combination Products	Otovel	ciprofloxacin and fluocinolone acetonide otic solution, 0.3%/0.025%	**1.** Direct the patient to ciprofloxacin-fluocinolone (authorized generic of Otovel), if formulary. **2.** If ciprofloxacin/fluocinolone (the authorized generic of Otovel) is non-formulary, approve if the patient has tried both 1) ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and 2) ciprofloxacin-hydrocortisone otic suspension (Cipro HC otic suspension, generics) [or one if one is formulary]. If neither are formulary, approve. **3.** If ciprofloxacin-fluocinolone (authorized generic of Otovel) is non-formulary: patients treating acute otitis media through tympanostomy tubes (AOMT), patients with a perforated ear drum (tympanic membrane), or patients < 1 year of age: approve if the patient has tried ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics), if formulary. If ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) are non-formulary, approve. **4.** If ciprofloxacin-fluocinolone (authorized generic of Otovel) is non-formulary: patient has a known hypersensitity to a preservative (e.g., benzalkonium chloride [BAK], benzyl alcohol), approve.	1 year
Otic Antibiotics and Combination Products	Cipro HC Otic Suspension	ciprofloxacin/ hydrocortisone otic suspension, 0.2%/1%	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Otolaryngology – Gene Therapy	Otarmeni	lunsotogene parvec-cwha intracochlear infusion	See standard *Otolaryngology – Gene Therapy – Otarmeni Prior Authorization Policy* criteria.	See PA duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Overactive Bladder Agents – Selective Beta-3 Adrenergic Receptor Agonists	Myrbetriq ER tablets	mirabegron extended-release tablets	If requesting brand Myrbetriq ER tablets: Approve if the patient has tried and cannot take generic mirabegron ER tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic mirabegron ER tablets or generic mirabegron ER tablets are non-formulary: **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Gemtesa, if formulary. If Gemtesa is non-formulary, approve. **2.** Patient < 18 years of age: Approve.	1 year
Overactive Bladder Agents – Selective Beta-3 Adrenergic Receptor Agonists	Myrbetriq Granules	mirabegron for extended-release oral suspension	**1.** Approve if the patient has tried and cannot take mirabegron ER tablets (Myrbetriq ER tablets, generics) OR the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Gemtesa, if formulary. If neither are formulary, approve. **2.** Patient is < 18 years of age: Approve.	1 year
Overactive Bladder Agents – Selective Beta-3 Adrenergic Receptor Agonists	Gemtesa	vibegron tablets	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with mirabegron ER tablets (Myrbetriq ER tablets, generics), if formulary. If mirabegron ER tablets (Myrbetriq ER tablets, generics) are non-formulary, approve. Note: If the patient tried Myrbetriq Granules, this would also count toward an approval. **2.** Approve Gemtesa if being requested for the treatment of overactive bladder symptoms in a patient with benign prostatic hyperplasia.	1 year
Overactive Bladder Agents (Oral and Topical)	Oxybutynin 2.5 mg tablet (brand)	oxybutynin 2.5 mg tablet	Approve if the patient has tried oxybutynin oral solution or syrup. If oxybutynin syrup is non-formulary approve if the patient meets one of the following (A or B): A. Patient has tried other strengths of oxybutynin tablets; OR B. Patient's dose requires a 2.5 mg increment.	1 year
Overactive Bladder Agents (Oral and Topical)	Detrol LA	tolterodine, extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Overactive Bladder Agents (Oral and Topical)	Vesicare	solifenacin succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Overactive Bladder Agents (Oral)	Vesicare LS	solifenacin succinate oral suspension	**1.** Approve if the patient has tried oxybutynin solution/syrup OR Myrbetriq Granules, if formulary. If neither are formulary, approve. **2.** Patient is < 5 years of age: approve if the patient has tried Myrbetriq Granules, if formulary. If Myrbetriq Granules are non-formulary, approve. **3.** Patients < 3 years of age, approve. Note: If the patient has tried any oxybutynin-containing product (e.g., immediate-release or extended-release tablets), this would meet the requirement for a trial of an oxybutynin product. Note: If the patient has tried mirabegron (Mybetriq tablets, generic) this would meet the requirement for a trial of Myrbetriq granules.	1 year
Overactive Bladder Agents (Oral)	Toviaz	fesoterodine fumarate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Pancreatic Enzymes	Creon	amylase/lipase/protease capsule	Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Zenpep, Pertzye, or Pancreaze. If none are formulary, approve.	1 year
Pancreatic Enzymes	Pancreaze	pancrelipase delayed-release (enteric-coated) capsules	Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if one is formulary): Creon, Pertzye, or Zenpep. If none are formulary, approve.	1 year
Pancreatic Enzymes	Pertzye	pancrelipase delayed-release capsules	Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Creon, Pancreaze, or Zenpep. If none are formulary, approve.	1 year
Pancreatic Enzymes	Zenpep	pancrelipase delayed-release capsules	Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Creon, Pancreaze, or Pertzye. If none are formulary, approve.	1 year
Pancreatic Enzymes	Viokace	pancrelipase tablets	**1.** Approve if the patient has tried one of Creon, Pancreaze, Pertzye, or Zenpep. If none are formulary, approve. **2.** Approve if, according to the prescriber, the patient requires a non-enteric coated product. **3.** For enteral feeding tube occlusion, approve.	1 year
Papillomatosis Agent	Papzimeos	zopapogene imadenovec-drba subcutaneous injection	See standard *Papillomatosis – Gene Therapy – Papzimeos Prior Authorization Policy* criteria.	See PA duration

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Formulary Exception Criteria

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Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Parathyroid Hormone (PTH) Analog	Yorvipath	palopegteriparatide subcutaneous injection	See standard *Hypoparathyroidism - Yorvipath Prior Authorization Policy* criteria.	See PA duration
Parkinsons' Disease Psychosis Medication	Nuplazid	pimavanserin tablets and capsules	**1.** Approve if the patient has tried one of quetiapine (Seroquel, generics) or clozapine (Clozaril, generics). **2.** Approve if according to the prescriber, the patient is unable to use either quetiapine (Seroquel, generics) or clozapine (Clozaril, generics). **3.** Approve if the patient is currently taking Nuplazid or has taken Nuplazid at any time in the past.	1 year
Pegylated Interferons	Pegasys	peginterferon alfa-2a vial/prefilled syringe/ProClick auto injector	Hepatitis C; Hepatitis B; Essential thrombocythemia; Polycythemia vera; Renal Cell Carcinoma; Chronic Myeloid Leukemia; Hairy Cell Leukemia; Erdheim-Chester Disease; Myelofibrosis; Mycosis Fungoides or Sezary Syndrome; Cutaneous anaplastic large cell lymphoma; Systemic mastocytosis; Adult T-Cell leukemia or lymphoma: Approve.	1 year
Phenylketonuria	Sephience	sepiapterin oral powder	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with a sapropterin tablet or powder packet (Kuvan, Javygtor, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on Sephience and is determined to be a responder, according to the prescriber.	1 year
Phenylketonuria	Palynziq	pegvaliase-pqpz injection for subcutaneous use	See standard *Phenylketonuria – Palynziq Prior Authorization Policy* criteria.	See PA duration
Phenylketonuria	Kuvan	sapropterin tablet and powder packet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Phosphate Binders	Auryxia and authorized generic	ferric citrate tablets	**1.** Approve if the patient has tried two formulary alternative from the following list (if two are formulary, or one if one is formulary): sevelamer hydrochloride tablets, sevelamer carbonate tablets/powder for oral suspension (Renvela, generics), Velphoro chewable tablets, lanthanum carbonate chewable tablets (Fosrenol, generics), or Fosrenol oral powder. If none are formulary, approve. **2.** Patients with iron deficient anemia and chronic kidney disease who are NOT on dialysis: approve.	1 year
Phosphate Binders	Fosrenol oral powder	lanthanum carbonate oral powder	**1.** Approve if the patient has tried two formulary alternatives from the following list (if two are formulary or one if one is formulary): sevelamer hydrochloride tablets, lanthanum carbonate chewable tablets (Fosrenol, generics), Velphoro chewable tablets, Auryxia tablets, or sevelamer carbonate tablets/powder for oral suspension (Renvela, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who are unable to chew and swallow tablets: approve if the patient has tried sevelamer carbonate powder for oral suspension (Renvela powder, generics), if formulary. If sevelamer carbonate powder for oral suspension (Renvela powder, generics) is non-formulary, approve.	1 year
Phosphate Binders	Velphoro	sucroferric oxyhydroxide chewable tablet	**1.** Approve if the patient has tried two formulary products from the following list (if two are formulary, or one if one is formulary): sevelamer hydrochloride tablets sevelamer carbonate tablets/powder for oral suspension (Renvela, generics), Auryxia tablets, lanthanum carbonate chewable tablets (Fosrenol, generics), or Fosrenol oral powder. If none are formulary, approve. **2.** Patient < 18 years of age, approve if the patient has tried one of the following, if formulary: sevelamer carbonate tablets or sevelamer carbonate powder for oral suspension (Renvela powder, generics). If neither are formulary, approve. **3.** Patient who is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried sevelamer carbonate powder for oral suspension (Renvela powder, generics), if formulary. If sevelamer carbonate powder for oral suspension (Renvela powder, generics) is non-formulary, approve.	1 year
Phosphate Binders	Fosrenol chewable tablets	lanthanum carbonate chewablet tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
PIK3CA-Related Overgrowth Spectrum Agent	Vijoice oral granules	alpelisib oral granules	Patient meets standard *Vijoice Prior Authorization Policy criteria* AND Patient has been prescribed a 50 mg dose AND is unable to use Vijoice 50 mg tablets prepared as an oral suspension.	See PA duration
PIK3CA-Related Overgrowth Spectrum Agent	Vijoice tablets	alpelisib tablets	See standard *Vijoice Prior Authorization Policy* criteria.	See PA duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Plaque Psoriasis Topical Agents	Vtama	tapinoraf 1% cream	Plaque Psoriasis. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient meets ALL of the following criteria (A, B, C, and D): A. Patient is ≥ 18 years of age; AND B. Patient has psoriasis involvement estimated to affect ≤ 20% of the body surface area; AND C) Patient meets one of the following criteria (i or ii): i. Patient meets all of the following criteria (a, b, and c): a) Patient has tried at least one medium-, medium-high, high-, and/or super-high potency prescription topical corticosteroid; AND b) This topical corticosteroid was applied daily for at least 4 consecutive weeks **[documentation required]**; AND c) Inadequate efficacy was demonstrated with this topical corticosteroid, according to the prescriber; OR ii. Patient is treating psoriasis affecting one of the following areas: face, eyes/eyelids, skin folds, and/or genitalia; AND D) Patient meets ALL of the following criteria (i, ii, and iii): i. Patient has tried at least one topical vitamin D analog; AND Note: Examples of topical vitamin D analogs include calcipotriene 0.005% foam (Sorilux, authorized generic), calcipotriene 0.005% cream (Dovonex, generic), calcipotriene 0.005% ointment (generic only), calcitriol 3 mcg/g ointment (Vectical, generic), calcipotriene 0.005% and betamethasone dipropionate 0.064% foam (Enstilar), calcipotriene 0.005% and betamethasone dipropionate 0.064% cream (Wynzora), calcipotriene 0.005% and betamethasone dipropionate 0.064% ointment (Taclonex, generic), calcipotriene 0.005% and betamethasone dipropionate 0.064% suspension (Taclonex, generic). Concomitant use of a topical vitamin d analog and a topical corticosteroid would meet the requirement. ii. This topical vitamin D analog was applied daily for at least 4 consecutive weeks **[documentation required]**; AND iii. Inadequate efficacy was demonstrated with this topical vitamin D analog, according to the prescriber. **2.** Patient has tried Zoryve 0.3% cream, if formulary. If Zoryve 0.3% cream is non-formulary, approve. Atopic Dermatitis in a patient ≥ 2 years of age. **1.** Patient is ≥ 6 years of age, approve if the patient has tried TWO of pimecrolimus cream (Elidel cream, generics), tacrolimus ointment, Eucrisa, or Zoryve cream (0.05% or 0.15%) [if two are formulary or one if one is formulary]. If none are formulary, approve. **2.** Patient is ≥ 2 years of age and < 6 years of age, approve if the patient has tried TWO of pimecrolimus cream (Elidel cream, generics), tacrolimus ointment, Eucrisa, or Zoryve 0.05% cream (if two are formulary or one if one is formulary). If none are formulary, approve.	1 year
Plasma-derived human plasminogen	Ryplazim	plasminogen, human-tvmh intravenous infusion	See standard *Hematology – Ryplazim Prior Authorization Policy* criteria	See PA duration
Postpartum depression Agents	Zurzuvae	zuranolone capsules	See standard *Psychiatry – Zurzuvae Prior Authorization Policy* criteria.	See PA duration
Postpartum depression Agents	Zulresso	brexanolone solution for injection	See standard *Psychiatry – Zulresso PA Policy* criteria.	See PA duration
Potassium Binders	Lokelma	sodium zirconium cyclosilicate powder for suspension	Approve if the patient has tried Veltassa, if formulary. If Veltassa is non-formulary, approve.	1 year
Potassium Binders	Veltassa	patiromer powder for suspension	**1.** Approve if the patient has tried Lokelma, if formulary. If Lokelma is non-formulary, approve. **2.** Patient is ≥ 12 years of age to < 18 years of age, approve.	1 year
Potassium Sparing Diuretics	Carospir	spironolactone oral suspension	**1.** Approve if the patient has tried and cannot take spironolactone tablets (Aldactone, generics), if formulary. If spironolactone tablets (Aldactone, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow spironolactone tablets.	1 year
Potassium Supplement	Pokonza solution, Pokonza powder for solution and potassium packet	potassium chloride solution and powder, for solution	Approve if the patient has tried one other oral potassium chloride product (e.g., potassium chloride powder for oral solution, potassium chloride oral solution). If generic potassium chloride oral solution is non-formulary, approve.	1 year
Potassium-Competitive Acid Blocker	Voquezna (single-ingredient)	vonoprazan tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with TWO proton-pump inhibitors. Note: Examples of proton-pump inhibitors include dexlansoprazole, esomeprazole, lansoprazole, omeprazole, omeprazole-sodium bicarbonate, pantoprazole, rabeprazole.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Prenatals vitamins	Natal PNV	ascorbic acid, cholecalciferol, thiamine hydrochloride, riboflavin,pyridoxal phosphate,levomefolate glucosamine, folic acid, methylcobalamin, calcium carbonate, ferrous gluconate, potassium iodide tablet, film coated	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year
Prenatals vitamins	Citranatal prenatal vitamins (examples include Citranatal RX tablets, Citranatal Harmony capsules)	various	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year
Prenatals vitamins	Pregenna	beta carotene, ascorbic acid, cholecalciferol, .alpha.-tocopherol acetate, pyridoxine hydrochloride, biotin, folic acid, levomefolate calcium, cyanocobalamin, calcium carbonate, magnesium oxide, ferrous bisglycinate, and potassium iodide tablet	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year
Prenatals vitamins	Trinaz	ascorbic acid, cholecalciferol, thiamine hydrochloride, riboflavin, pyridoxal phosphate anhydrous, folic acid, methylcobalamin, calcium carbonate, ferrous gluconate, and potassium iodide tablet, film coated	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year
Primary Immunoglobulin A Nephropathy Agents	Tarpeyo	budesonide delayed-release capsules	Primary Immunoglobulin A Nephropathy in a patient ≥ 18 years of age. Approve if the patient has tried one systemic corticosteroid (other than Tarpeyo) for the diagnosis. Note: Examples of systemic corticosteroids include methylprednisolone, prednisone.	10 months

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Primary Immunoglobulin A Nephropathy Agents	Vanrafia	atrasentan tablets	Primary Immunoglobulin A Nephropathy in a patient ≥ 18 years of age. **1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Filspari, if formulary; AND Note: If Filspari is non-formulary, criterion A is met. B. Patient meets ONE of the following (i or ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of Fabhalta or Voyxact, if formulary; OR Note: If neither are formulary, criterion B is met. ii. According to the prescriber, the patient has an increased risk for infection; OR **2.** Approve if the patient has already been started on therapy with Vanrafia.	1 year
Primary Immunoglobulin A Nephropathy Agents	Voyxact	sibeprenlimab-szsi subcutaneous injection	Primary Immunoglobulin A Nephropathy in a patient ≥ 18 years of age. 1. Approve if the patient meets BOTH of the following (A and B): A. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Filspari, if formulary; OR Note: If Filspari is non-formulary, criterion A is met. ii. Patient has hepatic impairment OR, according to the prescriber, is at risk of hepatic impairment; OR iii. Patient is pregnant or planning to become pregnant; AND B. Patient meets one of the following (i, ii, iii, or iv): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with ONE of Fabhalta or Vanrafia, if formulary; OR Note: If neither are formulary, criterion B is met. ii. According to the prescriber, the patient has an increased risk for infection, approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Vanrafia, if formulary. Note: If Vanrafia is non-formulary, criterion B is met. iii. Patient has hepatic impairment OR, according to the prescriber, is at risk of hepatic impairment; OR iv. Patient is pregnant or planning to become pregnant; OR **2.** Approve if the patient has already been started on therapy with Voyxact.	1 year
Primary Immunoglobulin A Nephropathy Agents	Filspari	sparsentan tablets	See standard *Nephrology – Filspari Prior Authorization Policy* criteria.	See PA duration
Primary Immunoglobulin A Nephropathy Agents	Trutakna	atacicept-vymj subcutaneous injection	Primary Immunoglobulin A Nephropathy in a patient ≥ 18 years of age. **1.** Approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Filspari, if formulary; OR Note: If Filspari is non-formulary, criterion A is met. B. Patient is pregnant or planning to become pregnant; OR C. Patient has hepatic impairment OR, according to the prescriber, is at risk of hepatic impairment. **2.** Approve if the patient has already been started on therapy with Trutakna.	1 year
Progestin – Vaginal Agents	Crinone 4% Gel	progesterone gel 4%	Approve if the patient has tried at least one product from the following list (if one is formulary): medroxyprogesterone [Provera, generics], megestrol acetate, norethindrone 5 mg tablets, or progesterone capsules (Prometrium, generics). If none are formulary, approve.	1 year
Progestin – Vaginal Agents	Crinone 8% Gel	progesterone gel 8%	**1.** For use as progesterone supplementation/replacement to achieve or maintain pregnancy: approve if the patient has tried progesterone 100 mg vaginal insert (Endometrin, generics), if formulary. If progesterone 100 mg vaginal insert (Endometrin, generics) are non-formulary, approve. **2.** Patient already started on a course of therapy with Crinone 8% gel for progesterone supplementation/replacement to achieve or maintain pregnancy: approve to complete the current course of therapy. **3.** Approve if the patient has tried at least one product from the following list (if one is formulary): medroxyprogesterone [Provera, generics], megestrol acetate, norethindrone 5 mg tablets, or progesterone capsules (Prometrium, generics). If none are formulary, approve.	1 year
Proton Pump Inhibitor Combination	Yosprala and authorized generic	aspirin and omeprazole delayed-release tablets	Approve if the patient has tried aspirin AND at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include a rabeprazole delayed-release (DR) product (Aciphex, generics; Aciphex Sprinkle, authorized generics), dexlansoprazole DR capsules (Dexilant, generics), an esomeprazole DR product (Nexium, generics; Nexium granules for oral suspension, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics; Prilosec granules for oral suspension), an omeprazole DR/sodium bicarbonate product (Zegerid, generics; Zegerid powder for oral suspension, generics; Konvomep). Note: The requested agent would NOT count as a trial of an alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Proton Pump Inhibitors (PPIs)	Dexilant and generic dexlansoprazole delayed-release capsules	dexlansoprazole delayed-release capsules	**1.** Approve if the patient has tried at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include a rabeprazole delayed-release (DR) product (Aciphex, generics; Aciphex Sprinkle, authorized generics), an esomeprazole DR product (Nexium, generics; Nexium granules for oral suspension, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics; Prilosec granules for oral suspension), an omeprazole DR/sodium bicarbonate product (Zegerid, generics; Zegerid powder for oral suspension, generics; Konvomep). Note: The requested agent would NOT count as a trial of an alternative. **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried at least three proton pump inhibitors (PPIs) from the following list, if formulary (or two if two are formulary, or one if one is formulary): 1) an esomeprazole product (esomeprazole DR capsules [Nexium, generics], esomeprazole packet [Nexium granules for oral suspension, generic]); 2) pantoprazole suspension (granules) [Protonix suspension, generic]; 3) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid Solutab, generics]); 4) an omeprazole product (omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.	1 year
Proton Pump Inhibitors (PPIs)	Konvomep	omeprazole and sodium bicarbonate oral suspension	**1**. Approve if the patient has tried at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include a rabeprazole delayed-release (DR) product (Aciphex, generics; Aciphex Sprinkle, authorized generics), dexlansoprazole DR capsules (Dexilant, generics), an esomeprazole DR product (Nexium, generics; Nexium granules for oral suspension, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics; Prilosec granules for oral suspension), an omeprazole DR/sodium bicarbonate product (Zegerid, generics; Zegerid powder for oral suspension, generics). Note: The requested agent would NOT count as a trial of an alternative. **2**. Patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried at least three proton pump inhibitors (PPIs) from the following list, if formulary (or two if two are formulary, or one if one is formulary): 1) an esomeprazole product (esomeprazole DR capsules [Nexium, generics], esomeprazole packet [Nexium granules for oral suspension, generic]); 2) pantoprazole suspension (granules) [Protonix suspension, generic]; 3) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid SoluTab, generics]); 4) an omeprazole product (omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.	1 year
Proton Pump Inhibitors (PPIs)	Aciphex Sprinkle and authorized generic	rabeprazole sodium delayed-release capsules	**1**. Approve if the patient has tried at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include dexlansoprazole DR capsules (Dexilant, generics), an esomeprazole DR product (Nexium, generics; Nexium granules for oral suspension, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics; Prilosec granules for oral suspension), an omeprazole DR/sodium bicarbonate product (Zegerid, generics; Zegerid powder for oral suspension, generics; Konvomep). Note: The requested agent would NOT count as a trial of an alternative. **2**. Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried at least two proton pump inhibitors (PPIs).	1 year
Proton Pump Inhibitors (PPIs)	Nexium packet (granules for oral suspension) 5 mg and 2.5 mg packets and esomeprazole delayed-release 5 mg and 2.5 mg granules for oral suspension (packets)	esomeprazole delayed-release granules for oral suspension (packet)	If requesting brand Nexium oral suspension (packet): Approve if the patient has tried and cannot take generic esomeprazole delayed-release granules for oral suspension (packet) due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic esomeprazole delayed-release granules for oral suspension or generic esomeprazole delayed-release granules for oral suspension are non-formulary: **1**. Approve if the patient has tried at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include a rabeprazole delayed-release (DR) product (Aciphex, generics; Aciphex Sprinkle, authorized generics), dexlansoprazole DR capsules (Dexilant, generics), an esomeprazole DR product (Nexium, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics; Prilosec granules for oral suspension), an omeprazole DR/sodium bicarbonate product (Zegerid, generics; Zegerid powder for oral suspension, generics; Konvomep). Note: The requested agent would NOT count as a trial of an alternative. **2**. Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried at least two proton pump inhibitors (PPIs). **3**. Patients < 1 year of age: approve if the patient has tried Prilosec DR suspension, if formulary. If Prilosec DR suspension is non-formulary, approve. **4**. Patients < 11 years of age and require administration via a feeding tube, approve if the patient has tried Prilosec DR suspension, if formulary. If Prilosec DR suspension is non-formulary, approve.	1 year
Proton Pump Inhibitors (PPIs)	Prilosec oral suspension	omeprazole delayed-release oral suspension	**1**. Approve if the patient has tried at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include a rabeprazole delayed-release (DR) product (Aciphex, generics; Aciphex Sprinkle, authorized generics), dexlansoprazole DR capsules (Dexilant, generics), an esomeprazole DR product (Nexium, generics; Nexium granules for oral suspension, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics), an omeprazole DR/sodium bicarbonate product (Zegerid, generics; Zegerid powder for oral suspension, generics; Konvomep). Note: The requested agent would NOT count as a trial of an alternative. **2**. Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried at least two proton pump inhibitors (PPIs). **3**. Patients < 1 year of age: approve if the patient has tried esomeprazole granules for oral suspension (Nexium DR packet {granules for oral suspension}, generics), if formulary. If esomeprazole granules for oral suspension (Nexium DR packet {granules for oral suspension}, generics) are non-formulary, approve. **4**. Patients < 11 years of age and requires administration via a feeding tube: approve if the patient has tried esomeprazole granules for oral suspension (Nexium DR packet {granules for oral suspension}, generics), if formulary. If esomeprazole granules for oral suspension (Nexium DR packet {granules for oral suspension}, generics) are non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Proton Pump Inhibitors (PPIs)	Zegerid capsules	omeprazole/ sodium bicarbonate capsules	Approve if the patient has tried at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include a rabeprazole delayed-release (DR) product (Aciphex, generics; Aciphex Sprinkle, authorized generics), dexlansoprazole DR capsules (Dexilant, generics), an esomeprazole DR product (Nexium, generics; Nexium granules for oral suspension, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics; Prilosec granules for oral suspension), Konvomep. Note: The requested agent would NOT count as a trial of an alternative.	1 year
Proton Pump Inhibitors (PPIs)	Zegerid packets	omeprazole/ sodium bicarbonate powder for oral suspension (packets)	Approve if the patient has tried at least five proton pump inhibitors (PPIs). Note: Examples of PPIs include a rabeprazole delayed-release (DR) product (Aciphex, generics; Aciphex Sprinkle, authorized generics), dexlansoprazole DR capsules (Dexilant, generics), an esomeprazole DR product (Nexium, generics; Nexium granules for oral suspension, generics), a pantoprazole DR product (Protonix, generics; Protonix granules for oral suspension, generics), a lansoprazole DR product (Prevacid, generics; Prevacid SoluTab, generics), an omeprazole DR product (Prilosec, generics; Prilosec granules for oral suspension), Konvomep. Note: The requested agent would NOT count as a trial of an alternative.	1 year
Proton Pump Inhibitors (PPIs)	Aciphex	rabeprazole sodium tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Proton Pump Inhibitors (PPIs)	Nexium capsules	esomeprazole delayed-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Proton Pump Inhibitors (PPIs)	Nexium packet (granules for oral suspension) 10 mg, 20 mg, 40 mg packet	esomeprazole delayed-release granules for oral suspension (packet)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Proton Pump Inhibitors (PPIs)	Prevacid	lansoprazole delayed-release (DR) capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Proton Pump Inhibitors (PPIs)	Prevacid SoluTab	lansoprazole orally disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Proton Pump Inhibitors (PPIs)	Protonix	pantoprazole sodium delayed-release (DR) tablets and intravenous (IV) injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Proton Pump Inhibitors (PPIs)	Protonix oral suspension	pantoprazole delayed-release oral suspension (granules)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Prurigo Nodularis Interleukin (IL)-31 Receptor Antagonist	Nemluvio	nemolizumab-ilto subcutaneous injection	Moderate to severe atopic dermatitis in a patient ≥ 12 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Adbry, Ebgylss, or Dupxient, if formulary. If none are formulary, approve. **2.** If the patient is < 40 kg, approve if the patient has tried one of Dupixent or Adbry, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Nemluvio for ≥ 4 months. Prurigo Nodularis in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy or significant intolerance with Dupixent, if formulary. If Dupixent is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Nemluvio.	1 year
Pulmonary Arterial Hypertension (PAH) - Activin Signaling Inhibitor	Winrevair	sotaterept-csrk subcutaneous injection	See standard *Pulmonary Arterial Hypertension – Winrevair Prior Authorization with Step Therapy Policy* criteria.	See PA duration

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Pulmonary Arterial Hypertension (PAH) – Combination Endothelin Receptor Antagonist and Phosphodiesterase 5 Inhibitors	Opsynvi	macitentan 10 mg-tadalafil 20 mg or 40 mg tablets	Pulmonary Arterial Hypertension World Health Organization Group 1. Approve if the patient meets BOTH of the following (A and B): A. Patient has used macitentan (Opsumit, generic) AND tadalafil (Adcirca, generics) taken concomitantly, if both are formulary; AND B. Patient was unable to adhere to the regimen using two separate products. If one of or both of macitentan (Opsumit, generic) or tadalafil (Adcirca, generics) are non-formulary, approve if the patient meets one of the following (A or B): A. Patient has concomitantly used BOTH of the following: 1) one endothelin receptor antagonist (macitentan (Opsumit, generic) or ambrisentan [Letaritis, generics]); AND 2) one phosphodiesterase-5 inhibitor (tadalafil [Adcirca, generics] or sildenafil [Revatio, generics]); OR Note: If there are no formulary endothelin receptor antagonists, approve. Note: If there are no formulary phosphodiesterase-5 inhibitors, approve. B. Patient has already been started on therapy with Opsynvi.	1 year
Pulmonary Arterial Hypertension (PAH) - Endothelin Receptor Antagonists	Opsumit	macitentan tablets	Pulmonary Arterial Hypertension World Health Organization Group 1. **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with ambrisentan (Letairis, generics). If ambrisentan (Letairis, generics) are non-formulary, approve. **2.** Approve if the patient has been established on Opsumit for ≥ 60 days.	1 year
Pulmonary Arterial Hypertension (PAH) - Endothelin Receptor Antagonists	Letairis	ambrisentan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Pulmonary Arterial Hypertension (PAH) - Inhaled Prostacyclins	Yutrepia	treprostinil inhalation powder	Pulmonary Arterial Hypertension World Health Organization Group 1; Interstitial Lung Disease Associated Pulmonary Hypertension World Health Organization WHO Group 3: **1.** Approve if the patient has tried one of Tyvaso inhalation solution or Tyvaso DPI, if formulary. If neither are formulary, approve. **2.** If the patient has already been started on therapy with Yutrepia, approve.	1 year
Pulmonary Arterial Hypertension (PAH) - Inhaled Prostacyclins	Tyvaso DPI	treprostinil oral inhalation powder	Pulmonary Arterial Hypertension World Health Organization Group 1; Interstitial Lung Disease Associated Pulmonary Hypertension World Health Organization WHO Group 3: **1.** Approve if the patient has tried ONE of Tyvaso inhalation solution or Yutrepia, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Tyvaso DPI.	1 year
Pulmonary Arterial Hypertension (PAH) - Inhaled Prostacyclins	Tyvaso Inhalation Solution	treprostinil inhalation solution	Pulmonary Arterial Hypertension World Health Organization Group 1; Interstitial Lung Disease Associated Pulmonary Hypertension World Health Organization WHO Group 3: **1.** Approve if the patient has tried ONE of Tyvaso DPI or Yutrepia, if formulary. If neither are formulary, approve. **2.** Approve if the patient has been started on Tyvaso inhalation solution or already has the device for Tyvaso inhalation solution.	1 year
Pulmonary Arterial Hypertension (PAH) - Inhaled Prostacyclins	Ventavis	iloprost inhalation solution	Pulmonary Arterial Hypertension PAH World Health Organization WHO Group 1: **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of the following: Tyvaso inhalation solution, Tyvaso DPI, or Yutrepia, if formulary. If none are formulary, approve. **2.** Approve if the patient has been started on Ventavis or already has the device for Ventavis.	1 year
Pulmonary Arterial Hypertension (PAH) - Other Agents	Adempas	riociguat tablets	See standard *Pulmonary Arterial Hypertension – Adempas Prior Authorization Policy* criteria.	See PA duration
Pulmonary Arterial Hypertension (PAH) - Other Agents	Uptravi Intravenous	selexipag intravenous infusion	Pulmonary Arterial Hypertension, World Health Organization Group 1: **1.** Approve if the patient is currently receiving Uptravi tablets and is unable to continuing taking Uptravi tablets. **2.** Approve if the patient has already been started on Uptravi intravenous infusion.	3 months
Pulmonary Arterial Hypertension (PAH) - Other Agents	Orenitram	treprostinil extended-release tablets	Pulmonary Arterial Hypertension, World Health Organization (WHO) Group 1: **1.** Approve if the patient has tried Uptravi tablets, if formulary. If Uptravi tablets are non-formulary, approve. Note: A trial of Uptravi Intravenous would also count as an approval. **2.** Approve Orenitram if the patient is receiving a strong cytochrome P450 2C8 inhibitor (e.g., gemfibrozil). **3.** Approve if the patient has already been started on Orenitram.	1 year
Pulmonary Arterial Hypertension (PAH) - Other Agents	Uptravi	selexipag tablets	Pulmonary Arterial Hypertension, World Health Organization (WHO) Group 1: **1.** Approve if the patient has tried Orenitram, if formulary. If Orenitram is non-formulary, approve. **2.** Patient is < 18 years of age, approve. **3.** Approve Uptravi if the patient has severe hepatic impairment (Child Pugh Class C). **4.** Approve if the patient has already been started on Uptravi.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Liqrev	sildenafil oral suspension 10 mg/mL	Pulmonary arterial hypertension World Health Organization Group 1. **1.** Direct the patient to sildenafil powder for oral suspension 10 mg/mL (Revatio oral suspension, generics), if formulary. **2.** Approve if, according to the prescriber, there is a significant clinical concern (e.g., a significant allergy or serious adverse reaction due to inactive ingredients) such that the patient is unable to use sildenafil powder for oral suspension 10 mg/mL (Revatio oral suspension, generics). **3.** If sildenafil powder for oral suspension (10 mg/mL) is non-formulary, approve if the patient meets one of the following (A or B): A. Patient has tried Tadliq, if formulary. If Tadliq is non-formulary, approve; OR Note: This criterion would also be satisfied if the patient tried any other tadalafil product. B. Patient has already been started on a sildenafil product (e.g., sildenafil tablets or suspension, Revatio, or Liqrev).	1 year
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Tadliq	tadalafil oral suspension	Pulmonary arterial hypertension World Health Organization Group 1. **1.** Approve if the patient is unable to swallow or has difficulty swallowing tadalafil tablets (Adcirca tablets, Alyq tablets, generics), if formulary. **2.** If tadalafil tablets (Adcirca tablets, Alyq tablets, generics) are non-formulary, approve if the patient meets one of the following (A or B): A. Patent has tried sildenafil powder for oral suspension (Revatio oral suspension, generics), if formulary. If sildenafil powder for oral suspension (Revatio oral suspension, generics) is non-formulary approve; OR Note: This criterion would also be satisfied if the patient tried any other sildenafil product. B . Patient has already been started on a tadalafil product (e.g., tadalafil tablets, Adcirca tablets, Alyq, Tadliq).	1 year
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Alyq and tadalafil 20 mg [PAH] tablets	tadalafil 20 mg tablets	**1.** Approve if the patient has tried a sildenafil product (tablets or suspension) [e.g., Revatio, Liqrev, or generics]. **2.** Approve if the patient has already been started on a tadalafil product (e.g., Adcirca, Alyq, Tadliq, or generics).	1 year
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Adcirca	tadalafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Pulmonary Arterial Hypertension Agents	Remodulin (brand)	treprostinil injection	Approve if the patient meets one of the following (A or B): A. Initial therapy: Patient meets one of the following (i or ii): i. Patient has tried generic treprostinil, if formulary. If generic treprostinil is non-formulary, approve; OR ii. Patient meets BOTH of the following (a and b): a. The request is for Remodulin for subcutaneous continuous infusion; AND b. Patient cannot take generic treprostinil because appropriate durable medical equipment is not available such as the patient does not have or cannot obtain a compatible pump that allows generic treprostinil to be administered: OR B. Patient has already been started on Remodulin or treprostinil therapy.	6 months
Pyrimidine Analogs	Xuriden	uridine triacetate granule	See standard *Metabolic Disorders – Xuriden Prior Authorization Policy* criteria.	See PA duration
Pyrimidine Analogs	Vistogard	uridine triacetate oral granules	See standard *Oncology (Oral) – Vistogard Prior Authorization Policy* criteria	See PA duration
Pyruvate kinase activator	Pyrukynd	mitapivat tablets	See standard *Hematology – Pyrukynd Prior Authorization Policy* criteria	See PA duration
Recombinant full-length, third-generation Factor VIII Products	Advate	antihemophilic Factor injection, plasma/albumin-free method	**1.** Approve if the patient has tried Kovaltry, if formulary. If Kovaltry is non-formulary, approve. **2.** If the patient is currently receiving Advate or has received Advate in the past, approve.	1 year
Recombinant full-length, third-generation Factor VIII Products	Kovaltry	antihemophilic factor [recombinant] for intravenous injection	**1.** Approve if the patient has tried Advate, if formulary. If Advate is non-formulary, approve. **2.** Patient is currently receiving Kovaltry or has received Kovaltry in the past: approve.	1 year
Respiratory – Short-acting Beta-2 agonist/ Short-acting muscarinic antagonist	Combivent Respimat	albuterol sulfate/ipratropium inhalation spray	Approve if the patient has tried one formulary albuterol inhaler: Ventolin HFA, albuterol HFA AND Atrovent HFA, if both are formulary. If no albuterol inhalers are formulary OR Atrovent HFA is non-formulary, approve. If neither are formulary, approve. **Note**: If the patient has tried the inhalation solution of the either the albuterol or ipratropium, this would count as the corresponding alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid Inhalers	ArmonAir Digihaler	fluticasone propionate powder, metered	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, fluticasone propionate diskus (authorized generic of Flovent Diskus), or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dosen inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative. **3.** Approve if the patient is pregnant AND currently receiving the requested medication for asthma.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid Inhalers	Flovent Diskus (brand and authorized generic)	fluticasone inhalation powder	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco; a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate HFA [authorized generic of Flovent HFA]); a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler); Pulmicort Flexhaler; or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta]; fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta]), or Qvar RediHaler, if formulary. If none are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate HFA [authorized generic of Flovent HFA]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried two formulary alternatives from the following list (if two if two are formulary or one if one is formulary): Asmanex Twisthaler or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **3**. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. 4. Approve if the patient is being treated for chronic graft versus host disease with lung involvement. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone furoate DPI (authorized generic of Arnuity Ellipta) and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid Inhalers	Flovent HFA (brand)	fluticasone inhalation aerosol HFA	**Direct the patient to fluticasone propionate HFA**, if formulary. If fluticasone propionate HFA is non-formulary: **1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is only formulary): Asmanex HFA AND Qvar RediHaler. If neither are formulary, approve. **ii.** If the patient is < 12 years of age and is unable to use BOTH a DPI AND a breath-actuated metered-dose inhaler (MDI) [i.e., Qvar Redihaler], approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): Qvar RediHaler AND Asmanex HFA. If none are formulary, approve. **ii.** If the patient is < 6 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. **c.** If the patient is 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is 4 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried Qvar RediHaler, if formulary. If Qvar RediHaler is non-formulary, approve. **ii.** If the patient is 4 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve. **d.** If the patient is < 4 years of age: approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, or Qvar RediHaler. If none are formulary, approve. **3**. If the patient is unable to use BOTH a DPI AND a breath actuated MDI, approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Alvesco, Asmanex HFA. If none are formulary, approve. **4.** Patients with eosinophilic esophagitis: approve, if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). **5**. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. **6**. Approve if the patient is being treated for chronic graft versus host disease with lung involvement. <u>Note</u>: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. <u>Note</u>: Arnuity Ellipta, fluticasone furoate DPI (authorized generic of Arnuity Ellipta) and fluticasone propionate diskus (authorized generic of Flovent Diskus) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid Inhalers	Fluticasone propionate HFA (authorized generic of Flovent HFA)	fluticasone propionate HFA	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. a. If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. i. If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is only formulary): Asmanex HFA AND Qvar RediHaler. If neither are formulary, approve. ii. If the patient is < 12 years of age and is unable to use BOTH a DPI AND a breath-actuated metered-dose inhaler (MDI) [i.e., Qvar Redihaler], approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. b. If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. i. If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): Qvar RediHaler AND Asmanex HFA. If none are formulary, approve. ii. If the patient is < 6 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. c. If the patient is 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. i. If the patient is 4 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried Qvar RediHaler, if formulary. If Qvar RediHaler is non-formulary, approve. ii. If the patient is 4 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve. d. If the patient is < 4 years of age: approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, or Qvar RediHaler. If none are formulary, approve. **3.** Patients with eosinophilic esophagitis: approve if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). **4**. If the patient is unable to use BOTH a DPI AND a breath actuated MDI, approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Alvesco, Asmanex HFA. If none are formulary, approve. **5**. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. **6**. Approve if the patient is being treated for chronic graft versus host disease with lung involvement. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone furoate DPI (authorized generic of Arnuity Ellipta) and fluticasone propionate diskus (authorized generic of Flovent Diskus) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year
Respiratory - Corticosteroid Inhalers	Pulmicort Flexhaler	budesonide inhalation powder	**1.** Approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone furoate DPI [authorized generic of Arnuity Ellipta], fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **3**. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. 4. Approve if the patient is being treated for chronic graft versus host disease with lung involvement. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone furoate DPI (authorized generic of Arnuity Ellipta), fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid Inhalers	Alvesco	ciclesonide inhalation aerosol	**1.** Approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex HFA, fluticasone propionate HFA (authorized generic of Flovent HFA), or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative. **3**. Approve if the patient is pregnant AND currently receiving the requested medication for asthma.	1 year
Respiratory - Corticosteroid Inhalers	Arnuity Ellipta and authorized generic	fluticasone furoate inhalation powder	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone (fluticasone propionate [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. a. If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. i. If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. b. If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary approve. i. If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: fluticasone propionate diskus (authorized generic of Flovent Diskus) and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative. **3**. Approve if the patient is pregnant AND currently receiving the requested medication for asthma.	1 year
Respiratory - Corticosteroid Inhalers	Asmanex HFA	mometasone furoate inhalation aerosol	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. a. If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), Qvar Redihaler, or Pulmicort Flexhaler. If none are formulary, approve. i. If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): fluticasone propionate HFA (authorized generic of Flovent HFA) AND Qvar Redihaler. If neither are formulary, approve. ii. If the patient is < 12 years of age and is unable to use BOTH a DPI AND a breath-actuated metered-dose inhaler (MDI) [i.e., Qvar Redihaler], approve if the patient has tried fluticasone propionate HFA (authorized generic of Flovent HFA), if formulary. If fluticasone propionate HFA (authorized generic of Flovent HFA) is non-formulary, approve. b. If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), or Qvar Redihaler. If none are formulary, approve. i. If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): fluticasone propionate HFA (authorized generic of Flovent HFA) AND Qvar Redihaler. If neither are formulary, approve. ii. If the patient is < 6 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve if the patient has tried fluticasone propionate HFA (authorized generic of Flovent HFA), if formulary. If fluticasone propionate HFA (authorized generic of Flovent HFA) is non-formulary, approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, fluticasone propionate HFA (authorized generic of Flovent HFA), or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. **3**. Approve if the patient is pregnant AND currently receiving the requested medication for asthma.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid Inhalers	Asmanex Twisthaler	mometasone inhalation powder	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex HFA, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex HFA, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]) AND Qvar RediHaler. If neither are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]) AND Qvar RediHaler. If neither are formulary, approve. **i.** If the patient is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is formulary): a fluticasone inhaler (fluticasone propionate [authorized generic of Flovent Diskus]) AND Qvar RediHaler. If neither are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. **3.** Approve if the patient is pregnant AND currently receiving the requested medication for asthma.	1 year
Respiratory - Corticosteroid Inhalers	Qvar RediHaler	beclomethasone HFA inhalation aerosol	**1.** Approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Pulmicort Flexhaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Pulmicort Flexhaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): Asmanex HFA AND fluticasone propionate HFA (authorized generic to Flovent HFA). If neither are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic to Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]) AND a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA). If neither are formulary, approve. **i.** If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): fluticasone propionate HFA (authorized generic of Flovent HFA) AND Asmanex HFA. If neither are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus], or fluticasone propionate HFA [authorized generic of Flovent HFA]) AND Asmanex Twisthaler. If neither are formulary, approve. **i.** If the patient is ≤ 4 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried fluticasone propionate HFA (authorized generic of Flovent HFA), if formulary. If fluticasone propionate HFA (authorized generic of Flovent HFA) is non-formulary, approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, or fluticasone propionate HFA (authorized generic of Flovent HFA). If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative. **3.** Approve if the patient is pregnant AND currently receiving the requested medication for asthma.	1 year
Respiratory - Corticosteroid Nebulized Solutions	Pulmicort	budesonide respules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid/Beta-Agonist Combination Inhalers	Airsupra	albuterol and budesonide inhalation aerosol	Approve if the patient meets BOTH of the following (1 AND 2): 1. Patient has tried one of a budesonide-formoterol aerosol (Symbicort, Breyna, generics) or Dulera [**documentation required**], if formulary; AND Note: If none are formulary, this would satisfy criteria #1. 2. Patient has tried one albuterol-containing inhaler (or levalbuterol-containing inhaler) taken concomitantly with one single-entity inhaled corticosteroid [**documentation required**]. 3. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. Note: Albuterol-containing inhalers include ProAir HFA, Proventil HFA, albuterol HFA, Ventolin HFA. Levalbuterol-containing inhalers include Xopenex HFA and levalbuterol HFA. Note: Examples of single-entity inhalers containing corticosteroids: Alvesco, Arnuity Ellipta, Asmanex HFA, Asmanex Twisthaler, Flovent Diskus, Flovent HFA, Pulmicort Flexhaler, Qvar RediHaler.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Advair HFA	fluticasone propionate/salmeterol inhalation aerosol	Direct to fluticasone propionate-salmeterol HFA, if formulary. If fluticasone-salmeterol HFA is non-formulary: 1. Approve if the patient has tried four of the following, if (four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 2. Patients < 18 years of age: approve if the patient has tried three of the following, if three are formulary (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol (Symbicort, Breyna, generics), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 3. Patients with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the patient has tried both 1) budesonide-formoterol aerosol (Symbicort, Breyna, generics) and 2) Dulera (if both are formulary or one if only one is formulary). If neither are formulary, approve. 4. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler and AirDuo RespiClick count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	AirDuo Digihaler	fluticasone/ salmeterol inhalation powder	1. Approve if the patient has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 2. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose DPI (AirDuo Respiclick, authorized generic), or fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic). If none are formulary, approve. 3. Patients < 18 years of age: approve if the patient has tried three of the following, if three are formulary (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), fluticasone-salmeterol HFA (Advair HFA, authorized generics), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 4. Patients < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol inhalation (Advair Diskus, Wixela, generics), or fluticasone propionate/salmeterol multidose DPI (AirDuo RespiClick, authorized generics), if one is formulary. If none are formulary, approve. 5. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler and AirDuo RespiClick count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	AirDuo RespiClick	fluticasone propionate/salmeterol inhalation powder	1. Approve if the patient has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (authorized generic of AirDuo RespiClick), or budesonide-formoterol aerosol (Symbicort, Breyna, generics). If none are formulary, approve. 2. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick), or fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic). If none are formulary, approve. 3. Patients < 18 years of age: approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick), or Dulera. If none are formulary, approve. 4. Patients < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol inhalation (Advair Diskus, Wixela, generics) or fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick), if one is formulary. If none are formulary, approve. 5. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Breo Ellipta	fluticasone furoate and vilanterol inhalation powder	If requesting Breo Ellipta 100-25 or 200-25: Direct the patient to fluticasone-vilanterol powder inhalation, if formulary. If fluticasone-vilanterol powder inhalation is non-formulary OR Breo Ellipta 50-25 is being requested: 1. Approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), budesonide-formoterol aerosol (Symbicort, Breyna, generics), or Dulera. If none are formulary, approve. 2. Patients < 12 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), Dulera, or budesonide-formoterol aerosol (Symbicort, Breyna, generics). If none are formulary, approve. 3. Patients ≤ 5 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) or Dulera. If neither are formulary, approve. 4. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) or fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), if one is formulary. If none are formulary, approve. a. Patient < 12 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): Approve if the patient has tried fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. 5. Patients with COPD: Approve if the patient has tried both 1) fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) and 2) budesonide-formoterol aerosol (Symbicort, Breyna, generics) [if both are formulary or one if only one is formulary]. If none are formulary, approve. 6. Patients with COPD who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) if formulary. If fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. 7. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. <u>Note:</u> Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler and AirDuo RespiClick count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Dulera	mometasone/formoterol inhalation aerosol	1. Approve if the patient has tried budesonide-formoterol aerosol (Symbicort, Breyna, generics) if formulary. If none are formulary, approve. 2. Patient is < 6 years of age, approve. 3. Approve if the patient is pregnant AND currently receiving the requested medication for asthma.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	fluticasone propionate/salmeterol HFA	fluticasone propionate/salmeterol HFA	Direct to Advair HFA (brand), if formulary. If Advair HFA (brand) is non-formulary: 1. Approve if the patient has tried four of the following, if (four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 2. Patients < 18 years of age: approve if the patient has tried three of the following, if three are formulary (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 3. Patients with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the patient has tried both 1) budesonide-formoterol (Symbicort, Breyna, generics) and 2) Dulera (if both are formulary or one if only one is formulary). If neither are formulary, approve. 4. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. <u>Note:</u> Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler and AirDuo RespiClick count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	fluticasone propionate/salmeterol multidose dry powder inhaler	fluticasone propionate/salmeterol inhalation powder (authorized generic to AirDuo RespiClick)	1. Approve if the patient has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), Dulera or budesonide-formoterol (Symbicort, Breyna, generics). If none are formulary, approve. 2. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, or fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic). If none are formulary, approve. 3. Patients < 18 years of age: approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol, (Symbicort, Breyna, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, or Dulera. If none are formulary, approve. 4. Patients < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), or AirDuo RespiClick, if formulary. If neither are formulary, approve. 5. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. <u>Note:</u> Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Fluticasone-vilanterol	fluticasone furoate and vilanterol inhalation powder	Direct the patient to Breo Ellipta (brand), if formulary. If Breo Ellipta (brand) is non-formulary: 1. Approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), budesonide-formoterol aerosol (Symbicort, Breyna, generics), or Dulera. If none are formulary, approve. 2. Patients < 12 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), Dulera, or budesonide-formoterol aerosol (Symbicort, Breyna, generics). If none are formulary, approve. 3. Patients ≤ 5 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) or Dulera. If neither are formulary, approve. 4. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), if one is formulary. If neither are formulary, approve. a. Patient < 12 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): Approve if the patient has tried fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. 5. Patients with COPD: Approve if the patient has tried both 1) fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) and 2) budesonide-formoterol aerosol (Symbicort, Breyna, generics) [if both are formulary or one if only one is formulary]. If none are formulary, approve. 6. Patients with COPD who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) if formulary. If fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. 7. Approve if the patient is pregnant AND currently receiving the requested medication for asthma. <u>Note:</u> Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler and AirDuo RespiClick count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Advair Diskus	fluticasone propionate/salmeterol inhalation powder	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Symbicort	budesonide/formoterol inhalation aerosol	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory – Inhaled Corticosteroid (ICS)/ Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhaler	Breztri Aerosphere	budesonide/ glycopyrrolate/ formoterol fumarate inhalation aerosol	**1.** Approve if the patient has tried Trelegy Ellipta, if formulary. If Trelegy Ellipta is non-formulary, approve if the patient meets ONE of the following (A or B): A. If the patient has tried at least ONE LAMA/LABA combination product: Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat, Duaklir Pressair; OR Note: A trial of a LAMA & a LABA inhaler used as separate inhalers would count as a trial a combination product. Note: If no LAMA/LABA combination inhalers are formulary, approve. B. If the patient has tried at least ONE Inhaled Ccorticosteroid/LABA combination product: fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone-salmeterol diskus, Wixela (Advair Diskus, generics), fluticasone-vilanterol (Breo Ellipta, authorized generic), Dulera, fluticasone-salmeterol respiclock (AirDuo RespiClick, authorized generic), or budesonide-formoterol (Symbicort, Breyna, generics). Note: A trial of a corticosteroid inhaler & LABA inhaler used as separate inhalers would count as a trial a combination product. Note: If no Inhaled Corticosteroid/LABA combination inhalers are formulary, approve. **2.** Patients with asthma (≥ 18 years of age): Approve if the patient Trelegy Ellipta, if formulary. If Trelegy Ellipta is non-formulary, approve if the patient has tried at least ONE Inhaled Corticosteroid/LABA combination product: fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone-salmeterol diskus, Wixela (Advair Diskus, generics), fluticasone-vilanterol (Breo Ellipta, authorized generic), Dulera, fluticasone-salmeterol respiclock (AirDuo RespiClick, authorized generic), or budesonide-formoterol (Symbicort, Breyna, generics). Note: A trial of a corticosteroid inhaler & LABA inhaler used as separate inhalers would count as a trial a combination product. Note: If no Inhaled Corticosteroid/LABA combination inhalers are formulary, approve. **3.** Patients with asthma (< 18 years of age): Approve if the patient has tried at least ONE Inhaled Corticosteroid/LABA combination product: fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone-salmeterol diskus, Wixela (Advair Diskus, generics), fluticasone-vilanterol (Breo Ellipta, authorized generic), Dulera, fluticasone-salmeterol respiclock (AirDuo RespiClick, authorized generic), or budesonide-formoterol (Symbicort, Breyna, generics). Note: A trial of a corticosteroid inhaler & LABA inhaler used as separate inhalers would count as a trial a combination product. Note: If no Inhaled Corticosteroid/LABA combination inhalers are formulary, approve. **4.** If the patient is pregnant and is currently receiving the requested medication for asthma, approve. Corticosteroid inhalers: Alvesco, Arnuity Ellipta (or fluticasone ellipta [authorized generic]), Asmanex HFA, Asmanex Twisthaler, fluticasone diskus (Flovent Diskus, authorized generic), fluticasone HFA (Flovent HFA, authorized generic/s), Pulmicort Flexhaler, or beclomethasone HFA, or Qvar RediHaler. LAMA Inhalers: Incruse Ellipta (or umeclidiunium ellipta [authorized generic]), tiotropium inhaler (Spiriva HandiHaler, generics), Spiriva Respimat, Tudorza Pressair. LABA Inhalers: Serevent Diskus, Striverdi Respimat.	1 year
Respiratory – Inhaled Corticosteroid (ICS)/ Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhaler	Trelegy Ellipta	fluticasone furoate, umeclidinium, and vilanterol inhalation powder	**1.** Approve if the patient has tried Breztri Aerosphere, if formulary. If Breztri Aerosphere is non-formulary, approve meets ONE of the following (A or B): A. If the patient has tried at least ONE LAMA/LABA combination product: Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat, Duaklir Pressair; OR Note: A trial of a LAMA & a LABA inhaler used as separate inhalers would count as a trial a combination product. Note: If no LAMA/LABA combination inhalers are formulary, approve. B. If the patient has tried at least ONE Inhaled Corticosteroid/LABA combination product: fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone-salmeterol diskus, Wixela (Advair Diskus, generics), fluticasone-vilanterol (Breo Ellipta, authorized generic), Dulera, fluticasone-salmeterol respiclock (AirDuo RespiClick, authorized generic), or budesonide-formoterol (Symbicort, Breyna, generics). Note: A trial of a corticosteroid inhaler & LABA inhaler used as separate inhalers would count as a trial a combination product. Note: If no Inhaled Corticosteroid/LABA combination inhalers are formulary, approve. **2.** Patients with asthma: Approve if the patient has tried Breztri Aerosphere, if formulary. If Breztri Aerosphere is non-formulary, approve if the patient has tried at least ONE Inhaled Corticosteroid/LABA combination product: fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone-salmeterol diskus, Wixela (Advair Diskus, generics), fluticasone-vilanterol (Breo Ellipta, authorized generic), Dulera, fluticasone-salmeterol respiclock (AirDuo RespiClick, authorized generic), or budesonide-formoterol (Symbicort, Breyna, generics). Note: A trial of a corticosteroid inhaler & LABA inhaler used as separate inhalers would count as a trial a combination product. Note: If no Inhaled Corticosteroid/LABA combination inhalers are formulary, approve. **3.** If the patient is pregnant and is currently receiving the requested medication for asthma, approve. Corticosteroid inhalers: Alvesco, Arnuity Ellipta (or fluticasone ellipta [authorized generic]), Asmanex HFA, Asmanex Twisthaler, fluticasone diskus (Flovent Diskus, authorized generics), fluticasone HFA (Flovent HFA, authorized generic/s), Pulmicort Flexhaler, or beclomethasone HFA, or Qvar RediHaler. LAMA Inhalers: Incruse Ellipta (or umeclidinium ellipta [authorized generic]), tiotropium inhaler (Spiriva HandiHaler, generics), Spiriva Respimat, Tudorza Pressair. LABA Inhalers: Serevent Diskus, Striverdi Respimat.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory - Inhaled Phosphodiesterase (PDE)-3 and PDE-4 Inhibitor	Ohtuvayre	ensifentrine inhalation suspension	Chronic obstructive pulmonary disease (COPD) in a patient ≥ 18 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH of the following products used concurrently: 1) a Long-Acting Muscarinic Antagonist (LAMA) product AND a Long-Acting Beta-Agonist (LABA) product. LAMA/LABA Inhalers: Anoro Ellipta, Bevespi Aerosphere, Duaklir Pressair, Stiolto Respimat. LAMA Inhalers: Incruse Ellipta, tiotropium inhaler (Spiriva HandiHaler, generics), Spiriva Respimat, Tudorza Pressair. LABA Inhalers/Nebulized: Serevent Diskus, Striverdi Respimat, formoterol fumarate inhalation solution (Perforomist, generics). ICS/LABA Inhalers: fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone-salmeterol diskus, Wixela (Advair Diskus, generics), fluticasone-vilanterol (Breo Ellipta, authorized generic), Dulera, fluticasone-salmeterol respiclock (AirDuo RespiClick, authorized generic), AirDuo Digihaler, or budesonide-formoterol (Symbicort, generics).	1 year
Respiratory - Long-Acting Muscarinic Antagonist (LAMA) Inhalers	Incruse Ellipta	umeclidinium inhalation powder	Direct to umeclidinium ellipta (authorized generic of Incruse Ellipta), if formulary. If umeclidinium ellipta (authorized generic of Incruse Ellipta) is non-formulary, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) a tiotropium inhaler (Spiriva Respimat or tiotropium cap-inhaler [Spiriva HandiHaler, generics]), and 2) Tudorza Pressair. If neither are formulary, approve.	1 year
Respiratory - Long-Acting Muscarinic Antagonist (LAMA) Inhalers	umeclidinium ellipta	umeclidinium inhalation powder	Direct to Incruse Ellipta (brand), if formulary. If Incruse Ellipta (brand) is non-formulary, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) a tiotropium inhaler (Spiriva Respimat or tiotropium cap-inhaler [Spiriva HandiHaler, generics]), and 2) Tudorza Pressair. If neither are formulary, approve.	1 year
Respiratory - Long-Acting Muscarinic Antagonist (LAMA) Inhalers	Spiriva HandiHaler and generic	tiotropium bromide inhalation powder	Approve if the patient has tried tiotropium cap-inhaler (generic Spiriva HandiHaler), if formulary. If tiotropium cap-inhaler (generic Spiriva HandiHaler) is non-formulary or generic tiotropium cap-inhaler (generic Spiriva HandiHaler) is being requested, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products from the following list, if formulary (or one if one is formulary): Incruse Ellipta, Spiriva Respimat, or Tudorza Pressair. If none are formulary, approve.	1 year
Respiratory - Long-Acting Muscarinic Antagonist (LAMA) Inhalers	Spiriva Respimat	tiotropium bromide solution for inhalation	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products from the following list, if formulary (or one if one is formulary): Incruse Ellipta, tiotropium cap-inhaler (Spiriva HandiHaler, generics), or Tudorza Pressair. If none are formulary, approve. **2.** Patients who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): approve. **3.** Patients with asthma: approve.	1 year
Respiratory - Long-Acting Muscarinic Antagonist (LAMA) Inhalers	Tudorza Pressair	aclidinium bromide inhalation powder	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) a tiotropium inhaler (tiotropium cap-inhaler [Spiriva HandiHaler, generics], or Spiriva Respimat). If neither are formulary, approve.	1 year
Respiratory – Long-Acting Muscarinic Antagonist (LAMA) Nebulized	Yupelri	revefenacin inhalation solution	**1.** Approve if the patient has tried one formulary alternative from the following list: Incruse Ellipta, Spiriva Respimat, tiotropium cap inhaler (Spiriva HandiHaler, generics), or Tudorza Pressair. If none are formulary, approve. **2.** If, per the prescriber, the patient is unable to use a dry-powder inhaler (DPI) or a soft-mist inhaler (e.g., low inspiratory flow, unable to coordinate breath and actuation of device), approve.	1 year
Respiratory – Short-acting muscarinic antagonists	Atrovent HFA	ipratropium bromide inhalation aerosol	**1**. Approve if the patient has tried, or is currently taking, one long-acting bronchodilator (for example, Incruse Ellipta, Spiriva Respimat, tiotropium cap inhaler [Spiriva HandiHaler, generics], Tudorza Pressair, Stiolto Respimat, Bevespi Aerosphere, Duaklir Pressair, Anoro Ellipta, Trelegy Ellipta, Serevent Diskus, Striverdi Respimat, fluticasone-salmeterol inhaler [Advair HFA/Diskus, generics, authorized generics], AirDuo RespiClick, Breo Ellipta, Dulera, budesonide-formoterol inhaler, Breyna [Symbicort, generics]). **2.** Patients with chronic obstructive pulmonary disease (COPD): approve if, per the prescriber, the patient is experiencing ONLY occasional shortness of breath and does NOT require therapy with a long-acting bronchodilator, approve. **3.** Patient with asthma, approve if the patient has tried, or is currently taking a short-acting beta agonist (for example, albuterol, ProAir HFA, Ventolin HFA, Proventil HFA, Xopenex HFA, levoalbuterol HFA). **4.** Patient is transitioning from an ipratropium bromide nebulizing solution to Atrovent HFA, approve.	1 year
Respiratory Drugs - Other	Daliresp	roflumilast tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Respiratory Syncytial Virus (RSV) - Monoclonal antibody	Enflonsia	clesrovimab-cfor intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried or is unable to use Beyfortus. If Beyfortus is non-formulary, approve. **2.** Approve if Beyfortus is not available. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried or is unable to use Beyfortus. If Beyfortus is non-formulary, approve. **2.** Approve if Beyfortus is not available. 3. Approve if the patient meets both of the following (a and b): a. The requested medication is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month
Retinoid (oral)	Sohonos	palovarotene capsules	See standard *Sohonos Prior Authorization Policy* criteria.	See PA duration
Rett Syndrome Agents	Daybue and Daybue Stix	trofinetide oral solution	See standard *Neurology – Daybue Prior Authorization Policy* criteria.	See PA duration
Rituximab-containing Agents	Rituxan Hycela	rituximab and hyaluronidase human injection for subcutaneous use	**1.** Approve if the patient has tried one the following: Rituxan, Truxima, Ruxience, Riabni, but cannot continue to use the product. **2.** Approve if, according to the prescriber, cannot use rituximab intravenous due to an inability to obtain IV access. **3.** If the patient has already been started on or has previously received therapy with Rituxan Hycela, approve.	1 year
Rituximab-containing Agents	Riabni	rituximab-arrx intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried three of the following, if three are formulary (or one or two of the following, if one or two is formulary): Truxima, Rituxan intravenous, Ruxience; AND Note: If none are formulary, approve. B. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Rituximab-containing Agents	Rituxan	rituximab intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried three of the following, if three are formulary (or one or two of the following, if one or two is formulary): Truxima, Riabni, Ruxience; AND Note: If none are formulary, approve. B. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Rituximab-containing Agents	Ruxience	rituximab-pvvr intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried three of the following, if three are formulary (or one or two of the following, if one or two is formulary): Rituxan intravenous, Riabni, Truxima; AND Note: If none are formulary, approve. B. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Rituximab-containing Agents	Truxima	rituximab-abbs intravenous injection	Approve if the patient meets BOTH of the following (A and B): A. The patient has tried three of the following, if three are formulary (or one or two of the following, if one or two is formulary): Rituxan intravenous, Riabni, Ruxience; AND Note: If none are formulary, approve. B. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Rosacea Agents (Topical)	Zilxi	minocycline 1.5% topical foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one formulary product from three of the four groups below, if there is a formulary product in the group: Group 1: An topical azelaic acid product (azelaic acid 15% gel [Finacea 15% gel, generics], Finacea 15% foam, Azelex 20% cream); Group 2: A topical sodium sulfacetamide 10%/sulfur 5% product. (any generic sodium sulfacetamide10%/sulfur 5% product, Rosula); Group 3: A topical metronidazole product (metronidazole 0.75% or 1% [MetroGel, generics; MetroCream, generics; MetroLotion, generics, Noritate]); Group 4: a topical ivermectin product (generic ivermectin cream or Soolantra).	1 year
Rosacea Agents (Topical)	Mirvaso and brimonidine 0.33% topical gel	brimonidine 0.33% topical gel	Facial redness associated with rosacea. Approve if the patient has tried Rhofade, if formulary. If Rhofade is non-formulary, deny. **NOTE:** It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. **NOTE**: Both Rhofade and Mirvaso (and respective generics) are topical vasoconstrictors of blood vessels that treat ONLY the facial redness associated with rosacea and not the underlying inflammatory disease state of rosacea.	1 year
Rosacea Agents (Topical)	Rhofade	oxymetazoline 1% topical gel	Facial redness associated with rosacea. Approve if the patient has tried Mirvaso or generic brimonidine 0.33% gel, if formulary. If both Mirvaso and generic brimonidine 0.33% gel are non-formulary, deny. **NOTE:** It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Rosacea Agents (Topical)	Epsolay	benzoyl peroxide 5% cream	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products from the following list: azelaic acid 15% gel (Finacea 15% gel, generics), Finacea 15% foam, Azelex 20% cream, sodium sulfacetamide 10%/sulfur 5% (Rosula, generics), metronidazole 0.75% or 1% (MetroGel, generics; MetroCream, generics; Lotion, generics), ivermectin cream (Soolantra, generics), Noritate, or Zilxi, if two are formulary, or one if only one is formulary. If none are formulary, approve.	1 year
Rosacea Agents (Topical)	Noritate	metronidazole cream 1%	**1.** Direct the patient to a topical metronidazole product. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical metronidazole agent. Note: Examples of topical metronidazole products include metronidazole 0.75% cream (MetroCream, generics), metronidazole 0.75% or 1% gel (Metrogel, generics), metronidazole 0.75% lotion (MetroLotion, generics).	1 year
Rosacea Agents (Topical)	Finacea	azelaic acid 15% foam	**1.** Patients with rosacea: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three other topical agents for rosacea. Note: Examples include: Azelex 20% cream, sodium sulfacetamide 10%/sulfur 5% products such as cleansers, gels (Rosula, generics), metronidazole 0.75% or 1% products such as gels, creams, and lotions (MetroGel, generics; MetroLotion, generics; MetroCream, generics; Noritate), ivermectin cream (Soolantra, generics), Zilxi foam, azelaic acid 15% gel (Finacea 15% gel, generics). **2.** Patients with acne vulgaris: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three other prescription topical products for acne. Note: Examples include: topical antibiotic products (e.g., clindamycin, erythromycin, benzoyl peroxide); topical retinoids (tretinoin [Atralin/generics, Avita/generics, Retin-A/generics, Retin-A Micro, Tretin-X/generics], adapalene [Differin/generics], tazorotene {Tazorac 0.1% cream or 0.1% gel or Fabior 0.1% foam]; Azelex cream; azelaic acid 15% gel (Finacea 15% gel, generics); dapsone (Aczone, generics); sulfacetamide-containing products; combination products (Acanya, Veltin, clindamycin/tretinoin gel [Ziana, generics], other generics).	1 year
Sedative-Hypnotics and Related Agents	Hetlioz	tasimelteon capsules	Non-24-Hour Sleep Wake Disorder (Non-24). Approve if the patient meets all of the following criteria (i, ii, iii, iv, and v): i. Patient is ≥ 18 years of age; AND ii. Patient is totally blind with no perception of light; AND iii. Diagnosis of Non-24 is confirmed by meeting ONE of the following conditions (a or b): a) Assessment of at least one physiologic circadian phase marker; OR Note: Examples of physiologic circadian phase markers include measurement of urinary melatonin levels, dim light melatonin onset (as measured in blood or saliva), and assessment of core body temperature. b) If assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for ≥ 1 week plus evaluation of sleep logs recorded for ≥ 1 month; AND iv. Patient meets BOTH of the conditions (a and b): a) Patient has received at least 6 months of continuous therapy (i.e., 6 consecutive months of daily treatment) with melatonin under the guidance of a physician who specializes in the treatment sleep disorders; AND b) Patient had inadequate efficacy with melatonin therapy according to the prescriber; AND Note: Examples of efficacy with melatonin therapy include entrainment, clinically meaningful or significant increases in nighttime sleep, and clinically meaningful or significant decreases in daytime sleep. v. The medication is prescribed by, or in consultation with, a physician who specializes in the treatment of sleep disorders. Coverage of Hetlioz is not recommended in the following situations: Nighttime Sleep Disturbances in Smith-Magenis Syndrome (SMS).	6 months
Sedative-Hypnotics and Related Agents	Hetlioz LQ	tasimelteon oral suspension	No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Hetlioz LQ. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)	N/A
Sedative-Hypnotics and Related Agents	zolpidem 7.5 mg capsules (brand)	zolpidem 7.5 mg capsules	Approve if the patient has tried three of the following agents, if three are formulary (or two if two are formulary, or one if only one is formulary): zolpidem tablets (other strengths) [Ambien, Ambiren CR, generics], eszopiclone tablets (Lunesta, generics), or zaleplon. If none are formulary, approve.	1 year
Sedative-Hypnotics and Related Agents	Edluar	zolpidem sublingual tablets	**1.** Approve if the patient has tried three of the following, if three are formulary (or two if two are formulary, or one if only one is formulary): zolpidem (Ambien, Ambien CR, generics), eszopiclone tablets (Lunesta, generics), or zaleplon. If none are formulary, approve. **2.** Patients who cannot swallow or have difficulties swallowing solid oral dosage forms: approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Sedative-Hypnotics and Related Agents	Ambien	zolpidem tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Sedative-Hypnotics and Related Agents	Ambien CR	zolipidem extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Sedative-Hypnotics and Related Agents	Lunesta	eszopiclone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Sedative-Hypnotics and Related Agents	Rozerem	ramelteon tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Sedative-Hypnotics and Related Agents - Direct Acting Orexin Antagonist (DORA)	Belsomra	suvorexant tablets	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three of the following if three are formulary (or two if only two are formulary, or one if only one is formulary): zolpidem (Ambien, Ambien CR, generics), zaleplon (generics), eszopiclone tablets (Lunesta, generics), doxepin 3 mg/6 mg (Silenor, generics), Dayvigo, Quviviq, or ramelteon (Rozerem, generics). If none are formulary, approve. **2.** If the patient is ≥ 65 years of age, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following: Dayvigo or Quviviq, if formulary. If neither are formulary, approve.	1 year
Sedative-Hypnotics and Related Agents - Direct Acting Orexin Antagonist (DORA)	Dayvigo	lemborexant tablets	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three of the following if three are formulary (or two if only two are formulary, or one if only one is formulary): zolpidem (Ambien,Ambien CR, generics), zaleplon (generics), eszopiclone tablets (Lunesta, generics), doxepin 3 mg/6 mg (Silenor, generics), Belsomra, Quviviq, or ramelteon (Rozerem, generics). If none are formulary, approve. **2.** If the patient is ≥ 65 years of age, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following: Belsomra or Quviviq, if formulary. If neither are formulary, approve.	1 year
Sedative-Hypnotics and Related Agents - Direct Acting Orexin Antagonist (DORA)	Quviviq	daridorexant tablets	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three of the following if three are formulary (or two if only two are formulary, or one if only one is formulary): zolpidem (Ambien, Ambien CR, generics), zaleplon (generics), eszopiclone tablets (Lunesta, generics), doxepin 3 mg/6 mg (Silenor, generics), Belsomra, Dayvigo, or ramelteon (Rozerem, generics). If none are formulary, approve. **2.** If the patient is ≥ 65 years of age, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following: Dayvigo or Belsomra, if formulary. If neither are formulary, approve.	1 year
Selective 5HT1A Receptor Agonist	Exxua	gepirone extended-release tablets	**1.** Approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR significant intolerance with THREE other antidepressants. Note: Examples of other antidepressants include selective serotonin reuptake inhibitors (citalopram, fluvoxamine, escitalopram, fluoxetine, sertraline, etc.), selective serotonin norepinephrine reuptake inhibitors (venlafaxine, desvenlafaxine, duloxetine, etc.), tertiary amine tricyclic antidepressant (amitriptyline, etc.), bupropion, mirtazapine, nefazodone, trazodone, Trintellix, vilazodone (Viibryd, generics). Note: Two antidepressants in the same class would count as two antidepressants. **2.** Patient is currently taking or has taken Exxua at any time in the past: approve. **3.** Suicidal ideation: approve.	1 year
Selective Estrogen Receptor Modifiers and Antiestrogens	Soltamox	tamoxifen oral solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried tamoxifen tablets, if formulary. If tamoxifen tablets are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tamoxifen tablets. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried tamoxifen tablets, if formulary. If tamoxifen tablets are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tamoxifen tablets. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of breast cancer for a patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Selective Estrogen Receptor Modifiers and Antiestrogens	Osphena	ospemifene tablets	Approve if the patient has tried one vaginal estrogen product from the following list (if one is formulary): estradiol cream (Estrace cream, generics), Femring vaginal ring, Premarin vaginal cream, Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), or Imvexxy If none are formulary, approve.	1 year
Selective Estrogen Receptor Modifiers and Antiestrogens - Medications for the Primary Prevention of Breast Cancer	Evista	raloxifene	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the requested non-formulary drug is being prescribed for the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS) AND, according to the prescriber, other formulary alternatives would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year
Selective Estrogen Receptor Modifiers and Antiestrogens - Medications for the Primary Prevention of Breast Cancer	tamoxifen tablets	tamoxifen tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the requested non-formulary drug is being prescribed for the primary prevention of breast cancer for a patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS) AND, according to the prescriber, other formulary alternatives would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Selective Serotonin Reuptake Inhibitor (SSRI) and a Serotonin (5HT)2 Receptor Antagonist	Raldesy	trazodone hydrochloride oral solution	**1.** Approve if the patient has tried trazodone tablets, if formulary. If trazodone tablets are non-formulary, approve. **2.** Approve if the patient has difficulty swallowing tablets or the patient cannot swallow tablets.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	escitalopram 15 mg capsules (brand)	escitalopram 15 mg capsules	Approve if the prescribed dose cannot be obtained with whole escitalopram tablets. Note: The patient is NOT required to split tablets in half.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	paroxetine mesylate 7.5 mg capsules (generic for Brisdelle)	paroxetine mesylate 7.5 mg capsules	Approve if the patient has tried one other strength of generic paroxetine. If generic paroxetine tablets are non-formulary, approve. Note: If the patient has tried a brand version of a generic product, then this would satisfy the requirement.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	Viibryd 10/20 mg starter pack	vilazodone tablets	Approve if the patient is unable to use vilazodone tablets (which are not packaged in a starter pack).	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	citalopram 30 mg capsules	citalopram capsules	**1.** Direct to citalopram 10 mg or 20 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the citalopram 10 mg and/or 20 mg tablets.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	Trintellix	vortioxetine tablets	**1.** Approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR significant intolerance with two formulary SSRIs from the following list (if two if two are formulary, or one if one is formulary): citalopram (Celexa, generics), fluvoxamine (generics) escitalopram (Lexapro, generics), fluoxetine (Prozac, generics), sertraline (Zoloft, generics), paroxetine HCl (Paxil, Paxil CR, generics), or vilazodone (Viibryd, generics). If none are formulary, approve. **2.** Patient is currently taking or has taken Trintellix at any time in the past: approve. **3.** Suicidal ideation: approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	Celexa	citalopram tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	Lexapro	escitalopram oxalate tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	Prozac	fluoxetine HCl pulvules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	Viibryd (non- starter pack) 10 mg, 20 mg, 40 mg	vilazodone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Selective Serotonin Reuptake Inhibitors (SSRIs)	Zoloft	sertraline HCl tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Savella	milnacipran tablets	Approve if the patient has tried duloxetine capsules (Cymbalta, generics), if formulary. If duloxetine capsules are non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Desvenlafaxine ER	desvenlafaxine extended-release tablets	**1.** Approve if the patient has tried two products from the following list (if two are formulary; or one if one is formulary): Fetzima, Drizalma Sprinkle, desvenlafaxine succinate extended-release (ER) [Pristiq, generics], venlafaxine ER capsules (Effexor XR, generics), duloxetine capsules (Cymbalta, generics), or venlafaxine extended-release tablets. If none are formulary, approve. **NOTE:** If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Patient is currently taking or has taken Desvenlafaxine at any time in the past: approve. **3.** Suicidal ideation: approve.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Drizalma Sprinkle	duloxetine delayed-release capsules	**1.** Approve if the patient has tried one product from the following list (if one is formulary): duloxetine capsules (Cymbalta, generics), Fetzima, desvenlafaxine succinate extended-release (ER) [Pristiq, generics], venlafaxine ER capsules (Effexor XR, generics), or venlafaxine extended-release tablets. If none are formulary, approve. **NOTE**: If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the patient is unable to swallow, has difficulty swallowing, or requires administration via a nasogastric tube.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Fetzima	levomilnacipran extended-release capsules	**1.** Approve if the patient has tried two products from the following list (if two are formulary; or one if one is formulary): desvenlafaxine succinate ER (Pristiq, generics), Drizalma Sprinkle, venlafaxine ER capsules (Effexor XR, generics), duloxetine capsules (Cymbalta, generics), or venlafaxine ER tablets. If none are formulary, approve. **NOTE:** If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the patient is currently taking or has taken Fetzima at any time in the past. **3.** Suicidal ideation: approve.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Venlafaxine besylate ER 112.5 mg (formerly Venbysi XR)	venlafaxine extended-release 112.5 mg tablets	**1.** Approve if the patient has tried two products from the following list (if two are formulary; or one if one is formulary): desvenlafaxine succinate ER (Pristiq, generics), Fetzima, Drizalma Sprinkle, venlafaxine ER capsules (Effexor XR, generics), duloxetine capsules (Cymbalta, generics), or venlafaxine ER tablets. If none are formulary, approve. NOTE: If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the patient is currently taking or has taken venlafaxine besylate ER at any time in the past. **3.** Suicidal ideation: approve.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Duloxetine (higher strengths) capsules (brand)	duloxetine capsules 80 mg, 90 mg, 120 mg	**1.** Approve if the patient has tried and cannot take duloxetine capsules (Cymbalta, generics). If duloxetine capsules (Cymbalta, generics) are non-formulary, approve. **2.** Approve if the patient requires a dose of duloxetine > 60 mg daily.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Cymbalta	duloxetine HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Effexor XR	venlafaxine HCl extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Pristiq	dexvenlafaxine succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Short-Acting Beta-Agonists (Inhaled)	ProAir Digihaler	albuterol sulfate inhalation powder	**1.** Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried ProAir Respiclick, if formulary. If ProAir Respiclick is non-formulary, approve.	1 year
Short-Acting Beta-Agonists (Inhaled)	ProAir Respiclick	albuterol sulfate inhalation powder	**1.** Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried ProAir Digihaler, if formulary. If ProAir Digihaler is non-formulary, approve.	1 year
Short-Acting Beta-Agonists (Inhaled)	Ventolin HFA and authorized generic	albuterol sulfate inhalation aerosol	Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve.	1 year
Short-Acting Beta-Agonists (Inhaled)	Xopenex HFA and levalbuterol HFA	levalbuterol inhalation aerosol	Approve if the patient has tried one single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve.	1 year
Sickle Cell Disease Agents	Endari	L-glutamine oral powder	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Sickle Cell Disease Agents	Adakveo	crizanlizumab-tmca injection for intravenous use	See standard *Sickle Cell Disease - Adakveo PA Policy* criteria.	See PA duration
Sickle Cell Disease Agents – Gene Therapy	Lyfgenia	lovotibeglogene autotemcel intravenous infusion	Patient meets the standard *Hematology – Gene Therapy – Lyfgenia Prior Authorization Policy* criteria AND Patient meets ONE of the following (1 or 2): **1.** If Casgevy is non-formulary, approve; OR **2.** If Casgevy if not available at the patient's treatment facility or treatment center, approve. If the patient does not meet 1 or 2 above, direct the patient to Casgevy. All reviews (approvals and denials) will be forwarded to the Medical Director for evaluation.	See PA duration
Sickle Cell Disease Agents – Gene Therapy	Casgevy	exagamglogene autotemcel	Patient meets the standard *Hematology – Gene Therapy – Casgevy Prior Authorization Policy* criteria AND criteria below for either Sickle Cell Disease OR Transfusion-Dependent Beta-Thalassemia. For Sickle Cell Disease: Patient meets ONE of the following (1, 2, 3, 4, or 5): **1.** If patient is < 12 years of age, approve; OR **2.** If Lyfgenia is non-formulary, approve; OR **3.** If the patient has more than two alpha-globin gene deletions, approve; OR **4.** If patient has an alpha-thalassemia trait, approve; OR **5.** If Lyfgenia is not available at the patient's treatment facility or treatment center, approve. If the patient does not meet 1, 2, 3, 4, or 5 above, direct the patient to Lyfgenia. For Transfusion-Dependent Beta-Thalassemia: Patient meets ONE of the following (1 or 2): **1.** If patient is < 4 years of age, approve; OR **2.** If Zynteglo is non-formulary, approve; OR **3.** If Zynteglo is not available at the patient's treatment facility or treatment center, approve. If the patient does not meet 1, 2, or 3 above, direct the patient to Zynteglo. All reviews (approvals and denials) will be forwarded to the Medical Director for evaluation.	See PA duration
Sickle Cell Disease Agents – Hydroxyurea Agents	Droxia	hydroxyurea capsules	Approve if the patient has tried Siklos, if formulary. If Siklos is non-formulary, approve.	1 year
Sickle Cell Disease Agents – Hydroxyurea Agents	Siklos	hydroxyurea tablets	**1.** Approve is the patient has tried Droxia, if formulary. If Droxia is non-formulary, approve. **2.** If the patient requires Siklos 100 mg or 1,000 mg tablets to achieve a dosage that cannot be achieved with the available strengths of Droxia, approve. **3.** If the patient cannot swallow Droxia capsules or has difficulty swallowing Droxia capsules, approve.	1 year
Sickle Cell Disease Agents – Hydroxyurea Agents	Xromi	hydroxyurea oral solution	**1.** Approve if the patient has tried one of Droxia or Siklos, if formulary. If neither are formulary, approve. **2.** Patient < 2 years of age, approve. **3.** If the patient is unable to swallow tablets or capsules OR has difficulty swallowing tablets or capsules, approve.	1 year
Smoking and Tobacco Cessation Products	Chantix, Nicorette, Nicotrol NS, Nicotrol Inhaler, Nicoderm CQ, Zyban	varenicline, nictone gum/lozenge, nicotine nasal spray, nicotine oral inhaler, nicotine transdermal, bupropion SR	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required.* Approve if the patient meets all of the following criteria (i, ii, and iii): i. The patient is greater than or equal to 18 years of age; AND ii. The patient is not pregnant; AND iii. The patient meets one of the following (a or b): a. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with the preferred formulary alternatives; OR b. According to the prescriber, other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug. *Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Sodium Hydrogen Exchanger 3 Inhibitor	Xphozah	tenapanor tablets	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried at least two phosphate binders; AND Note: Examples of phosphate binders include: sevelamer, lanthanum, ferric citrate, and sucroferric oxyhydroxide, calcium carbonate, and calcium acetate. B. Patient had an inadequate response and/or intolerance to at least two phosphate binders; OR **2.** Patient meets one of the following (A or B): A. Patient has a contraindication to at least two phosphate binders; OR Note: Contraindication to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia. B. Patient meets BOTH of the following (i and ii): i. Patient has inadequate response and/or intolerance to at least one phosphate binder; AND ii. Patient has a contraindications to at least one phosphate binder. Note: Contraindication to phosphate binders include bowel obstruction, iron overload, or hypercalcemia.	1 year
Somatostatin Analogs	Signifor	pasireotide SQ injection	**1.** Cushing's Disease. Approve if the patient has tried Signifor LAR, if formulary. If Signifor LAR is non-formulary, approve. **2.** Endogenous Cushing's Syndrome. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. Approve if patient has tried Signifor LAR, if formulary. If Signifor LAR is non-formulary, approve.	1 year
Somatostatin Analogs	Mycapssa	octreotide delayed-release capsules	Acromegaly. Approve if the patient has tried two of Palsonify, octreotide ER injectable suspension (Sandostatin LAR Depot, generics), Somatuline Depot, or lanreotide subcutaneous injection, if formulary (or one if one is formulary). If none are formulary, approve. Note: Octreotide ER injectable suspension and Sandostatin LAR Depot count as one alternative. Somatuline Depot and lanreotide subcutaneous injection count as one alternative. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Somatostatin Analogs	Signifor LAR	pasireotide IM injection	Acromegaly. Approve if the patient has tried two of Palsonify, octreotide ER injectable suspension (Sandostatin LAR Depot, generics), Somatuline Depot, or lanreotide subcutaneous injection, if formulary (or one if one is formulary). If none are formulary, approve. Note: Octreotide ER injectable suspension and Sandostatin LAR Depot count as one alternative. Somatuline Depot and lanreotide subcutaneous injection count as one alternative. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. Cushing's Disease. Approve if the patient has tried Signifor (not LAR). If Signifor (not LAR) is non-formulary, approve. Endogenous Cushing's Syndrome. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. Approve if patient has tried Signifor (not LAR), if formulary. If Signifor (not LAR) is non-formulary, approve.	1 year
Somatostatin Analogs	Bynfezia Pen	octreotide acetate injection for subcutaneous use	Approve if the patient has tried octreotide acetate injection (Sandostatin, generics) [NOT long-acting], if formulary. If octreotide acetate injection (Sandostatin, generics) [NOT long-acting] is non-formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Somatostatin Analogs	Sandostatin LAR Depot and generic octreotide ER injectable suspension	octreotide ER injectable suspension	If requesting brand Sandostatin LAR Depot: Approve if the brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent generic products, generic octreotide ER injectable suspension, if the generic is formulary. If requesting generic octreotide ER injectable suspension or generic octreotide ER injectable suspension is non-formulary: Acromegaly. Approve if the patient has tried one of Palsonify, Somatuline Depot, or lanreotide subcutaneous injection, if formulary. If none are formulary, approve. Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas). **1.** Approve if the patient has tried one of Somatuline Depot or lanreotide subcutaneous injection, if formulary. If neither are formulary, approve. **2.** Patient has already been started on therapy with Sandostatin LAR Depot or octreotide ER injectable suspension, approve. Pheochromocytoma/Paraganglioma. **1.** Approve if the patient has tried one of Somatuline Depot or lanreotide subcutaneous injection, if formulary. If neither are formulary, approve. **2.** Patient has already been started on therapy with Sandostatin LAR Depot or octreotide ER injectable suspension, approve. Diarrhea Associated with Chemotherapy; Enterocutaneous Fistula; Meningioma; Merkel Cell Carcinoma; Pancreatic Fistula; Small Bowel Bleeds/Angiodysplasia Related Bleeding; Thymoma/Thymic Carcinoma: Approve.	1 year
Somatostatin Analogs	lanreotide subcutaneous injection [Cipla]	lanreotide subcutaneous injection	Acromegaly. Approve if the patient has tried one of Palsonify, octreotide ER injectable suspension (Sandostatin LAR Depot, generics), or Somatuline Depot, if formulary. If none are formulary, approve. Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas). **1.** Approve if the patient has tried one of octreotide ER injectable suspension (Sandostatin LAR Depot, generics) or Somatuline Depot, if formulary. If none are formulary, approve. **2.** Patient has already been started on therapy with lanreotide subcutaneous injection, approve if the patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve. Pheochromoctoma/paraganglioma. **1.** Approve if the patient has tried one of octreotide ER injectable suspension (Sandostatin LAR Depot, generics) or Somatuline Depot, if formulary. If none are formulary, approve. **2.** Patient has already been started on therapy with lanreotide subcutaneous injection, approve if the patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve. Carcinoid syndrome; Thyroid stimulating hormone (TSH) – secreting Sellar Tumor(s); Small bowel bleeds/angiodysplasia related bleeding. Approve if the patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Somatostatin Analogs	Somatuline Depot	lanreotide injection	Acromegaly. Approve if the patient has tried one of Palsonify, octreotide ER injectable suspension (Sandostatin LAR Depot, generics), or lanreotide subcutaneous injection, if formulary. If none are formulary, approve. Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas). **1.** Approve if the patient has tried one of octreotide ER injectable suspension (Sandostatin LAR Depot, generics) or lanreotide subcutaneous injection, if formulary. If none are formulary, approve. **2.** Patient has already been started on therapy with Somatuline Depot, approve if the patient has tried lanreotide subcutaneous injection, if formulary. If lanreotide subcutaneous injection is non-formulary, approve. Pheochromoctoma/Paraganglioma. **1.** Approve if the patient has tried one of octreotide ER injectable suspension (Sandostatin LAR Depot, generics) or lanreotide subcutaneous injection, if formulary. If none are formulary, approve. **2.** Patient has already been started on therapy with Somatuline Depot, approve if the patient has tried lanreotide subcutaneous injection, if formulary. If lanreotide subcutaneous injection is non-formulary, approve. Carcinoid Syndrome; Thyroid stimulating hormone (TSH) – secreting Sellar Tumor(s); Small Bowel Bleeds/Angiodysplasia Related Bleeding. Approve if the patient has tried lanreotide subcutaneous injection, if formulary. If lanreotide subcutaneous injection is non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Somatostatin Receptor Agonist	Palsonify	paltusotine tablets	Acromegaly. Approve if the patient has tried one of octreotide ER injectable suspension (Sandostatin LAR Depot, generics), Somatuline Depot, or lanreotide subcutaneous injection, , if formulary. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Spinal Muscular Atrophy Agents	Itvisma	onasemnogene abeparvovec-brve intrathecal injection	See standard *Spinal Muscular Atrophy – Gene Therapy – Itvisma Prior Authorization Policy* criteria.	See PA duration
Spinal Muscular Atrophy Agents	Zolgensma	onasemnogene abeparvovec-xioi intravenous infusion	See standard *Spinal Muscular Atrophy – Gene Therapy – Zolgensma Prior Authorization Policy* criteria.	See PA duration
Spinal Muscular Atrophy Agents	Evrysdi	risdiplam oral solution and tablets	Patient meets the following: *Spinal Muscular Atrophy – Evrysdi Prior Authorization Policy* criteria AND Patient meets ONE of the following (1, 2, 3, or 4): **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Spinraza. If Spinraza is non-formulary, approve. **2.** Approve if, according to the prescribing physician, the patient is not a candidate for Spinraza (e.g., patient has decreased renal function or another related condition [glomerulonephritis] or it at risk for renal toxicity; patient has a low platelet count, is at risk for bleeding complications, or is at risk for thrombocytopenia/coagulation abnormalities) or Spinraza is contraindicated. **3.** Approve if, according to the prescribing physician, the patient is 1) not a candidate for intrathecal administration OR 2) the patient is unable to receive intrathecal administration, OR 3) intrathecal administration is not clinically suitable for the patient. **4.** Approve if the patient has already been started on Evrysdi.	See PA duration
Spinal Muscular Atrophy Agents	Spinraza	nusinersen intrathecal injection	Patient meets the following: *Spinal Muscular Atrophy – Spinraza Prior Authorization Policy* criteria AND Patient meets ONE of the following (1, 2, or 3): **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Evrysdi. If Evrysdi is non-formulary, approve. **2.** According to the prescribing physician, approve if the patient is not a candidate for Evrysdi or Evrysdi is contraindicated. **3.** Approve if the patient has already been started on Spinraza.	See PA duration
Steroid Products (Vaginal)	Intrarosa	prasterone vaginal inserts	**1.** Approve if the patient has tried one formulary alternative from the following list: Imvexxy, Femring vaginal ring, Premarin Cream, Estring vaginal ring, estradiol 0.01% cream (Estrace cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** Approve if, according to the prescriber, the patient is at an increased risk of endometrial cancer, stroke, or deep vein thrombosis (DVT).	1 year
Substance P/Neurokinin-1 (NK-1) Receptor Antagonist	Nereus	tradipitant capsules	Approve if the patient meets BOTH of the following (A and B): A. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried scopolamine patches: OR Note: A trial of brand or generic would satisfy criteria. ii. Scopolamine patches are non-formulary; OR iii. According to the prescriber, scopolamine patches are not appropriate due to the potential for adverse events; AND Note: Examples of potential for adverse events include a patient with open-angle glaucoma, significant benign prostatic hyperplasia, or history of urinary retention. B. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried promethazine oral tablets; OR Note: A trial of brand or generic would satisfy criteria. ii. Promethazine oral tablets are non-formulary; OR iii. According to the prescriber, promethazine tablets are not appropriate due to the potential for adverse events. Note: Examples of potential adverse events include a patient with a history of severe central nervous system depression, respiratory depression, patient older than 65 years of age and is considered a high risk for falls or delirium.	1 year
Testosterone Products (Injectable)	Aveed	testosterone undecanoate for intramuscular use	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone enanthate injection [generics], testosterone cypionate injection [Depo-Testosterone, generics], Azmiro, or Xyosted. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Testosterone Products (Injectable)	Azmiro	testosterone cypionate for intramuscular injection	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone cypionate injection (Depo-Testosterone, generics) or testosterone enanthate injection (generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Testosterone Products (Injectable)	Testopel	testosterone pellet for injection	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone cypionate injection (Depo-Testosterone, generics), testosterone enanthate injection (generics), Azmiro, or Xyosted. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Testosterone Products (Injectable)	Xyosted	testosterone enanthate subcutaneous injection	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone cypionate injection (Depo-Testosterone, generics), testosterone enanthate injection (generics), or Azmiro. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year
Testosterone Products (Oral)	Kyzatrex and Undecatrex	testosterone undecanoate capsules	Approve if the patient has tried both of Jatenzo and Tlando capsules, if formulary (or one if one is formulary). If neither are non-formulary, approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).	1 year
Testosterone Products (Oral)	Jatenzo	testosterone undecanoate oral capsules	**1**. Approve if the patient meets BOTH of the following, if formulary (or one if one is formulary) [a and b]: a. Patient has tried Tlando, if formulary; AND b. Patient has tried one of Kyzatrex or Undecatrex, if formulary. Note: Kyzatrex and Undecatrex count as one alternative. **2**. If neither are formulary, approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).	1 year
Testosterone Products (Oral)	Tlando	testosterone undecanoate oral capsules	**1**. Approve if the patient meets BOTH of the following, if formulary (or one if one is formulary) [a and b]: a. Patient has tried Jatenzo, if formulary; AND b. Patient has tried one of Kyzatrex or Undecatrex, if formulary. Note: Kyzatrex and Undecatrex count as one alternative. **2**. If neither are formulary, approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).	1 year
Testosterone Products (Topical)	Natesto	testosterone nasal gel	Approve if the patient has tried three other topical testosterone products (e.g., Androgel 1% or generics, Axiron [generics only], Androgel 1.62% or generics, Fortesta or generics, Testim or generics, Vogelxo or generics.)	1 year
Testosterone Products (Topical)	Vogelxo	testosterone gel	Approve if the patient has tried three other topical testosterone products (e.g., Androgel 1% or generics, Axiron [generics only], Androgel 1.62% or generics, Fortesta or generics, Testim or generics.)	1 year
Testosterone Products (Topical)	Androgel	testosterone 1% gel packets and pump, 1.62% (2021)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Testosterone Products (Topical)	Testim	testosterone gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Tetracycline-Derivatives - Oral Agents for Rosacea	Oracea and doxycycline 40 mg capsules (authorized generic of Oracea)	doxycycline 40 mg capsules	Inflammatory Rosacea. Approve if the patient meets both of the following (A and B): A. Patient has tried two of the following: 1) a topical metronidazole-containing product, 2) a topical azelaic acid-containing product or 3) topical ivermectin; AND B. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, has experienced inadequate efficacy with one other generic, oral doxycycline product after a 4 week duration with the product; OR ii. Patient has tried, and according to the prescriber, has experienced a significant intolerance with one other generic, oral doxycycline product.	9 months
Tetracycline-Derivatives -Oral Agents for Rosacea	Emrosi	minocycline extended-release capsules	Inflammatory Rosacea. Approve if the patient meets both of the following (A and B): A. Patient has tried two of the following: 1) a topical metronidazole-containing product, 2) a topical azelaic acid-containing product or 3) topical ivermectin; AND B. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, has experienced inadequate efficacy with one other generic, oral minocycline product after a 4 week duration with the product; OR ii. Patient has tried, and according to the prescriber, has experienced a significant intolerance with one other generic, oral minocycline product.	1 year
Thiazide Diuretics	Inzirqo	hydrochlorothiazide oral suspension	**1.** Approve if the patient tried and cannot take hydrochlorothiazide tablets or capsules. If hydrochlorothiazide tablets and capsules are non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or capsules or has difficulty swallowing tablets or capsules. **3.** Approve if the prescribed dose cannot be obtained with whole tablets or capsules of any hydrochlorothiazide strengths.	1 year
Thiazide-like Diuretics	Hemiclor	chlorthalidone 12.5 mg tablets	**1.** Direct the patient to generic chlorthalidone tablets. Generics available as 25 mg, 50 mg. Note: The patient is not required to split tablets. **2.** Approve if the prescribed dose cannot be obtained with the 25 mg and/or 50 mg strength tablets.	1 year
Thiazide-like Diuretics	Thalitone 15 mg	chlorthalidone 15 mg tablets	**1.** Direct the patient to generic chlorthalidone tablets. Generics available as 25 mg, 50 mg. **2.** Approve if the prescribed dose cannot be obtained with the 25 mg and/or 50 mg strength tablets. Note: Patient is not required to split tablets	1 year
Thiotepa Injectable Products	Tepadina	thiotepa intravenous	Breast Cancer; Ovarian Cancer, Hematopoietic Cell Transplantation, Primary Central Nervous System Lymphoma: approve if the patient has tried and cannot take one of the following: generic thiotepa injection or Tepylute, if formulary. If neither are formulary, approve. Other Indications: approve if the patient has tried and cannot take generic thiotepa injection, if formulary. If not formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Thiotepa Injectable Products	Tepylute	thiotepa intravenous	Approve if the patient has tried and cannot take one of the following: generic thiotepa injection or Tepadina, if formulary. If neither are formulary, approve.	1 year
Thrombocytopenia agents	Doptelet Sprinkle	avatrombopag oral granules	Immune Thrombocytopenia. **1.** Approve if the patient has tried ONE of the following: 1) eltrombopag olamine oral suspension (Promacta suspension, generics) OR 2) Nplate. If neither are formulary, approve. Note: If the patient has tried eltrombopag olamine tablets (Promacta tablets, generics) or Alvaiz, this would also satisfy the requirement. **2.** Approve if the patient has already been started on therapy with Doptelet Sprinkle or tablets.	1 year
Thrombocytopenia agents	Doptelet tablets	avatrombopag tablets	Immune Thrombocytopenia. **1.** Approve if the patient has tried ONE of the following: 1) an eltrombopag product (eltrombopag olamine [Promacta tablets/oral suspension, generics], Alvaiz) OR 2) Nplate. If none are formulary, approve. **2.** Patient is <18 years of age, approve if the patient has tried ONE of the following products: 1) an eltrombopag product (eltrombopag olamine [Promacta tablets/oral suspension, generics], Alvaiz) OR 2) Nplate. If none are formulary, approve. **3.** Patient is < 6 years of age, approve if the patient has tried ONE of the following: 1) eltrombopag olamine (Promacta tablets/suspension, generics) OR 2) Nplate. If neither are formulary, approve. 4. Approve if the patient has already been started on therapy with Doptelet tablets or Doptelet Sprinkle. Doptelet is being used pre-procedure and the patient has thrombocytopenia and chronic liver disease. **1.** Approve if the patient has tried Mulpleta, if formulary. If Mulpleta is non-formulary, approve. **2.** Approve if the patient has already started a course of therapy with Doptelet in order to finish the course.	1 year
Thrombocytopenia agents	Nplate	romiplostim for subcutaneous injection	Immune Thrombocytopenia. **1.** Approve if the patient has tried ONE of the following: 1) an eltrombopag product (eltrombopag olamine [Promacta tablets/oral suspension, generics], Alvaiz) OR 2) Doptelet tablets or Doptelet Sprinkle. If none are formulary, approve. Note: If the patient cannot swallow solid oral dosage forms and neither eltrombopag olamine suspension (Promacta oral suspension) nor Doptelet Sprinkle are formulary, approve. **2.** Patient is < 6 years of age, approve if the patient has tried ONE of the following: 1) eltrombopag olamine (Promacta tablets/oral suspension, generics) OR 2) Doptelet tablets or Doptelet Sprinkle. If none are formulary, approve. Note: If the patient cannot swallow solid oral dosage forms and neither eltrombopag olamine suspension (Promacta oral suspension) nor Doptelet Sprinkle are formulary, approve. **3.** Approve if the patient has already been started on therapy with Nplate. Hematopoietic Syndrome of Acute Radiation Syndrome; Chemotherapy-Induced Thrombocytopenia; Thrombocytopenia in Myelodysplastic Syndrome; Thrombocytopenia due to Immune Checkpoint Inhibitor Therapy: Approve. Note: Examples of checkpoint inhibitors are Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Yervoy (ipilimumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Bavencio (avelumab intravenous infusion), Imfinzi (durvalumab intravenous infusion), and Libtayo (cemiplimab-rwlc intravenous infusion).	1 year
Thrombocytopenia agents	Tavalisse	fostamatinib disodium hexahydrate tablets	Immune Thrombocytopenia. **1.** Approve if the patient has tried TWO of the following: 1) an eltrombopag product (eltrombopag olamine [Promacta tablets/oral suspension, generics], Alvaiz), 2) Nplate, OR 3) Doptelet tablets. If none are formulary, approve. Note: Doptelet Sprinkle would also count as a trial of Doptelet. Note: The patient would not be required to try two different eltrombopag products if those are the only formulary alternatives. **2.** Approve if the patient has already been started on therapy with Tavalisse.	1 year
Thrombocytopenia agents	Wayrilz	rilzabrutinib tablets	Immune Thrombocytopenia. **1.** Approve if the patient has tried, or is currently taking, ONE of the following: eltrombopag olamine (Promacta, generics), Alvaiz, Nplate, or Doptelet. If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Wayrilz.	1 year
Thrombocytopenia agents	Mulpleta	lusutrombopag tablets	Mulpleta is being used pre-procedure and the patient has thrombocytopenia and chronic liver disease. **1.** Approve if the patient has tried Doptelet, if formulary. If Doptelet is non-formulary, approve. **2.** Approve if the patient has already started a course of therapy with Mulpleta in order to finish the course.	1 month
Thrombocytopenia agents	Promacta	eltrombopag tablets and oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Thrombocytopenia agents	Alvaiz	eltrombopag choline tablets	Immune Thrombocytopenia. **1.** Approve if the patient has tried ONE of 1) eltrombopag olamine (Promacta tablets, generics), 2) Nplate, OR 3) Doptelet tablets. If none are formulary, approve. Note: If the patient has tried eltrombopag olamine oral suspension (Promacta oral suspension) or Doptelet Sprinkle this counts toward an approval. **2.** Approve if the patient has already been started on therapy with Alvaiz. Aplastic Anemia; Hematologic Toxicity in a Patient Receiving Immune Effector Cell Therapies; Thrombocytopenia in a Patient with Chronic Hepatitis C; Thrombocytopenia in a Patient with Myelodysplastic Syndrome; Thrombocytopenia in a Patient Post-Allogeneic Transplantation; Thrombocytopenia due to Immune Checkpoint Inhibitor Therapy. **1.** Approve if the patient has tried eltrombopag olamine (Promacta tablets, generics). If eltrombopag olamine (Promacta tablets, generics) are non-formulary, approve. Note: If the patient has tried eltrombopag olamine oral suspension (Promacta oral suspension) this counts toward an approval. **2.** Approve if the patient has already been started on therapy with Alvaiz.	1 year
Thymidine Kinase 2 Deficiency Agents	Kygevvi	doxecitine and doxribtimine powder for oral solution	See standard *Kygevvi Prior Authorization Policy* criteria.	See PA duration
Thyroid Supplements	Thyquidity	levothyroxine sodium oral solution	**1.** Approve if the patient has tried four formulary levothyroxine products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), or Tirosint capsules **[documentation required]**. If none are formulary, approve. **2.** If the patient cannot swallow or has difficulty swallowing tablets or capsules **[documentation required]**, approve if the patient has tried Tirosint oral solution, if formulary. If Tirosint oral solution is non-formulary, approve.	1 year
Thyroid Supplements	Tirosint and authorized generic	levothyroxine capsules	**1.** Approve if the patient has tried four formulary levothyroxine products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), or Tirosint oral solution **[documentation required]**. If none are formulary, approve. **2.** Approve if a 13 mcg product is being requested.	1 year
Thyroid Supplements	Tirosint-SOL	levothyroxine oral solution	**1.** Approve if the patient has tried four formulary levothyroxine products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), or Tirosint capsules **[documentation required]**. If none are formulary, approve. **2.** If the patient cannot swallow or has difficulty swallowing tablets or capsules **[documentation required]**, approve if the patient has tried Thyquidity oral solution, if formulary. If Thyquidity oral solution is non-formulary, approve.	1 year
Thyroid Supplements	Cytomel	liothyronine sodium tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Thyroid Supplements	Synthroid	levothyroxine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Thyroid Supplements - Desiccated Thyroid Supplements	Adthyza	thyroid tablets	**1.** Approve if the patient has tried one levothyroxine product (e.g., levothyroxine, Synthroid, Levoxyl) AND one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). **2.** Patient currently receiving Adthyza: Approve if the patient has tried one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). Note: Some desiccated thyroid products are currently not available, such as Nature thyroid, WP thyroid, Westhroid, and Thyroid tablet, but a previous trial of these would count as a trial of a desiccated thyroid product.	1 year
Thyroid Supplements - Desiccated Thyroid Supplements	Armour Thyroid	thyroid tablets	**1.** Approve if the patient has tried one levothyroxine product (e.g., levothyroxine, Synthroid, Levoxyl) AND one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). **2.** Patient currently receiving Armour thyroid: Approve if the patient has tried one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). Note: Some desiccated thyroid products are currently not available, such as Nature thyroid, WP thyroid, Westhroid, and Thyroid tablet, but a previous trial of these agents would count as a trial of a desiccated thyroid product.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Topical Agents for Atopic Dermatitis	Opzelura	ruxolitinib 1.5% cream	Mild to Moderate Atopic Dermatitis. Approve if the patient meets ALL of the following (A, B, C, D, and E): A. Patient is ≥ 2 years of age; AND B. Patient has atopic dermatitis involvement estimated to affect ≤ 20% of the body surface area; AND C. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or significant intolerance with one of pimecrolimus cream (Elidel cream, generics) or tacrolimus ointment (Protopic, generics), if one is formulary; AND Note: If neither are formulary, would still require a trial of a topical corticosteroid. D. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or significant intolerance with at least one medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid; OR ii. Patient is treating atopic dermatitis affecting one of the following areas: face, eyes/eyelids, skin folds, and/or genitalia; AND E. Patient has tried BOTH 1) Vtama and 2) Zoryve 0.15% cream or Zoryve o.o5% cream, if formulary (or one if one is formulary). If neither are formulary, criterion E is considered as met. Nonsegmental Vitiligo. Approve if the patient meets all of the following (A, B, C, and D): A. Patient is ≥ 12 years of age; AND B. Patient has vitiligo involvement estimated to affect ≤ 10% of the body surface area; AND C) Patient meets ONE of the following (i or ii): i. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or significant intolerance with at least one high-, and/or super-high-potency prescription topical corticosteroid; OR ii. Patient is treating vitiligo affecting one of the following areas: face, eyes/eyelids, skin folds, and/or genitalia; AND D. Patient has tried, and according to the prescriber, has experienced inadequate efficacy or significant intolerance with one of pimecrolimus cream (Elidel cream, generics) or tacrolimus ointment (Protopic, generics), if one is formulary. Note: If neither are formulary, would still require a trial of a topical corticosteroid.	6 months
Topical Agents for Atopic Dermatitis	Eucrisa	crisaborole ointment, 2%	**1.** Approve if the patient has tried TWO of pimecrolimus cream (Elidel cream, generics), tacrolimus ointment, Zoryve cream (0.05% or 0.15%), or Vtama (if two are formulary or one if one is formulary). If none formulary, approve. **2.** Patient < 6 years of age, approve if the patient has tried TWO of pimecrolimus cream (Elidel cream, generics), tacrolimus ointment, or Zoryve 0.05% cream, if formulary. If neither are formulary, approve. **3.** Patients less than 2 years of age, approve.	1 year
Topical agents for Condyloma acuminatum	Condylox 0.5% topical gel	podofilox 0.5% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Topical Antiparasitics	Eurax 10% lotion, crotan 10% lotion, pruradik 10% lotion	crotamiton 10% lotion	**1.** Approve if the patient has tried permethrin 5% cream, if formulary. If permethrin 5% cream is non-formulary, approve. **2.** Approve if the requested product is being used for symptomatic treatment of pruritic skin (not associated with scabies). **3.** Approve if the patient has already started on therapy with crotamiton lotion and is using it to complete a course of therapy.	3 months
Topical Corticosteroid-containing Agents – Halobetasol Agents	Bryhali	halobetasol propionate 0.01% lotion	Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. NOTE: The products must be chemically unique.	1 year
Topical Corticosteroid-containing Agents – Halobetasol Agents	Lexette and halobetasol propionate 0.05% topical foam	halobetasol propionate topical foam 0.05%	Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. NOTE: The products must be chemically unique.	1 year
Topical Corticosteroid-containing Agents – Halobetasol Agents	Ultravate Lotion and halobetasol propionate lotion 0.05%	halobetasol propionate lotion 0.05%	Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. NOTE: The products must be chemically unique.	1 year
Topical Corticosteroid-containing Agents – Halobetasol Agents	Duobrii	halobetasol propionate 0.01%/ tazarotene 0.045% lotion	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products AND one tazarotene-containing product. Note: Examples of prescription-strength topical corticosteroid products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. Note: Examples of tazarotene-containing products are tazarotene cream; tazarotene gel (Tazorac cream, generics, Tazorac gel, generics).	1 year

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Topical Dermatological Drugs - Miscellaneous	Veregen	sinecatechins ointment 15%	**1.** Approve if the patient has tried both 1) podofilox topical solution or gel (e.g., Condylox, generics) AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If none are formulary, approve. **2.** For perianal warts, approve if the patient has tried both 1) podofilox topical gel (e.g., Condylox gel, generics) AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If neither are formulary approve.	1 year
Topical Dermatological Drugs - Miscellaneous	Clenia Plus and authorized generic	sodium sulfacetamide 9%- sulfur 4.25% suspension	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 9.8%-4.8% topical cleanser, generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide/sulfur.	1 year
Topical Dermatological Drugs - Miscellaneous	sulfacetamide-sulfur 8-4% cleanser	sulfacetamide-sulfur 8-4% cleanser	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide-sulfur.	1 year
Topical Dermatological Drugs - Miscellaneous	Zma Clear	sodium sulfacetamide 9% and sulfur 4.5% suspension	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 9.8%-4.8% topical cleanser, generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide-sulfur.	1 year
Topical Dermatological Drugs - Miscellaneous	ZTlido	lidocaine topical system 1.8%	Approve if the patient has tried lidocaine 5% patch (Lidoderm, generics). If lidocaine 5% patch (Lidoderm, generics) is non-formulary, approve.	1 year
Topical Dermatological Drugs - Miscellaneous	sodium sulfacetamide 10% - sulfur 1% emulsion	sodium sulfacetamide 10% -sulfur 1% emulsion	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sulfacetamide sodium/sulfur 10%-5% topical cleanser, generic sodium sulfacetamide-sulfur 9.8%-4.8% topical cleanser, generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide/sulfur.	1 year
Topical Dermatological Drugs - Miscellaneous	Livixil Pak with occlusive dressing	lidocaine 2.5% and prilocaine 2.5% cream and occlusive dressing	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list, if formulary (or three if three are formulary or two if two are formulary or one if only one is formulary): lidocaine and prilocaine cream (EMLA cream, generics), lidocaine cream (generics, multiple strengths), lidocaine and tetracaine cream (brand), DermacinRx Prizopak. If none are formulary, approve.	1 year
Topical Dermatological Drugs - Miscellaneous	Pliaglis and lidocaine 7% and tetracaine 7% cream (brand)	lidocaine 7% and tetracaine 7% cream	Approve if the patient has tried and cannot use two of the following, if two are formulary (or one if only one is formulary): lidocaine and prilocaine cream (generics), lidocaine cream (generics, multiple strengths), Livixil Pak, DermacinRx Prizopak. If none are formulary, approve.	1 year
Topical Dermatological Drugs - Miscellaneous	Alcortin A	hydrocortisone 2%/ iodoquinol 1%/ aloe 1% gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five single-entity corticosteroid topical agents AND one prescription topical anti-infective agent. Note: Examples of topical corticosteroids include: hydrocortisone cream/lotion/ointment [multiple brand and generic products], betamethasone cream/ointment/lotion [Diprolene, generics], clobetasol cream/gel/lotion [Temovate, Clobex, generics], fluocinolone ointment/cream [Synalar, generics], fluocinonide cream/ointment/gel [generics], mometasone cream/lotion/ointment [Elocon, generics], triamcinolone cream/ointment/lotion [generics]. Note: Examples of prescription topical anti-infectives include: mupirocin 2% cream [Bactroban, generics], mupirocin 2% ointment [Bactroban, generics], Centany ointment, Centany AT ointment, Altabax ointment).	1 year
Topical Dermatological Drugs - Miscellaneous	Novacort gel	hydrocortisone 2%/ pramoxine 1%/ aloe 1% gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Epifoam, hydrocortisone-pramoxine cream, Pramosone cream, Pramosone lotion, or Pramosone ointment. If none are formulary, approve.	1 year
Topical Dermatological Drugs - Miscellaneous	Qutenza	capsaicin 8% patch	Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with two other topical agents (i.e., over-the-counter (OTC) capsaicin products and lidocaine patch [Lidoderm patch, generic]).	1 year
Topical Dermatological Drugs - Miscellaneous	Lidoderm	lidocaine 5% patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Topical Dermatological Drugs – Miscellaneous	Regranex	becaplermin gel 0.01%	Diabetic Lower Extremity Ulcers. Approve if the patient meets ALL of the following (A, B, and C): A. Patient is ≥ 16 years of age; AND B. Ulcers are classified as Stage III or IV; AND Note: This refers to the International Association of Enterostomal Therapy (IAET) classification system for wounds. C. Regranex is being used in adjunct to standard ulcer/wound care practices (e.g., sharp debridement, pressure relief, and infection control).	1 year
Topical Dermatological Drugs - Tazarotene	Tazorac 0.05% cream and tazarotene cream 0.05% cream	tazarotene cream 0.05%	If requesting brand Tazorac 0.05% cream: Approve if the patient has tried generic tazarotene 0.05% cream, if formulary. If generic tazarotene 0.05% cream is non-formulary or generic tazarotene is being requested, approve if the patient has tried one of 1) tazarotene 0.1% cream (Tazorac 0.1% cream, generics) or 2) tazarotene gel (Tazorac gel, generics), if one is formulary. If neither are formulary, approve.	1 year
Topical Diaper Dermatitis Agents	Vusion and miconazole-zinc oxide-petroleum	miconazole-zinc oxide-petroleum ointment	Approve if the patient has tried one topical antifungal agent. Note: Examples include: miconazole, clotrimazole, ketoconazole, nystatin.	1 year
Topical Doxepin	doxepin, prudoxin 5% cream	doxepin 5% cream	Approve if the patient has tried TWO topical corticosteroids. Note: Examples of topical corticosteroids include alclometasone cream or ointment, desonide cream or ointment, fluocinolone cream or ointment, hydrocortisone cream or ointment.	1 year
Topical Janus Kinase (JAK) inhibitor	Anzupgo	delgocitinib 2% cream	Chronic hand eczema in a patient ≥ 18 years of age. Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with at least ONE medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid.	1 year
Topical Mammalian Target of Rapamycin (mTOR) Inhibitor Immunosuppressant	Hyftor	sirolimus 0.2% topical gel	See standard *Dermatology – Hyftor Prior Authorization Policy* criteria.	See PA duration
Topical Products - Miscellaneous	Tri-luma cream	fluocinolone acetonide 0.01%/hydroquinone 4%/tretinoin 0.05% cream	Direct the patient to the separate entities: fluocinolone 0.01% cream- hydroquinone 4% cream- tretinoin 0.05% cream.	N/A
Topical Roflumilast Agents	Zoryve foam	roflumilast 0.3% foam	Seborrheic dermatitis in a patient ≥ 9 years of age. Approve if the patient meets BOTH of the following (A and B): A. Patient meets ONE of the following (i or ii): i. Patient has tried one of topical ketoconazole or topical ciclopirox (cream/gel/shampoo); OR ii. Patient is ≥ 9 years of age and < 12 years of age; AND B. Patient has tried at least one low-, medium-, medium-high, high-, and/or super-high potency prescription topical corticosteroid. Plaque Psoriasis in a patient ≥ 12 years of age. If either Zoryve 0.3% cream or Vtama cream is formulary, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried one of Zoryve 0.3% cream or Vtama cream, if formulary; OR B. Patient is using the requested medication on the scalp; OR C. Patient is < 18 years of age, approve if the patient tried Zoryve 0.3% cream, if formulary. If Zoryve 0.3% cream is non-formulary, approve. If neither Zoryve 0.3% cream nor Vtama are formulary: Approve if the patient meets ONE of the following criteria (A or B): A. Patient has tried at least one medium-, medium-high, high-, and/or super-high potency prescription topical corticosteroid AND at least one topical vitamin D analog; OR Note: Examples of topical vitamin D analogs include calcipotriene 0.005% cream (Dovonex, generic), calcipotriene 0.005% foam, calcipotriene 0.005% ointment, calcipotriene 0.005% solution, calcitriol 3 mcg/g ointment (Vectical, generic), Sorilux. Note: Combination products containing a medium-, medium-high, high-, and/or super-high potency prescription topical corticosteroid and a topical vitamin D analog would meet the requirement. Examples of combination products include calcipotriene 0.005% and betamethasone dipropionate 0.064% ointment (Taclonex, generic), calcipotriene 0.005% and betamethasone dipropionate 0.064% suspension (Taclonex, generic), Enstilar, Wynzora. B. Patient is treating psoriasis affecting one of the following areas: face, eyes/eyelids, skin folds, and/or genitalia.	1 year
Topical Roflumilast Agents	Zoryve 0.05% and 0.15% Cream	roflumilast 0.05% and 0.15% cream	Atopic dermatitis in a patient ≥ 2 years of age. Approve if the patient has tried TWO of pimecrolimus cream (Elidel cream, generics), tacrolimus ointment, Eucrisa, or Vtama (if two are formulary or one if one is formulary). If none are formulary, approve.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Topical Roflumilast Agents	Zoryve 0.3% Cream	roflumilast 0.3% cream	Plaque Psoriasis in a patient ≥ 2 years of age. If either Zoryve 0.3% foam or Vtama cream is formulary, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried one of Zoryve 0.3% foam or Vtama cream, if formulary; OR B. Patient is ≥ 9 and < 18 years of age, approve if the patient tried Zoryve 0.3% foam, if formulary. If Zoryve 0.3% foam is non-formulary, approve; OR C. Patient is < 9 years of age, approve. If neither Zoryve 0.3% foam nor Vtama are formulary: Approve if the patient meets ONE of the following criteria (A or B): A. Patient has tried at least one medium-, medium-high, high-, and/or super-high potency prescription topical corticosteroid AND at least one topical vitamin D analog; OR Note: Examples of topical vitamin D analogs include calcipotriene 0.005% cream, calcipotriene 0.005% foam, calcipotriene 0.005% ointment, calcipotriene 0.005% solution, calcitriol 3 mcg/g ointment (Vectical, generic), Sorilux. Note: Combination products containing a medium-, medium-high, high-, and/or super-high potency prescription topical corticosteroid and topical vitamin D analog would meet the requirement. Examples of combination products include calcipotriene 0.005% and betamethasone dipropionate 0.064% ointment (Taclonex, generic), calcipotriene 0.005% and betamethasone dipropionate 0.064% suspension (Taclonex, generic), Enstilar, Wynzora. B. Patient is treating psoriasis affecting one of the following areas: face, eyes/eyelids, skin folds, and/or genitalia.	1 year
Transplant-Associated Thrombotic Microangiopathy Agents	Yartemlea	narsoplimab-wuug intravenous infusion	See standard *Transplantation – Yartemlea Prior Authorization Policy* criteria.	See PA duration
Urinary Tract Analgesic	Pyridium	phenazopyridine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Ursodiol Products	Reltone	ursodiol capsules 200 mg, 400 mg	**1.** Approve if the patient has tried generic ursodiol capsules or tablets. **2.** Approve, if according to the prescriber, the patient is unable to achieve the appropriate dosage requirement with ursodiol capsules.	1 year
Urticaria Agents - Bruton's Tyrosine Kinase (BTK) Inhibitors	Rhapsido	remibrutinib tablets	Chronic Spontaneous Urticaria. **1.** Initial therapy in a patient ≥ 18 years of age: Approve if the patient has tried BOTH Dupixent and Xolair, if formulary (or one if one is formulary). If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Rhapsido.	1 year
Vaccines – Chikungunya virus	Vimkunya	chikungunya vaccine [recombinant] intramuscular injection	For prevention of disease caused by Chikungunya virus, approve in patients ≥ 12 years of age.	30 days
Vaccines - Cholera	Vaxchora	cholera vaccine, live, oral; suspension for oral administration	For prevention of cholera in persons traveling to cholera-affected areas: approve.	1 month
Vaccines - COVID	mNEXSPIKE	COVID-19 vaccine [mRNA] intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient is unable to use one of Spikevax IM injection [Moderna] or Comirnaty IM injection [Pfizer]. **2.** If neither Spikevax IM injection [Moderna] nor Comirnaty IM injection [Pfizer] are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient is unable to use one of Spikevax IM injection [Moderna] or Comirnaty IM injection [Pfizer]. **2.** If neither Spikevax IM injection [Moderna] nor Comirnaty IM injection [Pfizer] are formulary, approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	30 days

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - COVID	Nuvaxovid	COVID-19 vaccine [adjuvanted] intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient is unable to use one mRNA COVID vaccine (e.g., Spikevax IM injection [Moderna], Comirnaty IM injection [Pfizer]). **2.** If neither Spikevax IM injection [Moderna] nor Comirnaty IM injection [Pfizer] are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient is unable to use one mRNA COVID vaccine (e.g., Spikevax IM injection [Moderna], Comirnaty IM injection [Pfizer]). **2.** If neither Spikevax IM injection [Moderna] nor Comirnaty IM injection [Pfizer] are formulary, approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	30 days
Vaccines – Dengue disease	Dengvaxia	dengue tetravalent vaccine [live] suspension for subcutaneous injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient meets the following criteria (A and B): A) The patient has laboratory-confirmed previous dengue infection; AND B) According to the prescriber, the patient is living in a Dengue endemic area. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient meets the following criteria (a and b): a. The patient has laboratory-confirmed previous dengue infection; AND b. According to the prescriber, the patient is living in a Dengue endemic area. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Adacel	Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried Boostrix, if formulary. If Boostrix is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Boostrix, if formulary. If Boostrix is non-formulary, approve. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Boostrix	Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried Adacel, if formulary. If Adacel is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Adacel, if formulary. If Adacel is non-formulary, approve. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Daptacel	Diphtheria and tetanus toxoids and acellular pertussis vaccine adsorbed (DTaP)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Infanrix, if formulary. If Infanrix is non-formulary, approve. **2.** Patient has started the DTaP series with Daptacel (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Infanrix, if formulary. If Infanrix is non-formulary, approve. **2.** Patient has started the DTaP series with Daptacel (i.e., already received at least one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Infanrix	Diphtheria and tetanus toxoids and acellular pertussis vaccine adsorbed (DTaP)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Daptacel, if formulary. If Daptacel is non-formulary, approve. **2.** Patient has started the DTaP series with Infanrix (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Daptacel, if formulary. If Daptacel is non-formulary, approve. **2.** Patient has started the DTaP series with Infanrix (i.e., already received at least one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Kinrix	DTaP and inactivated poliovirus vaccine (DTaP-IPV)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient had previously received Infanrix or Pediarix. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient had previously received Infanrix or Pediarix. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Pediarix	DTaP, hepatitis B and inactivated poliovirus vaccine (DTaP-HepB-IPV)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one formulary DTaP vaccine: Infanrix or Daptacel, one formulary hepatitis B vaccine: Engerix-B or Recombivax, AND one formulary inactivated poliovirus vaccine: Ipol. If only two are formulary, approve. If only one is formulary, approve. If none are formulary, approve. **NOTE:** A trial of a combination vaccine containing the components above would meet the requirement for approval (e.g. Kinrix or Quadracel would count for DTaP and IPV). **2.** If the patient has already started the series with Pediarix (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one formulary DTaP vaccine: Infanrix or Daptacel, one formulary hepatitis B vaccine: Engerix-B or Recombivax, AND one formulary inactivated poliovirus vaccine: Ipol. If only two are formulary, approve. If only one is formulary, approve. If none are formulary, approve. **NOTE**: A trial of a combination vaccine containing the components above would meet the requirement for approval (e.g. Kinrix or Quadracel would count for DTaP and IPV). **2.** If the patient has already started the series with Pediarix (i.e., already received at least one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Pentacel	DTaP, inactivated poliovirus, and haemophilus influenza typ b conjugate (tetanus toxoid conjugate) vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one formulary DTaP vaccine: Infanrix or Daptacel, one formulary inactivated poliovirus vaccine: Ipol, AND one formulary haemophilus influenza type b vaccine: ActHIB, PedvaxHIB, Hiberix. If only two are formulary, approve. If only one is formulary, approve. If none are formulary, approve. **NOTE:** A trial of a combination vaccine containing the components above would meet the requirement for approval. **2.** Patients < 2 months of age: approve. **3.** If the patient has already started the series with Pentacel (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one formulary DTaP vaccine: Infanrix or Daptacel, one formulary inactivated poliovirus vaccine: Ipol, AND one formulary haemophilus influenza type b vaccine: ActHIB, PedvaxHIB, Hiberix. If only two are formulary, approve. If only one is formulary, approve. If none are formulary, approve. **NOTE**: A trial of a combination vaccine containing the components above would meet the requirement for approval. **2.** Patients < 2 months of age: approve. **3.** If the patient has already started the series with Pentacel (i.e., already received at least one dose of the series): approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Quadracel	DTaP and inactivated poliovirus (DTaP-IPV)	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient had previously received Daptacel or Pentacel. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient had previously received Daptacel or Pentacel. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	TENIVAC	tetanus and diphtheria toxoids adsorbed	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. 1. Approve. 2. Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Diphtheria, tetanus and pertussis-containing vaccines	Vaxelis	diphtheria and tetanus toxoids and acellular pertussis adsorbed, inactivated poliovirus, haemophilus b conjugate [meningococcal protein conjugate] and hepatitis B [recombinant] vaccine for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one formulary DTaP vaccine: Pentacel, Daptacel, one formulary inactivated poliovirus vaccine: Ipol, one formulary haemophilus influenza type b vaccine: ActHIB, PedvaxHIB, Hiberix, AND one formulary hepatitis B vaccine: Engerix-B, Recombivax HB. If there are no formulary DTaP vaccines, approve. If there are no formulary inactivated poliovirus vaccines, approve. If there are no formulary haemophilus influenza type b vaccines, approve. If there are no formulary hepatitis B vaccines, approve. **2.** Patients < 2 months of age: approve. **3.** Approve if the patient is of American Indian and/or Alaska Native descent. **4.** If the patient has already started the series with Vaxelisl (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one formulary DTaP vaccine: Pentacel, Daptacel, one formulary inactivated poliovirus vaccine: Ipol, one formulary haemophilus influenza type b vaccine: ActHIB, PedvaxHIB, Hiberix, AND one formulary hepatitis B vaccine: Engerix-B, Recombivax HB. If there are no formulary DTaP vaccines, approve. If there are no formulary inactivated poliovirus vaccines, approve. If there are no formulary haemophilus influenza type b vaccines, approve. If there are no formulary hepatitis B vaccines, approve. **2.** Patients < 2 months of age: approve. **3.** Approve if the patient is of American Indian and/or Alaska Native descent. **4.** If the patient has already started the series with Vaxelisl (i.e., already received at least one dose of the series): approve. **5.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines – Ebola	Ervebo	Ebola Zaire vaccine live, suspension for intramuscular injection	For the prevention of diseases caused by Zaire ebolavirus, approve.	30 days
Vaccines - Haemophilus influenza type b	ActHIB	Haemophilus b conjugate vaccine [tetanus toxoid conjugate]	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of PedvaxHIB or Hiberix, if one is formulary. If both are non-formulary, approve. **2.** Patient has latex allergy, approve if the patient has tried Hiberix, if formulary. If Hiberix is non-formulary, approve. **3.** Patient has received any dose in the haemophilus influenza type b vaccine series using ActHIB: approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of PedvaxHIB or Hiberix, if one is formulary. If both are non-formulary, approve. **2.** Patient has latex allergy, approve if the patient has tried Hiberix, if formulary. If Hiberix is non-formulary, approve. **3.** Patient has received any dose in the haemophilus influenza type b vaccine series using ActHIB: approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Haemophilus influenza type b	Hiberix	Haemophilus b conjugate vaccine [tetanus toxoid conjugate]	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of PedvaxHIB or ActHIB, if one is formulary. If both are non-formulary, approve. **2.** Patient has latex allergy, approve if the patient has tried ActHIB, if formulary. If ActHIB is non-formulary, approve. **3.** Patient has received any dose in the haemophilus influenza type b vaccine series using Hiberix: approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of PedvaxHIB or ActHIB, if one is formulary. If both are non-formulary, approve. **2.** Patient has latex allergy, approve if the patient has tried ActHIB, if formulary. If ActHIB is non-formulary, approve. **3.** Patient has received any dose in the haemophilus influenza type b vaccine series using Hiberix: approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Haemophilus influenza type b	PedvaxHIB	Haemophilus b conjugate vaccine [meningococcal conjugate]	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of ActHIB or Hiberix, if one is formulary. If both are non-formulary, approve. **2.** Patient with anaphylaxis to any tetanus toxoid containing vaccine: approve. **3.** Approve if the patient is of American Indian and/or Alaska Native descent. **4.** Patient has received any dose in the haemophilus influenza type b vaccine series using PedvaxHIB: approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of ActHIB or Hiberix, if one is formulary. If both are non-formulary, approve. **2.** Patient with anaphylaxis to any tetanus toxoid containing vaccine: approve. **3.** Approve if the patient is of American Indian and/or Alaska Native descent. **4.** Patient has received any dose in the haemophilus influenza type b vaccine series using PedvaxHIB: approve. **5.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Hepatitis Vaccines	Twinrix	Hepatitis A inactivated and hepatitis B (recombinant) vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one formulary hepatitis A vaccine from the following list: Havrix, Vaqta AND one formulary hepatitis B vaccine from the following list: Heplisav-B, Recombivax HB, or Engerix-B. If neither hepatitis A vaccine is formulary, approve. If none of hepatitis B vaccine are formulary, approve. **2.** Patient has started the vaccine series with Twinrix (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** 1. Approve if the patient has tried one formulary hepatitis A vaccine from the following list: Havrix, Vaqta AND one formulary hepatitis B vaccine from the following list: Heplisav-B, Recombivax HB, or Engerix-B. If neither hepatitis A vaccine is formulary, approve. If none of hepatitis B vaccine are formulary, approve. **2.** Patient has started the vaccine series with Twinrix (i.e., already received at least one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Hepatitis Vaccines	Engerix-B	Hepatitis B vaccine recombinant	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one formulary alternative from the following list: Heplisav-B or Recombivax HB. If neither are formulary, approve. **2.** Patient is < 18 years of age: approve if the patient has tried Recombivax HB, if formulary. If Recombivax HB is non-formulary, approve. **3.** Patient has latex allergy: Patient is ≥ 18 years of age, approve if the patient has tried Heplisav-B, if formulary. If Heplisav-B is non-formulary, approve. Patient is < 18 years of age, approve. **4.** If patient requires subcutaneous administration, approve if patient has tried Recombivax-HB, if formulary. If Recombivax HB is non-formulary, approve. a. Patient has a latex allergy, approve. **5.** If the patient has started the vaccination series with Engerix-B (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one formulary alternative from the following list: Heplisav-B or Recombivax HB. If neither are formulary, approve. **2.** Patient is < 18 years of age: approve if the patient has tried Recombivax HB, if formulary. If Recombivax HB is non-formulary, approve. **3.** Patient has latex allergy: Patient is ≥ 18 years of age, approve if the patient has tried Heplisav-B, if formulary. If Heplisav-B is non-formulary, approve. Patient is < 18 years of age, approve. **4.** If patient requires subcutaneous administration, approve if patient has tried Recombivax-HB, if formulary. If Recombivax HB is non-formulary, approve. a. Patient has a latex allergy, approve. **5.** If the patient has started the vaccination series with Engerix-B (i.e., already received at least one dose of the series): approve. **6.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Hepatitis Vaccines	Havrix	hepatitis A vaccine [inactivated]	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Vaqta, if formulary. If Vaqta is non-formulary, approve. **2.** Patient with latex allergy: approve Havrix vials. **3.** If the patient has started the vaccination series with Havrix (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Vaqta, if formulary. If Vaqta is non-formulary, approve. **2.** Patient with latex allergy: approve Havrix vials. **3.** If the patient has started the vaccination series with Havrix (i.e., already received at least one dose of the series): approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Hepatitis Vaccines	Recombivax HB	Hepatitis B vaccine recombinant	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one formulary alternative from the following list: Heplisav-B or Engerix-B. If neither are formulary, approve. **2.** Patient is < 18 years of age: Approve if the patient has tried Engerix-B if formulary. If Engerix-B is non-formulary, approve. **3.** If patient requires subcutaneous administration, approve if patient has tried Engerix-B, if formulary. If Engerix-B is non-formulary, approve. **4.** If the patient has started the vaccination series with Recombivax HB (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one formulary alternative from the following list: Heplisav-B or Engerix-B. If neither are formulary, approve. **2.** Patient is < 18 years of age: Approve if the patient has tried Engerix-B if formulary. If Engerix-B is non-formulary, approve. **3.** If patient requires subcutaneous administration, approve if patient has tried Engerix-B, if formulary. If Engerix-B is non-formulary, approve. **4.** If the patient has started the vaccination series with Recombivax HB (i.e., already received at least one dose of the series): approve. **5.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Hepatitis Vaccines	Vaqta	hepatitis A vaccine [inactivated]	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Havrix, if formulary. If Havrix is non-formulary, approve. **2.** If the patient has started the vaccination series with Vaqta (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Havrix, if formulary. If Havrix is non-formulary, approve. **2.** If the patient has started the vaccination series with Vaqta (i.e., already received at least one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines – Hepatitis Vaccines	Heplisav-B	hepatitis B vaccine [recombinant], adjuvanted solution for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one formulary alternative from the following list: Engerix-B or Recombivax HB. If neither are formulary, approve. **2.** Patient has latex allergy: approve if the patient has tried Engerix-B, if formulary. If Engerix-B is non-formulary, approve. **3.** If the patient has started the vaccination series with Heplisav-B (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one formulary alternative from the following list: Engerix-B or Recombivax HB. If neither are formulary, approve. **2.** Patient has latex allergy: approve if the patient has tried Engerix-B, if formulary. If Engerix-B is non-formulary, approve. **3.** If the patient has started the vaccination series with Heplisav-B (i.e., already received at least one dose of the series): approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines – Measles	M-M-R II	measles, mumps, and rubella vaccine, live lyophilized for injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried Priorix, if formulary. If Priorix is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Priorix, if formulary. If Priorix is non-formulary, approve. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines – Measles	Priorix	measles, mumps, and rubella vaccine, live	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has used M-M-R-II, if formulary. If M-M-R II is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has used M-M-R-II, if formulary. If M-M-R II is non-formulary, approve. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Meningococcal	MenQuadfi	meningococcal vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Menveo (2 vial formulation), if formulary. If Menveo (2 vial formulation) is non-formulary, approve. Note: If the patient has tried Menveo 1 vial formulation, this would satisfy a requirement for a trial of Menveo 2 vial formulation. **2.** If the patient is less than 2 months of age, approve. **3.** If the patient has started the vaccination series with MenQuadfi (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Menveo (2 vial formulation), if formulary. If Menveo (2 vial formulation) is non-formulary, approve. Note: If the patient has tried Menveo 1 vial formulation, this would satisfy a requirement for a trial of Menveo 2 vial formulation. **2.** If the patient is less than 2 months of age, approve. **3.** If the patient has started the vaccination series with with MenQuadfi (i.e., already received at least one dose of the series): approve. 4. Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Meningococcal	Menveo (1 vial formulation)	meningococcal vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried one of Menveo (2 vial formulation), or MenQuadfi, if formulary. If neither are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of Menveo (2 vial formulation), or MenQuadfi, if formulary. If neither are formulary, approve. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Meningococcal	Menveo (2 vial formulation)	meningococcal vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried MenQuadfi, if formulary. If MenQuadfi is non-formulary, approve. **2.** If the patient has started the vaccination series with Menveo (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried MenQuadfi, if formulary. If MenQuadfi is non-formulary, approve. **2.** If the patient has started the vaccination series with Menveo (i.e., already received at least one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Meningococcal	Trumenba	meningococcal group B vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Bexsero, if formulary. If Bexsero is non-formulary, approve. **2.** If the patient has started the vaccination series with Trumenba (i.e., already received at least one dose of the series): approve. **3.** Patients with latex allergy: approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Bexsero, if formulary. If Bexsero is non-formulary, approve. **2.** If the patient has started the vaccination series with Trumenba (i.e., already received at least one dose of the series): approve. **3.** Patients with latex allergy: approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Meningococcal	Penbraya	meningococcal groups A, B, C, W and Y vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. For prevention (active immunization) of Meningococcal Disease. **1.** Approve if the patient has tried one formulary Meningococcal B vaccine: Bexsero or Trumenba AND one formulary Meningococcal vaccine that covers serogroups A, C, W and Y: Menveo (2 vial formulation) or Menquadfi. If there are no formulary Meningococcal B vaccines, approve. If there are no formulary Meningococcal vaccines that cover serogroups A, C, W and Y, approve. Note: If Menveo is the only formulary product (in that category) and the patient has tried Menveo (1 vial formulation), approve. **2.** If the patient has already started the vaccination series with Penbraya (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. For prevention (active immunization) of Meningococcal Disease. **1.** Approve if the patient has tried one formulary Meningococcal B vaccine: Bexsero or Trumenba AND one formulary Meningococcal vaccine that covers serogroups A, C, W and Y: Menveo (2 vial formulation) or Menquadfi. If there are no formulary Meningococcal B vaccines, approve. If there are no formulary Meningococcal vaccines that cover serogroups A, C, W and Y, approve. Note: If Menveo is the only formulary product (in that category) and the patient has tried Menveo (1 vial formulation), approve. **2.** If the patient has started the vaccination series with Penbraya (i.e., already received at least one dose of the series): approve. **3.** The patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Meningococcal	Penmenvy	meningococcal groups A, B, C, W and Y vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. For prevention (active immunization) of Meningococcal Disease. **1.** Approve if the patient has tried one formulary Meningococcal B vaccine: Bexsero or Trumenba AND one formulary Meningococcal vaccine that covers serogroups A, C, W and Y: Menveo (2 vial formulation) or Menquadfi. If there are no formulary Meningococcal B vaccines, approve. If there are no formulary Meningococcal vaccines that cover serogroups A, C, W and Y, approve. Note: If Menveo is the only formulary product (in that category) and the patient has tried Menveo (1 vial formulation), approve. **2.** If the patient has already started the vaccination series with Penmenvy (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. For prevention (active immunization) of Meningococcal Disease. **1.** Approve if the patient has tried one formulary Meningococcal B vaccine: Bexsero or Trumenba AND one formulary Meningococcal vaccine that covers serogroups A, C, W and Y: Menveo (2 vial formulation) or Menquadfi. If there are no formulary Meningococcal B vaccines, approve. If there are no formulary Meningococcal vaccines that cover serogroups A, C, W and Y, approve. Note: If Menveo is the only formulary product (in that category) and the patient has tried Menveo (1 vial formulation), approve. **2.** If the patient has started the vaccination series with Penmenvy (i.e., already received at least one dose of the series): approve. **3.** The patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Meningococcal	Bexsero	meningococcal group B vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Trumenba, if formulary. If Trumenba is non-formulary, approve. **2.** If the patient has started the vaccination series with Bexsero (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Trumenba, if formulary. If Trumenba is non-formulary, approve. **2.** If the patient has started the vaccination series with Bexsero (i.e., already received at least one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Miscellaneous	BioThrax	anthrax vaccine adsorbed	For the prevention of anthrax (anthrax vaccination): approve.	1 year
Vaccines - Miscellaneous	Jynneos	smallpox and monkeypox vaccine,	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. For prevention of smallpox or monkeypox, approve.	60 days
Vaccines - Miscellaneous	ProQuad	measles, mumps, rubella, and varicella virus vaccine, live	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried both 1) a measles vaccine (MMR II or Priorix) AND 2) Varivax (varicella virus vaccine, live). If both measles vaccines are non-formulary OR Varivax is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried both 1) a measles vaccine (MMR II or Priorix) AND 2) Varivax (varicella virus vaccine, live) If both measles vaccines are non-formulary OR Varivax is non-formulary, approve.	1 year
Vaccines - Miscellaneous	ACAM2000	smallpox and mpox vaccine, live	**1.** Approve if the patient has tried Jynneos. If Jynneos is non-formulary, approve. **2.** Patient is < 18 years of age, approve.	30 days

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Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Pneumococcal	Prevnar 20	pneumococcal 20-valent conjugate vaccine suspension for intramuscular injection	~~Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required~~. Patient is < 18 years of age. **1.** Approve if the patient has tried Vaxenuvance, if formulary. If Vaxenuvance is non-formulary, approve. **2.** If the patient has already started the series with Prevnar 20 (i.e., already received at least one dose of the series): approve. **3.** If, according to the prescriber, the patient has an underlying medical condition or risk factor and Prevnar 20 is needed, approve. Patient is ≥ 18 years of age. **1.** Approve if the patient is unable to receive Capvaxive. **2.** If Capvaxive is non-formulary, approve. **3.** Patient has previously received Prevnar 13 or Pneumovax 23, approve. **4.** If, according to the prescriber, the patient has an underlying medical condition or risk factor and Prevnar 20 is needed, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Patient is < 18 years of age. a. Approve if the patient has tried Vaxenuvance, if formulary. If Vaxenuvance is non-formulary, approve.	1 year
Vaccines - Pneumococcal	Vaxneuvance	pneumococcal 15-valent conjugate vaccine	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Patient is < 18 years of age. **1.** Approve if the patient has tried Prevnar 20, if formulary. If Prevnar 20 is non-formulary, approve. **2.** If the patient has already started the series with Vaxneuvance (i.e., already received at least one dose of the series): approve. **3.** If, according to the prescriber, the patient has an underlying medical condition or risk factor and Vaxneuvance is needed, approve. Patient is ≥ 18 years of age. **1.** Approve if the patient is unable to receive BOTH Prevnar 20 and Capvaxive. **2.** If neither Prevnar 20 nor Capvaxive is formulary, approve. **3.** If, according to the prescriber, the patient has an underlying medical condition or risk factor and Vaxneuvance is needed, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Patient is < 18 years of age. a. Approve if the patient has tried Prevnar 20, if formulary. If Prevnar 20 is non-formulary, approve. b. If the patient has already started the series with Vaxneuvance (i.e., already received at least one dose of the series): approve. c. If, according to the prescriber, the patient has an underlying medical condition or risk factor and Vaxneuvance is needed, approve. **2.** Patient is ≥ 18 years of age. a. Approve if the patient is unable to receive BOTH Prevnar 20 and Capvaxive. b. If neither Prevnar 20 nor Capvaxive is formulary, approve. c. If, according to the prescriber, the patient has an underlying medical condition or risk factor and Vaxneuvance is needed, approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Pneumococcal	Capvaxive	pneumococcal 21-valent conjugate vaccine intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Patient is ≥ 18 years of age. **1.** Approve if the patient is unable to receive Prevnar 20. **2.** If Prevnar 20 is non-formulary, approve. **3.** If, according to the prescriber, the patient is at high risk of pneumococcal disease, approve if the patient is unable to receive Pneumovax 23. If Pneumovax 23 is non-formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Patient is ≥ 18 years of age. **1.** Approve if the patient is unable to receive Prevnar 20. **2.** If Prevnar 20 is non-formulary, approve. **3.** If, according to the prescriber, the patient is at high risk of pneumococcal disease, approve if the patient is unable to receive Pneumovax 23. If Pneumovax 23 is non-formulary, approve. **4.** Patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	30 days
Vaccines - Pneumococcal	Pneumovax 23	pneumococcal vaccine polyvalent, sterile, liquid vaccine for intramuscular or subcutaneous injection	[illegible] is required. Patient is < 18 years of age. **1.** Approve if the patient is unable to receive Prevnar 20 and Vaxneuvance. **2.** Approve if BOTH Prevnar 20 and Vaxneuvance are non-formulary. **3.** If, according to the prescriber, the patient is at high risk of pneumococcal disease, approve if the patient is unable to receive Capvaxive. If Capvaxive is non-formulary, approve. **4.** If, according to the prescriber, the patient has an underlying medical condition or risk factor and Pneumovax 23 is needed, approve. Patient is ≥ 18 years of age. **1.** Approve if the patient is unable to receive Prevnar 20. **2.** If Prevnar 20 is non-formulary, approve. **3.** If the patient has already received a dose of Vaxneuvance, approve. **4.** If, according to the prescriber, the patient has an underlying medical condition or risk factor and Pneumovax 23 is needed, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Patient is < 18 years of age. **1.** Approve if the patient is unable to receive Prevnar 20 and Vaxneuvance. **2.** Approve if BOTH Prevnar 20 and Vaxneuvance are non-formulary. **3.** If, according to the prescriber, the patient is at high risk of pneumococcal disease, approve if the patient is unable to receive Capvaxive. If Capvaxive is non-formulary, approve. **4.** If, according to the prescriber, the patient has an underlying medical condition or risk factor and Pneumovax 23 is needed, approve. **5.** Patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Rabies Vaccines and Human Rabies Immune Globulin	HyperRAB	rabies immune globulin (human) and solvent/detergent treated	Approve if the patient has tried one of Imogam Rabies – HT or Kedrab, if one is formulary. If neither are formulary, approve.	1 year
Vaccines - Rabies Vaccines and Human Rabies Immune Globulin	Imogam Rabies - HT	rabies immune globulin (human) USP, heat treated	Approve if the patient has tried one of HyperRAB or Kedrab, if one is formulary. If neither are formulary, approve.	1 year
Vaccines - Rabies Vaccines and Human Rabies Immune Globulin	Kedrab	rabies immune globulin (human) injection	Approve if the patient has tried one of HyperRAB or Imogam Rabies – HT, if one is formulary. If neither are formulary, approve.	1 year
Vaccines - Rabies Vaccines and Human Rabies Immune Globulin	Imovax	Rabies vaccine (Winstar rabies virus strain PM-1503-3M grown in human diploid cell cultures [HDCV])	**1.** Approve if the patient has tried RabAvert, if formulary. If RabAvert is non-formulary, approve. **2.** Patient has started rabies vaccine series with Imovax (i.e., already received one dose of the series): approve.	1 year
Vaccines - Rabies Vaccines and Human Rabies Immune Globulin	RabAvert	rabies vaccine for human use	**1.** Approve if the patient has tried Imovax, if formulary. If Imovax is non-formulary, approve. **2.** Patient has started rabies vaccine series with RabAvert (i.e., already received one dose of the series): approve.	1 year
Vaccines - Respiratory Syncytial Virus (RSV)	Arexvy	respiratory syncytial virus vaccine [adjuvanted] intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried or is unable to take one of Abrysvo or mResvia, if formulary. If neither are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried or is unable to take one of Abrysvo or mResvia, if formulary. If neither are formulary, approve. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month
Vaccines - Respiratory Syncytial Virus (RSV)	Abrysvo	respiratory syncytial virus vaccine intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried or is unable to take one of Arexvy or mResvia, if formulary. If neither are formulary, approve. **2.** Pregnant patients 32 through 36 weeks gestational age for the prevention of respiratory syncytial virus, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried or is unable to take one of Arexvy or mResvia, if formulary. If neither are formulary, approve. **2.** Pregnant patients 32 through 36 weeks gestational age for the prevention of respiratory syncytial virus, approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Respiratory Syncytial Virus (RSV)	mResvia	respiratory syncytial virus vaccine, suspension for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried or is unable to take one of Arexvy or Abrysvo, if formulary. If neither are formulary, approve. **2.** Approve if, according to the prescriber, the patient is at risk of Guillain-Barre syndrome (GBS). Note: Examples of patients who have a higher risk of GBS are patients with Campylobacter jejuni infections; patients with immune-mediated and/or rheumatological disorders (e.g., multiple sclerosis, autoimmune hemolytic anemia, rheumatoid arthritis, systemic lupus erythematosus). OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried or is unable to take one of Arexvy or Abrysvo, if formulary. If neither are formulary, approve. **2.** Approve if, according to the prescriber, the patient is at risk of Guillain-Barre syndrome (GBS). Note: Examples of patients who have a higher risk of GBS are patients with Campylobacter jejuni infections; patients with immune-mediated and/or rheumatological disorders (e.g., multiple sclerosis, autoimmune hemolytic anemia, rheumatoid arthritis, systemic lupus erythematosus). **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month
Vaccines - Rotavirus	Rotarix	rotavirus vaccine oral lyophilized powder	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried RotaTeq, if formulary. If RotaTeq is non-formulary, approve. **2.** Patient has started rotavirus vaccine series with Rotarix (i.e., already received one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried RotaTeq, if formulary. If RotaTeq is non-formulary, approve. **2.** Patient has started rotavirus vaccine series with Rotarix (i.e., already received one dose of the series): approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Rotavirus	RotaTeq	rotavirus vaccine oral solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried Rotarix, if formulary. If Rotarix is non-formulary, approve. **2.** Patient with latex allergy: approve. **3.** Patient has started the rotavirus vaccine series with RotaTeq (i.e., already received at least one dose of the series): approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried Rotarix, if formulary. If Rotarix is non-formulary, approve. **2.** Patient with latex allergy: approve. **3.** Patient has started the rotavirus vaccine series with RotaTeq (i.e., already received at least one dose of the series): approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Seasonal Influenza	Afluria Trivalent	influenza virus vaccine, trivalent, for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Fluarix Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Fluarix Trivalent, Flucelvax Trivalent, FluLaval Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary, or one if one is formulary). **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Fluarix Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Fluarix Trivalent, Flucelvax Trivalent, FluLaval Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary, or one if one is formulary). **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Seasonal Influenza	Fluad Trivalent	influenza vaccine, adjuvanted injectable emulsion for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** If the patient is ≥ 65 years of age, approve if the patient has tried one of Flublok Trivalent or Fluzone High-Dose Trivalent, if formulary; If none are formulary, approve. **2.** If the patient is < 65 years of age: approve if the patient has tried three formulary injectable influenza virus vaccines: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** If the patient is ≥ 65 years of age, approve if the patient has tried one of Flublok Trivalent or Fluzone High-Dose Trivalent, if formulary; If none are formulary, approve. **2.** If the patient is < 65 years of age: approve if the patient has tried three formulary injectable influenza virus vaccines: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Seasonal Influenza	Fluarix Trivalent	influenza virus vaccine, trivalent, for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Flucelvax Trivalent, FluLaval Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Flucelvax Trivalent, FluLaval Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary or one if one is formulary). **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Seasonal Influenza	Flublok Trivalent	influenza vaccine solution, trivalent, for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Patient is < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccines: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **3.** Patients with an egg allergy: approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Patient is < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccines: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **3.** Patients with an egg allergy: approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Seasonal Influenza	Flucelvax Trivalent	influenza virus vaccine, trivalent, for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, FluLaval Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **4.** Patients with an egg allergy: approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** if the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** if the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, FluLaval Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **4.** Patients with an egg allergy: approve. **5.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Seasonal Influenza	Flulaval Trivalent	influenza virus vaccine, trivalent, for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, Fluzone Trivalent, or Flublok Trivalent, if formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Seasonal Influenza	Fluzone High-Dose Trivalent	influenza virus vaccine, trivalent, for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** If the patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent or Flublok Trivalent, if formulary. If none are formulary, approve. **2.** If the patient is < 65 years of age: approve if the patient has tried three formulary injectable influenza virus vaccines: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** If the patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent or Flublok Trivalent, if formulary. If none are formulary, approve. **2.** If the patient is < 65 years of age: approve if the patient has tried three formulary injectable influenza virus vaccines: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, FluLaval Trivalent, or Fluzone Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **3.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines - Seasonal Influenza	Fluzone Trivalent	influenza virus vaccine, trivalent, for intramuscular injection	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, or FluLaval Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, or FluLaval Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** If the patient is < 18 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flucelvax Trivalent, or FluLaval Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 18 years of age to < 65 years of age, approve if the patient has tried three formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, or FluLaval Trivalent, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve. **3.** If a patient is ≥ 65 years of age, approve if the patient has tried one of Fluad Trivalent, Flublok Trivalent, or Fluzone High-Dose Trivalent, if formulary. If none are formulary, approve. **4.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vaccines - Seasonal Influenza	FluMist Trivalent	Influenza virus vaccine, nasal	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried one formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, FluLaval Trivalent, Fluzone Trivalent. If none are formulary, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one formulary injectable influenza virus vaccine: Afluria Trivalent, Fluarix Trivalent, Flublok Trivalent, Flucelvax Trivalent, FluLaval Trivalent, Fluzone Trivalent. If none are formulary, approve. **2.** Approve if the patient meets both of the following (a and b): a. The requested vaccine is being used in accordance with the current Centers for Disease Control and Prevention (CDC) immunization schedule and/or current recommendations from the Advisory Committee on Immunization Practices (ACIP); AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year
Vaccines – Tick borne Encephalitis	TicoVac	tick-borne encephalitis vaccine intramuscular injection	For active immunization to prevent tick-borne encephalitis: approve.	1 year
Vaccines – Travel Vaccine	Ixiaro	Japanese encephalitis vaccine, inactivated, adsorbed suspension for intramuscular injection	Japanese encephalitis prophylaxis: Approve	1 year
Vaccines - Zoster vaccine, Varicella vaccine and Varicella Immune Globulin	VariZIG	varicella zoster immune globulin (lyophilized powder and liquid formulation)	For varicella zoster post-exposure prophylaxis: approve.	1 month
Vasculitis Agents	Tavneos	avacopan capsules	Anti-Neutrophil Cytoplasmic Autoantibody (ANCA)-Associated Vasculitis. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets the following (A, B, and C): A. Patient has granulomatosis with polyangiitis or microscopic polyangiitis; AND Note: Granulomatosis with polyangiitis is also known as Wegener's granulomatosis. B. Patient has active disease; AND Note: This includes patients that have newly diagnosed or relapsed disease. This does not include patients already in remission. C. Patient has tried or is currently taking at least one nonglucocorticoid immunosuppressant. Note: Examples of nonglucocorticoid immunosuppressants include cyclophosphamide, rituximab, methotrexate, azathioprine, or mycophenolate mofetil. **2.** Patient has been established on Tavneos for at least 6 months.	1 year
Vertigo Agents	Antivert 50 mg tablet and authorized generic meclizine 50 mg	meclizine 50 mg tablet	Patient meets both of the following (i and ii): i. Patient has tried generic 25 mg tablets; AND ii. Patient cannot take generic 25 mg tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.	1 year
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors	Ingrezza and titration pack; sprinkle caps	valbenazine capsules	Tardive dyskinesia in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance wth one of Austedo or Austedo XR, if formulary. If neither are formulary, approve. Note: If the patient has tried tetrabenazine tablets (Xenazine, generics), approve. **2.** Approve if the patient meets BOTH of the following (A and B): A. Ingrezza sprinkle capsules are being requested; AND B. Patient has difficulty swallowing oral dosage forms (capsules/tablets) or is unable to swallow oral dosage forms (capsules/tablets). Huntington's Chorea in a patient ≥ 18 years of age. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Austedo, Austedo XR, or tetrabenazine tablets (Xenazine, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient meets BOTH of the following (A and B): A. Ingrezza sprinkle capsules are being requested; AND B. Patient has difficulty swallowing oral dosage forms (capsules/tablets) or is unable to swallow oral dosage forms (capsules/tablets).	1 year

Data Class: Confidential

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors	Austedo	deutetrabenazine tablets	Tardive dyskinesia in a patient ≥ 18 years of age. Approve if the patient has tried Austedo XR, if formulary. If Austedo XR is non-formulary, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Ingrezza **[documentation required]**, if formulary. If Ingrezza is non-formulary, approve. Huntington's Chorea in a patient ≥ 18 years of age. Approve if the patient has tried Austedo XR, if formulary. If Austedo XR is non-formulary, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Ingrezza or tetrabenazine tablets (Xenazine, generics) **[documentation required]**, if formulary. If neither are formulary, approve.	1 year
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors	Austedo XR	deutetrabenazine extended-release tablets	Tardive dyskinesia in a patient ≥ 18 years of age. Approve if the patient has tried Austedo (non XR), if formulary. If Austedo (non-XR) is non-formulary, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Ingrezza **[documentation required]**, if formulary. If Ingrezza is non-formulary, approve. Huntington's Chorea in a patient ≥ 18 years of age. Approve if the patient has tried Austedo (non XR), if formulary. If Austedo (non-XR) is non-formulary, approve if the patient tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Ingrezza or tetrabenazine tablets (Xenazine, generics) **[documentation required]**, if formulary. If neither are formulary, approve.	1 year
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors	Xenazine	tetrabenazine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Vitamin D Analog Combination Agents (Topical)	Enstilar	calcipotriene 0.005%/betamethasone dipropionate 0.064% foam	Approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR significant intolerance with five generic prescription-strength topical corticosteroid products (e.g., betamethasone dipropinate, clobetasol propionate, diflorasone diacetate) AND a calcipotriene-containing product (e.g., calcipotriene cream).	1 year
Vitamin D Analog Combination Agents (Topical)	Wynzora	calcipotriene/ betamethasone dipropionate 0.005%/ 0.064% topical cream	Approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR significant intolerance with five generic prescription-strength topical corticosteroid products (e.g., betamethasone dipropinate, clobetasol propionate, diflorasone diacetate) AND a calcipotriene-containing product (e.g., calcipotriene cream).	1 year
Vitamin D Analogs (Oral)	Rayaldee	calcifediol extended-release capsules	Approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR significant intolerance with two of the following, if two are formulary (or one if one is formulary): doxercalciferol capsules (Hectorol, generics), calcitriol capsules/oral solution (Rocaltrol, generics), or paricalcitol capsules (Zemplar, generics). If none are formulary, approve.	1 year
Vitamin D Analogs (Topical)	Taclonex	calcipotriene 0.005%/betamethasone dipropionate 0.064% topical suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year
Vitamin D Analogs (Topical)	Sorilux and authorized generic	calcipotriene foam	**1.** Approve if the patient has tried calcipotriene solution, if formulary. If calcipotriene solution is non-formulary, approve. **2.** Approve if the patient has tried calcipotriene cream or ointment. **3.** If the patient is using the requested medication for plaque psoriasis and is between the ages ≥ 4 and < 18 years of age, approve.	1 year
Vitamins and Minerals	Nascobal nasal spray	cyanocobalamin nasal spray	Approve if the patient has tried one other single-entity vitamin B12 (cyanocobalamin) product.	1 year

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/9/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		9/24/2025	No	
Yes		8/11/2026	No	
Yes		8/11/2026	No	
		1/30/2026	No	
		1/30/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		10/22/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/30/2026	No	
Yes		1/30/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		1/30/2026	No	
		1/30/2026	No	
		1/30/2026	No	
		1/30/2026	No	
		1/30/2026	No	
Yes		1/30/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/30/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		9/26/2025	No	
		9/26/2025	No	
Yes		9/26/2025	No	
Yes		5/8/2026	No	
		4/1/2026	No	
		7/20/2026	No	
		7/20/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/12/2026	No	
Yes	Yes	5/22/2026	No	
		8/25/2025	Yes	
		11/19/2025	No	
		12/8/2025	No	
		12/8/2025	Yes	
Yes		4/15/2026	No	
		1/21/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		6/1/2026	No	
		1/9/2026	Yes	
		1/9/2026	Yes	
		1/9/2026	Yes	
		1/9/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		1/23/2026	No	
Yes		7/9/2025	No	
Yes		12/4/2025	No	Yes
Yes		5/21/2026	No	
Yes		1/21/2026	No	
Yes	Yes	7/29/2026	No	
Yes	Yes	7/29/2026	No	
Yes	Yes	8/5/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/7/2025	Yes	
		12/4/2025	No	
Yes	Yes	6/1/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes	Yes	7/22/2026	No	
Yes	Yes	7/22/2026	No	
	Yes	2/6/2026	Yes	
		2/6/2026	Yes	
		2/6/2026	Yes	
		1/30/2026	Yes	
		7/18/2025	No	Yes

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/18/2025	No	Yes
		7/18/2025	No	Yes
		7/18/2025	No	Yes
		7/18/2025	No	Yes
		9/8/2025	No	Yes
Yes		7/15/2026	No	
Yes		9/8/2025	No	
		6/1/2026	No	
Yes		10/7/2025	Yes	Yes
MSB Exclusion *This criteria applies only to the NPF		N/A	Yes	
Yes		12/4/2025	No	
Yes		8/11/2026	No	

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Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/29/2026	No	
Yes - brand only		8/11/2026	Yes	
Yes		10/28/2025	No	
Yes		4/8/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes	Yes	12/5/2025	No	
Yes	Yes	12/5/2025	No	
		7/15/2025	No	
		10/22/2025	No	
		12/8/2025	Yes	
		3/25/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/15/2025	No	
Yes		7/18/2025	No	
Yes		8/15/2025	No	
Yes		9/4/2025	No	
		12/8/2025	No	
Yes - Authorized generic		12/8/2025	No	
Yes		12/8/2025	No	
Yes		1/5/2026	No	
Yes		1/7/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/9/2026	No	
		1/9/2026	No	
Yes		1/21/2026	No	
Yes		1/23/2026	No	
Yes		1/23/2026	No	
Yes		1/23/2026	No	
		1/23/2026	Yes	
		2/18/2026	Yes	
Yes		2/25/2026	Yes	
Yes		3/11/2026	No	
		5/22/2026	No	
		6/1/2026	No	
		7/22/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		12/5/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/7/2025	Yes	
		10/7/2025	Yes	
		10/7/2025	No	
Yes		10/7/2025	Yes	
	Yes	4/24/2026	No	
MSB Exclusion *This criteria applies only to the NPF		10/15/2025	No	
Yes	Yes	4/24/2026	No	
Yes	Yes	4/24/2026	No	
	Yes	4/24/2026	No	
Yes		9/19/2025	Yes	
Yes		1/23/2026	No	
	Yes	5/8/2026	No	
Yes	Yes	6/5/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		10/30/2025	No	
MSB Exclusion *This criteria applies only to the NPF		1/23/2026	No	
Yes		7/28/2026	Yes	
Yes		7/28/2026	Yes	
		7/28/2026	No	
		7/28/2026	Yes	
Yes		9/8/2025	Yes	
		10/21/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		9/8/2025	No	
		7/22/2026	No	
		4/8/2026	Yes	
Yes		5/28/2026	No	Yes
Yes		4/8/2026	Yes	
		4/8/2026	Yes	
Yes		5/22/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		1/5/2026	Yes	
Yes		1/5/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/21/2026	No	
		1/23/2026	No	
		7/16/2026	No	
		7/22/2026	No	
Yes		1/1/2026	No	
Yes		1/1/2026	No	
Yes - Authorized generic only		1/1/2026	No	
Yes		1/1/2026	No	
Yes		1/1/2026	No	
Yes		1/1/2026	No	
Yes		1/1/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/1/2026	No	
		4/8/2026	Yes	
Yes		1/9/2026	No	
		2/2/2026	No	
Yes		6/1/2026	No	
Yes		6/1/2026	No	
Yes		9/8/2025	No	
		10/7/2025	Yes	
		10/7/2025	No	
		10/7/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		1/9/2026	No	
Yes		1/9/2026	No	
Yes		1/9/2026	No	
Yes		12/8/2025	No	
		12/5/2025	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	6/1/2026	No	
	Yes	6/1/2026	Yes	
	Yes	8/25/2025	No	
Yes	Yes	2/5/2026	Yes	
Yes		2/5/2026	Yes	
Yes		4/1/2026	No	
Yes	Yes	6/1/2026	No	
Yes	Yes	8/25/2025	No	
		10/21/2025	No	
Yes - AG only		10/21/2025	No	
		4/1/2026	No	
		12/8/2025	No	Yes
	Yes	12/8/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		1/1/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		7/22/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
	Yes	1/9/2026	No	
	Yes	8/25/2025	No	
	Yes	8/25/2025	No	
	Yes	8/25/2025	No	
	Yes	8/25/2025	No	
	Yes	8/25/2025	No	
	Yes	8/25/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	10/30/2025	No	
	Yes	10/30/2025	No	
	Yes	1/9/2026	No	
	Yes	1/9/2026	No	
	Yes	1/9/2026	No	
		12/8/2025	Yes	
		12/8/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		1/7/2026	No	
Yes		1/9/2026	No	
Yes		1/23/2026	No	
Yes	Yes	5/21/2026	No	
	Yes	7/2/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/2/2026	Yes	
	Yes	7/2/2026	Yes	
Yes	Yes	7/2/2026	Yes	
	Yes	7/2/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes	Yes	7/2/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/2/2026	No	
Yes		7/18/2025	No	
MSB Exclusion *This criteria applies only to the NPF		9/26/2025	No	
Yes		10/7/2025	No	
Yes		11/20/2025	No	
Yes		12/2/2025	No	
		12/8/2025	No	
	Yes	12/16/2025	No	
	Yes	12/16/2025	Yes	
	Yes	12/16/2025	No	
Yes -authorized generic only		12/16/2025	No	
		12/16/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	12/16/2025	Yes	
	Yes	1/5/2026	Yes	
		1/5/2026	Yes	
Yes		1/7/2026	No	
Yes		1/7/2026	No	
		2/19/2026	No	
Yes	Yes	2/19/2026	Yes	
	Yes	2/23/2026	Yes	
Yes		2/25/2026	No	
		7/15/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		7/9/2025	No	
	Yes	12/8/2025	Yes	
	Yes	12/8/2025	Yes	
		12/8/2025	No	
		1/20/2026	No	
		7/16/2026	No	
		1/9/2026	No	Yes
		12/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/8/2025	No	
		12/16/2025	Yes	
		12/16/2025	Yes	
		1/9/2026	No	Yes
		5/12/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		10/28/2025	No	
Yes		1/9/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		9/8/2025	No	
		4/29/2026	No	
		1/23/2026	Yes	
		4/8/2026	No	
		4/8/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		4/8/2026	No	
		4/8/2026	No	
Yes		12/16/2025	No	
Yes		12/8/2025	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		1/23/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		1/5/2026	Yes	
Yes *This criteria applies only to the NPF		8/11/2026	Yes	
Yes		7/17/2025	No	
Yes		2/4/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/5/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		8/25/2025	Yes	
		12/4/2025	No	Yes
Yes		2/2/2026	No	
Yes		2/2/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		8/11/2026	No	
		7/22/2026	No	
		7/17/2026	No	
Yes		6/16/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/16/2026	Yes	
Yes		6/16/2026	Yes	
		6/16/2026	No	
Yes		6/16/2026	Yes	
Yes		6/16/2026	Yes	
Yes		6/16/2026	Yes	
		6/16/2026	Yes	
		6/1/2026	No	
		6/1/2026	Yes	
Yes - Forteo brand		7/1/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/1/2025	Yes	
		7/1/2025	Yes	
Yes		5/22/2026	Yes	
		6/16/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		6/16/2026	No	
Yes		6/16/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/16/2026	Yes	
Yes		6/16/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		6/16/2026	Yes	
		6/16/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		6/16/2026	Yes	
Yes		6/16/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	1/7/2026	No	
	Yes	1/7/2026	No	
Yes	Yes	1/7/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/27/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	2/2/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	2/2/2026 (continued)	No (continued)	
Yes		12/5/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		12/5/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		12/5/2025	No	
Yes		12/5/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/5/2025	No	
		12/5/2025	No	
		6/18/2026	No	
	Yes	6/26/2026	No	
		2/5/2026	No	
		6/18/2026	No	
	Yes	1/23/2026	Yes	
		5/14/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/4/2025	No	
		12/4/2025	No	
		12/4/2025	No	
Yes		7/23/2026	No	Yes
Yes		7/23/2026	No	
		4/6/2026	No	
		4/6/2026	No	
		1/9/2026	No	
		1/23/2026	Yes	
Yes		4/8/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		1/25/2026	No	
Yes		1/25/2026	No	
Yes		1/25/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/10/2025	Yes	Yes
	Yes	8/5/2026	No	
	Yes	7/15/2025	Yes	
	Yes	11/17/2025	Yes	
	Yes	12/4/2025	Yes	
	Yes	1/23/2026	Yes	
	Yes	7/24/2026	No	
	Yes	7/24/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	8/7/2026	No	
		7/1/2026	No	
		12/2/2025	No	
		3/20/2026	No	
	Yes	4/7/2026	Yes	
	Yes	4/7/2026	Yes	
	Yes	8/11/2025	No	
	Yes	12/2/2025	No	
	Yes	2/26/2026	No	
Yes		6/5/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/5/2026	No	
		8/27/2025	No	
		9/17/2025	No	
		9/17/2025	No	
	Yes	10/21/2025	No	
		11/5/2025	No	
		12/17/2025	No	
		12/17/2025	No	
		1/14/2026	No	
		2/5/2026	No	
		2/11/2026	No	
		3/11/2026	No	
		3/25/2026	No	
		4/22/2026	No	
		6/3/2026	No	
		6/10/2026	No	
		6/18/2026	No	
		7/1/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/5/2026	No	
		1/21/2026	No	
		1/21/2026	No	
		1/21/2026	No	
Yes		1/21/2026	No	
		11/20/2025	No	
		3/25/2026	No	
		4/1/2026	No	
Yes		3/19/2026	No	
	Yes	11/24/2025	Yes	
	Yes	11/24/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/18/2025	No	
		7/18/2025	No	
Yes		1/23/2026	No	
		6/1/2026	No	
Yes	Yes	7/1/2026	No	
		10/1/2025	No	
	Yes	11/20/2025	No	
		12/18/2025	No	
		2/25/2026	No	
		2/25/2026	No	
		3/25/2026	No	
		6/18/2026	No	
		6/18/2026	No	
		7/8/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/5/2026	No	
		2/25/2026	No	
		4/30/2026	No	
		5/13/2026	No	
		3/18/2026	No	
		3/18/2026	No	
		2/11/2026	No	
Yes	Yes	3/3/2026	No	
	Yes	4/16/2026	No	
	Yes	4/16/2026	No	
Yes	Yes	10/30/2025	Yes	
		1/21/2026	No	
		3/12/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/17/2026	No	
Yes	Yes	2/23/2026	No	
		3/12/2026	No	
		3/12/2026	No	
	Yes	2/2/2026	No	
		4/1/2026	No	
		9/3/2025	No	
		8/13/2026	No	
		2/25/2026	No	
		3/4/2026	No	
		5/13/2026	No	
		4/1/2026	No	
		5/14/2026	No	
		12/17/2025	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/12/2026	No	
		2/5/2026	No	
		3/11/2026	No	
Yes	Yes	6/3/2026	No	
		5/13/2026	No	
Yes		12/16/2025	No	
Yes	Yes	12/10/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	3/11/2026	Yes	
		7/1/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		8/27/2025	No	
		8/5/2026	No	
Yes		4/10/2026	No	
		1/21/2026	No	
Yes	Yes	1/25/2026	No	
Yes		4/2/2026	No	
		4/29/2026	No	
		2/11/2026	No	
		5/22/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/25/2026	No	
		7/1/2026	No	
	Yes	7/31/2026	No	
		5/12/2026	No	
Yes		10/28/2025	No	
Yes		10/28/2025	No	
Yes	Yes	12/4/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	12/16/2025	No	
	Yes	8/11/2026	No	
	Yes	8/6/2025	Yes	
	Yes	8/11/2025	Yes	
		1/5/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/23/2026	No	
	Yes	2/23/2026	Yes	
		2/25/2026	Yes	
	Yes	2/2/2026	Yes	
	Yes	2/2/2026	Yes	
		7/9/2025	No	
	Yes	7/15/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/25/2026	No	
	Yes	6/25/2026	Yes	
	Yes	6/29/2026	Yes	
Yes		5/22/2026	Yes	
		5/22/2026	Yes	
		5/22/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/22/2026	Yes	
Yes		8/27/2025	Yes	
Yes		8/27/2025	Yes	
Yes		8/27/2025	No	
		8/27/2025	Yes	
Yes		8/27/2025	Yes	
		8/27/2025	Yes	
Yes	Yes	2/3/2026	No	
Yes	Yes	2/3/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	2/3/2026	No	
Yes	Yes	8/12/2026	Yes	
		9/3/2025	No	
	Yes	10/10/2025	No	
	Yes	10/21/2025	Yes	
		8/12/2026	No	
		6/24/2026	No	
Yes	Yes	6/25/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/14/2026	No	
	Yes	2/26/2026	Yes	
	Yes	7/21/2026	Yes	
		6/5/2026	No	
		6/5/2026	No	
Yes		6/5/2026	No	
	Yes	2/4/2026	No	
	Yes	7/21/2026	No	
Yes		10/22/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/15/2025	Yes	
		4/29/2026	No	
	Yes	5/30/2025	Yes	
		4/15/2026	No	
Yes	Yes	1/20/2026	Yes	
	Yes	5/19/2026	Yes	
		5/13/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	10/7/2025	No	
	Yes	10/21/2025	Yes	
		10/22/2025	No	
		3/25/2026	No	
Yes	Yes	10/30/2025	No	
	Yes	3/25/2026	No	
	Yes	6/1/2026	Yes	
	Yes	7/23/2026	No	
	Yes	7/23/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/9/2025	No	
MSB Exclusion *This criteria applies only to the NPF		3/13/2026	No	
	Yes	7/22/2026	No	
	Yes	7/22/2026	No	
		6/3/2026	No	
	Yes	12/5/2025	Yes	
Yes	Yes	12/5/2025	Yes	
	Yes	12/4/2025	No	
	Yes	1/25/2026	No	
Yes	Yes	4/2/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	4/2/2026	Yes	
	Yes	4/2/2026	Yes	
Yes	Yes	4/2/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	11/20/2025	Yes	
	Yes	1/5/2026	Yes	
	Yes	1/15/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	4/15/2026	Yes	
	Yes	7/2/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes	Yes	12/8/2025	Yes	
		6/24/2026	No	
	Yes	6/25/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		11/20/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/23/2026	Yes	
Yes	Yes	1/23/2026	Yes	
		1/23/2026	No	
Yes		1/23/2026	Yes	
Yes		1/23/2026	Yes	
		1/23/2026	Yes	
Yes		1/23/2026	Yes	
Yes		1/23/2026	Yes	
	Yes	5/30/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		7/1/2025	No	
MSB Exclusion *This criteria applies only to the NPF		7/1/2025	No	
	Yes	7/18/2025	Yes	
	Yes	9/26/2025	Yes	
	Yes	9/26/2025	No	
Yes		10/22/2025	No	
MSB Exclusion *This criteria applies only to the NPF		1/1/2026	No	
		2/25/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	4/1/2026	No	
		4/15/2026	No	
Yes	Yes	4/16/2026	No	
		5/14/2026	No	
	Yes	7/6/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/24/2026	No	
		7/24/2026	No	
Yes		7/24/2026	No	
		2/11/2026	No	
	Yes	7/9/2025	Yes	
		7/9/2025	No	
		9/8/2025	No	
		12/4/2025	No	
		12/4/2025	No	
		12/5/2025	Yes	
		1/14/2026	No	
		2/19/2026	No	
		4/22/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/1/2026	No	
		7/1/2026	No	
		3/11/2026	No	
Yes		3/11/2026	No	
		3/11/2026	No	
		7/9/2025	No	
		7/9/2025	No	
		7/9/2025	No	
		7/9/2025	No	
		7/9/2025	No	
	Yes	1/23/2026	No	
		8/12/2026	No	
		5/12/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	8/11/2025	No	
	Yes	2/23/2026	Yes	
		7/22/2026	Yes	
Yes - brand only	Yes	7/9/2025	No	
		10/28/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	10/7/2025	No	
		2/4/2026	No	
	Yes	7/1/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		8/27/2025	No	
Yes	Yes	7/24/2026	Yes	
Yes	Yes	6/16/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	6/16/2026	No	
	Yes	6/16/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		2/20/2026	Yes	
Yes		4/10/2026	No	
Yes		4/10/2026	Yes	
Yes		4/10/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/10/2026	No	
Yes		4/10/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		12/8/2025	No	
		12/8/2025	No	
Yes		12/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/8/2025	No	
Yes		2/25/2026	No	
		4/10/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		4/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/10/2026	No	
Yes		9/15/2025	No	
		12/5/2025	No	
Yes		1/23/2026	No	
	Yes	4/2/2026	No	
	Yes	4/2/2026	No	
MSB Exclusion *This criteria applies only to the NPF		4/10/2026	No	
		7/11/2025	No	
		7/11/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/17/2025	No	
		3/11/2026	No	
Yes	Yes	2/25/2026	Yes	
		7/18/2025	No	
		7/18/2025	No	
		1/21/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		1/7/2026	No	
Yes		1/7/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/30/2025	No	
		7/6/2026	No	
Yes		8/20/2025	No	
Yes	Yes	7/6/2026	No	
Yes		11/7/2025	No	
Yes		11/7/2025	No	
		6/8/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		6/8/2026	No	
Yes		6/8/2026	Yes	
Yes		6/8/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/8/2026	Yes	
Yes		6/8/2026	Yes	
Yes		6/8/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		6/8/2026	Yes	
		7/9/2025	Yes	
Yes		7/9/2025	Yes	
Yes		7/9/2025	Yes	
Yes		7/9/2025	Yes	
Yes		7/9/2025	No	
Yes		7/9/2025	Yes	
		7/9/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	3/19/2026	No	
		9/10/2025	No	
		1/21/2026	No	
Yes	Yes	2/11/2026	No	
Yes	Yes	3/19/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	4/7/2026	No	
	Yes	4/7/2026	No	
Yes	Yes	2/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	2/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	2/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	2/11/2026	No	
		2/25/2026	Yes	
Yes		2/25/2026	Yes	
		2/25/2026	No	
		2/25/2026	Yes	
Yes	Yes	6/16/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/16/2026	Yes	
	Yes	6/16/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes	Yes	6/16/2026	Yes	
		12/8/2025	Yes	
		12/5/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/5/2025	No	
MSB Exclusion *This criteria applies only to the NPF		12/5/2025	No	
		4/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/10/2026	No	
Yes		4/10/2026	No	
		7/6/2026	No	
Yes		8/21/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		9/8/2025	No	
MSB Exclusion *This criteria applies only to the NPF		12/5/2025	No	
MSB Exclusion *This criteria applies only to the NPF		12/5/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		12/5/2025	No	
MSB Exclusion *This criteria applies only to the NPF		12/5/2025	No	
Yes		4/10/2026	No	
Yes		4/10/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/10/2026	No	
Yes		4/10/2026	No	
		4/10/2026	No	
Yes		4/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		7/22/2026	No	
		12/5/2025	Yes	
		12/5/2025	No	
		12/5/2025	No	
		12/5/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/8/2025	No	
		1/21/2026	No	
		2/25/2026	No	
		7/23/2026	No	
Yes		2/23/2026	No	
		1/23/2026	No	
Yes		8/11/2026	No	Yes
Yes		8/11/2026	No	
Yes		12/4/2025	No	Yes
		1/23/2026	No	Yes
		1/23/2026	No	Yes
		1/23/2026	No	Yes
		2/4/2026	No	Yes
		2/4/2026	No	Yes
Yes		7/23/2026	No	Yes

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/29/2025	No	
Yes *This criteria applies only to the NPF		2/2/2026	No	
Yes		2/2/2026	No	
Yes		2/2/2026	No	
Yes		2/23/2026	No	
Yes		2/2/2026	No	
Yes		2/2/2026	No	
Yes		2/2/2026	No	
Yes		6/1/2026	No	
Yes		6/1/2026	No	
Yes		6/1/2026	No	
Yes		6/1/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		11/21/2025	No	
Yes		7/15/2025	No	
Yes		7/15/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		7/15/2025	No	
		3/11/2026	No	
		9/8/2025	No	
	Yes	2/23/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	2/23/2026	Yes	
	Yes	2/23/2026	Yes	
	Yes	4/29/2026	Yes	
		4/29/2026	No	
	Yes	4/29/2026	Yes	
Yes - brand only		7/1/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		10/8/2025	No	
		6/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/8/2026	No	
Yes		10/21/2025	No	
		7/29/2026	No	
		7/15/2025	Yes	
		7/15/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/8/2025	Yes	
Yes		12/8/2025	No	
		1/5/2026	Yes	
Yes		1/5/2026	Yes	
Yes		1/5/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes - Authorized generic only		1/5/2026	Yes	
		1/5/2026	Yes	
Yes - Authorized generic only		1/5/2026	No	
Yes		1/5/2026	No	
Yes		7/15/2025	Yes	
Yes		7/15/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/2/2026	No	
Yes		8/15/2025	No	
		2/2/2026	No	
Yes		2/2/2026	No	
		2/2/2026	No	
Yes		2/2/2026	No	
		7/24/2026	Yes	
		7/24/2026	Yes	
		7/24/2026	Yes	
		7/24/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/24/2026	Yes	
Yes - brand only		7/24/2026	Yes	
		7/24/2026	Yes	
		5/30/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/30/2025	Yes	
		7/9/2025	No	
Yes		7/9/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/25/2026	Yes	
Yes		4/8/2026	No	
Yes - Certain NDCs		5/22/2026	Yes	
Yes		5/22/2026	Yes	
		5/22/2026	Yes	
		8/5/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/4/2026	Yes	
		2/4/2026	Yes	
		5/14/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		5/14/2025	Yes	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
		10/10/2025	No	
		10/10/2025	No	
		10/10/2025	No	
		10/10/2025	No	
		10/10/2025	No	
Yes		8/11/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/11/2026	Yes	
Yes		8/11/2026	Yes	
Yes		8/11/2026	Yes	
		8/11/2026	Yes	
		8/11/2026	Yes	
Yes		8/11/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes - vial only		8/11/2026	Yes	
		8/11/2026	Yes	
		8/11/2026	Yes	
		9/5/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/5/2026	Yes	
Yes		1/5/2026	Yes	
Yes		1/9/2026	Yes	
Yes		3/5/2026	No	
Yes		3/5/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		4/8/2026	No	
		4/8/2026	No	
Yes		12/8/2025	No	
Yes		1/7/2026	No	
Yes		12/16/2025	Yes	
		12/16/2025	Yes	
Yes		2/25/2026	Yes	
Yes		2/25/2026	Yes	
		2/25/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/1/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		7/1/2026	No	
		5/28/2026	Yes	
Yes		5/28/2026	Yes	
Yes		5/28/2026	Yes	
Yes		5/28/2026	Yes	
Yes		5/28/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		7/1/2026	No	
Yes		1/7/2026	No	Yes
Yes		5/15/2026	No	Yes
Yes		2/4/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes - certain diabetic supplies		12/16/2025	Yes	
		2/26/2026	No	
		2/26/2026	No	
		2/26/2026	No	
Yes - Bigfoot Unity Program Kit, Eversense 365		2/26/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/8/2026	No	
Yes		4/8/2026	No	
Yes		4/8/2026	No	
Yes		2/4/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		6/12/2026	No	
Yes- AG only		1/23/2026	Yes	
Yes		1/21/2026	No	
Yes		1/21/2026	No	
		1/21/2026	No	
Yes		2/4/2026	No	
Yes		2/4/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/4/2026	No	
Yes		2/11/2026	No	
Yes		3/18/2026	No	
Yes		4/29/2026	No	
Yes		5/12/2026	No	
		9/8/2025	No	
		9/8/2025	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		10/10/2025	No	
Yes		3/18/2026	No	Yes
		4/8/2026	No	
		6/24/2026	No	
		7/17/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	5/1/2026	No	
		12/9/2025	No	
		3/11/2026	No	
Yes		4/1/2026	No	
		4/22/2026	No	
		4/22/2026	No	
		4/22/2026	No	
		4/22/2026	No	
		4/22/2026	No	
		4/29/2026	No	
		5/13/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/16/2026	No	
		12/5/2025	No	
		1/30/2026	No	
Yes		4/29/2026	No	
	Yes	12/5/2025	No	
	Yes	1/7/2026	No	
	Yes	1/7/2026	No	
		5/12/2026	No	
		12/4/2025	No	
		1/5/2026	Yes	
		1/5/2026	Yes	
Yes		1/5/2026	Yes	
		10/7/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		3/26/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		7/15/2025	Yes	
		7/15/2025	Yes	
		7/15/2025	Yes	
Yes		12/16/2025	Yes	
Yes		12/16/2025	Yes	
Yes		12/16/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/16/2025	Yes	
		1/5/2026	Yes	
		1/14/2026	No	
MSB Exclusion *This criteria applies only to the NPF		7/15/2025	N/A	
Yes		12/5/2025	Yes	
		12/5/2025	Yes	
Yes		6/1/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/1/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	N/A	
MSB Exclusion *This criteria applies only to the NPF		N/A	N/A	
MSB Exclusion *This criteria applies only to the NPF		N/A	N/A	
		3/19/2026	No	
		3/19/2026	No	
Yes		3/19/2026	No	
Yes		3/19/2026	No	
Yes		3/19/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/30/2025	No	
Yes		12/30/2025	No	
Yes		8/13/2025	No	
Yes		8/13/2025	No	
		8/13/2025	No	
Yes		8/5/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
	Yes	10/7/2025	No	
		9/24/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/17/2025	No	
		12/17/2025	No	
		12/17/2025	No	
		12/17/2025	No	
		12/17/2025	No	
		1/9/2026	No	
Yes	Yes	1/23/2026	Yes	
	Yes	4/8/2026	Yes	
	Yes	4/29/2026	No	
	Yes	4/29/2026	No	
	Yes	4/29/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/4/2025	No	
		7/23/2026	No	
Yes	Yes	7/24/2026	No	
Yes	Yes	7/24/2026	No	
	Yes	7/24/2026	No	
	Yes	7/24/2026	No	
		8/25/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/25/2025	No	
Yes		12/5/2025	Yes	
Yes		7/11/2025	Yes	
		7/11/2025	Yes	
		7/11/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		10/30/2025	No	
		N/A	Yes	
Yes		4/29/2026	No	Yes
		N/A	Yes	
Yes		2/25/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		5/21/2026	No	
		7/22/2026	Yes	
		7/22/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		12/9/2025	No	
Yes		8/29/2025	No	
Yes		2/2/2026	No	
Yes		2/25/2026	No	
		3/11/2026	No	
		4/8/2026	No	
		7/8/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		3/25/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	1/30/2026	Yes	
Yes	Yes	1/30/2026	Yes	
Yes	Yes	1/30/2026	Yes	
		5/13/2026	No	
MSB Exclusion *This criteria applies only to the NPF		8/12/2026	No	
Yes		10/10/2025	No	
		10/10/2025	Yes	
		12/8/2025	No	
		12/16/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		2/25/2026	No	Yes
Yes		7/13/2026	Yes	
		7/16/2026	Yes	
Yes		7/16/2026	Yes	
		7/16/2026	Yes	
		1/5/2026	Yes	
	Yes	3/4/2026	Yes	
	Yes	4/8/2026	No	
		9/8/2025	Yes	
		1/23/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/23/2026	No	
		1/23/2026	No	
	Yes	7/25/2025	Yes	
	Yes	7/25/2025	Yes	
	Yes	9/16/2025	Yes	
Yes	Yes	9/16/2025	No	
Yes	Yes	2/23/2026	Yes	
Yes	Yes	2/23/2026	No	
	Yes	2/23/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	2/23/2026	Yes	
	Yes	1/5/2026	Yes	
	Yes	9/8/2025	Yes	
	Yes	1/5/2026	Yes	
		1/23/2026	No	
		2/2/2026	No	
		5/13/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		1/20/2026	No	
		8/4/2025	No	
		12/8/2025	No	
		1/7/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/7/2026	Yes	
Yes		1/7/2026	Yes	
Yes		1/7/2026	Yes	
		1/7/2026	Yes	
		1/7/2026	Yes	
Yes		1/7/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/15/2025	Yes	
Yes		8/15/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/7/2026	Yes	
	Yes	10/10/2025	No	
		7/22/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		10/21/2025	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		10/21/2025	No	
		10/21/2025	No	
		10/21/2025	No	
		12/17/2025	No	
		1/20/2026	No	
		2/3/2026	No	
Yes	Yes	2/10/2026	No	
Yes		2/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		2/19/2026	No	
Yes		1/5/2026	No	
		9/24/2025	No	
		7/18/2025	No	
	Yes	7/18/2025	No	
	Yes	1/5/2026	Yes	
	Yes	1/5/2026	Yes	
Yes	Yes	1/5/2026	Yes	
	Yes	7/15/2025	Yes	
Yes	Yes	7/15/2025	Yes	
Yes	Yes	4/8/2026	Yes	
	Yes	12/4/2025	Yes	
		2/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	12/4/2025	No	
	Yes	12/4/2025	No	
	Yes	12/4/2025	No	
	Yes	12/4/2025	No	
	Yes	12/4/2025	Yes	
	Yes	12/4/2025	Yes	
	Yes	12/4/2025	Yes	
Yes	Yes	12/5/2025	No	
Yes	Yes	12/5/2025	No	
		6/18/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/24/2026	Yes	
Yes	Yes	7/24/2026	Yes	
	Yes	7/24/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	12/5/2025	Yes	
	Yes	2/2/2026	Yes	
	Yes	2/2/2026	Yes	
	Yes	2/2/2026	Yes	
	Yes	7/11/2025	No	
		3/4/2026	No	
		10/15/2025	No	
		1/23/2026	Yes	
		1/23/2026	Yes	
		1/23/2026	Yes	
		1/23/2026	No	
		7/28/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		7/18/2025	No	
Yes		7/18/2025	No	
		8/25/2025	No	
		8/25/2025	No	
Yes		2/25/2026	No	
Yes		2/25/2026	Yes	
		4/8/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/8/2026	No	
		7/6/2026	No	
Yes		7/6/2026	No	
		4/8/2026	No	
		7/23/2026	No	
		7/2/2026	Yes	
		7/2/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/5/2026	Yes	
		6/26/2026	No	
		10/21/2025	No	
Yes	Yes	7/15/2025	No	
Yes		11/5/2025	No	
	Yes	2/4/2026	No	
	Yes	2/4/2026	Yes	
	Yes	9/26/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	9/26/2025	No	
	Yes	9/26/2025	No	
	Yes	9/26/2025	Yes	
	Yes	1/20/2026	Yes	
Yes		11/11/2025	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		3/3/2026	Yes	
Yes		8/25/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/25/2025	No	
MSB Exclusion *This criteria applies only to the NPF		8/25/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/25/2025	Yes	
		8/25/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		8/25/2025	No	
Yes		8/25/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		8/25/2025	No	
		8/25/2025	Yes	
Yes		6/5/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes - Authorized generic only		7/22/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		3/20/2026	Yes	
		3/18/2026	No	
Yes		10/10/2025	Yes	
Yes		10/10/2025	Yes	
		10/10/2025	Yes	
		10/10/2025	Yes	
		12/4/2025	No	
	Yes	12/4/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	12/4/2025	No	
Yes	Yes	7/15/2025	No	
		12/4/2025	No	
	Yes	12/5/2025	No	
	Yes	12/5/2025	No	
		2/23/2026	Yes	
		2/23/2026	Yes	
		12/4/2025	No	
		12/4/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/4/2025	No	
		12/4/2025	Yes	
	Yes	8/12/2025	No	
	Yes	9/8/2025	No	
	Yes	9/8/2025	No	
	Yes	10/7/2025	No	
	Yes	12/5/2025	No	
	Yes	12/16/2025	Yes	
		12/17/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/8/2025	No	
	Yes	7/9/2025	No	
Yes	Yes	4/8/2026	No	
	Yes	4/8/2026	No	
	Yes	12/4/2025	Yes	
	Yes	9/8/2025	Yes	
		9/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/4/2025	Yes	
		12/4/2025	Yes	
Yes	Yes	12/5/2025	Yes	
		2/11/2026	No	
	Yes	5/8/2026	No	
Yes	Yes	7/17/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/16/2025	Yes	
	Yes	12/16/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		1/9/2026	No	
		12/4/2025	No	
		12/4/2025	No	
		12/5/2025	No	
		2/11/2026	No	
Yes		12/4/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/4/2025	Yes	
Yes		12/4/2025	Yes	
Yes		12/4/2025	Yes	
Yes		12/4/2025	Yes	
Yes		12/4/2025	Yes	
Yes		12/4/2025	Yes	
Yes		7/2/2026	Yes	
Yes		7/2/2026	Yes	
Yes		7/2/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		7/2/2026	Yes	
Yes		7/2/2026	Yes	
Yes		7/2/2026	Yes	
		7/2/2026	Yes	
		7/2/2026	Yes	
Yes		7/2/2026	Yes	
Yes		7/2/2026	Yes	
		3/13/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		3/20/2026	No	
Yes		4/7/2026	Yes	
Yes		5/13/2026	No	
		8/5/2026	No	
		2/4/2026	No	
		2/4/2026	No	
		4/15/2026	No	
	Yes	4/14/2026	No	
	Yes	4/14/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		1/21/2026	No	
		4/22/2026	No	
Yes		6/16/2026	No	
	Yes	6/22/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		3/5/2026	Yes	
		3/5/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		3/5/2026	Yes	
Yes		3/5/2026	No	
Yes		3/5/2026	Yes	
		3/5/2026	Yes	
		3/5/2026	Yes	
		3/5/2026	No	
		3/5/2026	No	
Yes		3/5/2026	No	
		3/5/2026	No	
		2/2/2026	Yes	
		2/2/2026	Yes	
		2/2/2026	Yes	
		2/2/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		2/2/2026	Yes	
Yes		1/15/2026	Yes	
		1/15/2026	Yes	
		1/15/2026	Yes	
		1/15/2026	Yes	
		1/15/2026	Yes	
Yes	Yes	2/11/2026	Yes	
Yes	Yes	2/11/2026	No	
	Yes	2/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/23/2026	No	
	Yes	7/23/2026	Yes	
	Yes	10/21/2025	No	
	Yes	10/21/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/8/2025	No	
		10/7/2025	No	
	Yes	12/8/2025	No	Yes
Yes	Yes	12/8/2025	No	Yes
		12/8/2025	No	
	Yes	12/8/2025	No	
		2/25/2026	No	
		7/15/2025	Yes	
		7/15/2025	Yes	
Yes		1/9/2026	No	Yes
Yes		1/9/2026	No	Yes
Yes		1/30/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/13/2026	No	
		4/29/2026	No	
		6/10/2026	No	
		6/10/2026	No	
		7/18/2025	No	
Yes		1/23/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		6/1/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
	Yes	4/10/2026	Yes	
	Yes	4/10/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	8/20/2025	No	
	Yes	6/3/2026	No	
	Yes	6/3/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	6/29/2026	No	
Yes	Yes	8/10/2026	No	
Yes	Yes	5/28/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	5/28/2026	No	
Yes	Yes	5/28/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	5/28/2026	Yes	
		4/23/2026	No	
Yes		4/23/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/23/2026	No	
		4/23/2026	No	
Yes		4/23/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/23/2026	No	
Yes		4/23/2026	No	
Yes		4/23/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		4/23/2026	No	
Yes		4/23/2026	No	
		4/23/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/1/2026	Yes	
		1/1/2026	Yes	
Yes		2/19/2026	Yes	
Yes		2/19/2026	Yes	
Yes		2/19/2026	Yes	
	Yes	7/22/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/5/2026	No	
		4/10/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/13/2026	No	
		8/10/2026	No	
Yes	Yes	8/10/2026	No	
		8/10/2026	No	
		8/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/13/2026 (continued)	No (continued)	
		8/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/11/2026	No	
	Yes	6/25/2026	No	
	Yes	6/3/2026	No	
	Yes	8/11/2026	No	
	Yes	1/5/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	3/13/2026	No	
	Yes	6/3/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/25/2026	No	
	Yes	6/25/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/25/2026	No	
Yes	Yes	8/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	8/10/2026	No	
Yes	Yes	8/10/2026	No	
Yes	Yes	8/10/2026	No	
Yes	Yes	8/10/2026	No	
Yes	Yes	8/10/2026	No	
Yes	Yes	8/10/2026	No	
Yes		7/1/2026	No	
	Yes	4/24/2026	No	
Yes		7/1/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/25/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/25/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/25/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/25/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
	Yes	1/30/2026	No	
Yes	Yes	8/10/2026	No	
Yes	Yes	8/10/2026	No	
		5/22/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/22/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	
Yes		8/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/10/2026	No	
	Yes	3/25/2026	No	
	Yes	5/13/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	5/13/2026	No	
		5/22/2026	No	
		7/9/2026	No	
		7/24/2026	No	
Yes		7/16/2026	No	
		6/20/2025	Yes	
		6/20/2025	Yes	
Yes		6/20/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/1/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		1/5/2026	No	
	Yes	4/16/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		7/6/2026	No	
		8/5/2026	No	
	Yes	10/10/2025	No	
	Yes	10/10/2025	No	
		7/15/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/8/2025	Yes	
Yes	Yes	2/25/2026	No	Yes
Yes	Yes	2/25/2026	No	Yes
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		7/18/2025	Yes	
		2/2/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		10/28/2025	Yes	
Yes		10/28/2025	Yes	
Yes		10/28/2025	Yes	
		10/28/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		10/28/2025	Yes	
		8/21/2025	No	
Yes		8/21/2025	Yes	
Yes		8/21/2025	Yes	
Yes		8/21/2025	Yes	
Yes		8/21/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		12/2/2025	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/2/2025	No	
Yes		1/5/2026	No	
Yes		1/5/2026	No	
		7/6/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		7/11/2025	Yes	
		7/11/2025	Yes	
	Yes	2/18/2026	No	
	Yes	5/15/2026	Yes	
		6/10/2026	No	
Yes		3/18/2026	No	
		2/11/2026	No	
		7/8/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		12/10/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/10/2025	No	
Yes		12/10/2025	No	
		7/25/2025	Yes	
Yes		7/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/25/2025	Yes	
		11/12/2025	No	
Yes	Yes	6/1/2026	No	
Yes		8/25/2025	Yes	
		8/25/2025	Yes	
		6/3/2026	No	
		8/7/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		10/30/2025	No	
Yes		11/13/2025	No	
		5/20/2025	Yes	
Yes		7/6/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/6/2026	Yes	
		7/6/2026	Yes	
		8/15/2025	No	
		1/23/2026	No	
		1/23/2026	No	
Yes		1/23/2026	No	
		6/1/2026	No	
Yes		6/1/2026	No	
		7/11/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/21/2026	Yes	
		1/21/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		1/23/2026	No	
		5/13/2026	No	
		7/8/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		10/21/2025	No	
Yes		10/7/2025	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		12/8/2025	No	
		4/29/2026	No	
Yes		3/3/2026	No	
Yes		3/3/2026	No	
		8/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/11/2026	No	
		4/15/2026	No	
	Yes	7/11/2025	Yes	
	Yes	7/11/2025	Yes	
		2/25/2026	No	
		7/11/2025	No	
		1/21/2026	No	
	Yes	7/28/2026	No	
	Yes	7/28/2026	No	
	Yes	7/28/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	7/28/2026	No	
MSB Exclusion *This criteria applies only to the NPF		7/15/2025	N/A	
	Yes	5/28/2026	No	
	Yes	1/9/2026	No	
	Yes	1/23/2026	No	
Yes	Yes	2/4/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/16/2026	Yes	
	Yes	8/11/2026	No	
Yes- brand only	Yes	5/28/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		7/1/2026	No	
	Yes	7/6/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	7/6/2026	No	
Yes		7/6/2026	No	
Yes		7/22/2026	No	
Yes		7/28/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		12/29/2025	Yes	
		12/29/2025	Yes	
Yes		3/25/2026	No	
		10/10/2025	No	
		10/10/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		10/28/2025	No	
		12/16/2025	No	
Yes		1/23/2026	No	
Yes		2/2/2026	No	Yes
		2/2/2026	No	Yes
		2/2/2026	No	Yes
Yes		2/11/2026	No	
Yes		4/2/2026	No	
Yes		6/1/2026	No	
Yes - brand only		8/11/2025	No	Yes
Yes		8/11/2025	No	Yes
Yes - brand only		8/11/2025	No	Yes
		7/22/2026	No	
		12/4/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/4/2025	Yes	
Yes	Yes	6/5/2026	Yes	
		2/19/2026	No	
		5/28/2026	No	
		5/28/2026	No	
Yes	Yes	6/16/2026	Yes	
Yes	Yes	5/28/2026	Yes	
Yes		7/6/2026	No	
Yes		1/16/2026	No	
		11/20/2025	No	
Yes		9/8/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		9/8/2025	Yes	
		9/8/2025	Yes	
		9/8/2025	Yes	
		8/11/2026	Yes	
Yes		2/23/2026	Yes	Yes
		7/18/2025	No	
MSB Exclusion *This criteria applies only to the NPF		7/1/2026	No	
	Yes	2/4/2026	Yes	
	Yes	12/29/2025	No	
		2/5/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/2/2025	No	
		12/2/2025	No	
Yes		3/30/2026	No	
		4/1/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		4/1/2026	No	
		4/29/2026	No	
		5/12/2026	No	
	Yes	6/1/2026	Yes	
		12/30/2025	No	
		7/16/2026	No	
		10/8/2025	No	
Yes	Yes	10/8/2025	No	
		2/4/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	5/14/2026	No	
		12/17/2025	No	
	Yes	4/24/2026	No	
		9/10/2025	No	
		9/26/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes- generic only		7/1/2025	No	
Yes		7/1/2025	No	
Yes		10/30/2025	No	
Yes		7/28/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		7/15/2025	N/A	
Yes		12/8/2025	Yes	
		12/8/2025	No	
		12/8/2025	Yes	
Yes		12/8/2025	Yes	
		12/8/2025	Yes	
Yes		12/8/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/5/2026	No	
Yes		1/5/2026	Yes	
Yes		1/7/2026	No	
Yes		1/23/2026	No	
Yes		2/5/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes- brand only		4/8/2026	No	
Yes		6/29/2026	No	
		6/29/2026	No	
		6/29/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/3/2026	No	
	Yes	1/27/2026	No	
	Yes	1/27/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		3/4/2026	No	
		6/1/2026	No	
Yes		10/28/2025	No	
Yes		1/7/2026	No	
Yes		1/7/2026	No	
Yes		2/5/2026	No	
Yes		9/15/2025	No	
Yes		12/4/2025	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/2/2026	No	
Yes		4/6/2026	No	
Yes		8/25/2025	No	
		3/11/2026	No	
Yes		3/11/2026	No	
		7/15/2025	No	
		1/30/2026	No	
	Yes	1/30/2026	Yes	
		7/22/2026	No	
	Yes	1/30/2026	No	
	Yes	1/30/2026	No	
	Yes	1/30/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/7/2025	No	
		1/7/2026	No	
		7/1/2026	No	
Yes		11/19/2025	No	
Yes	Yes	8/7/2026	Yes	
	Yes	8/7/2026	Yes	
Yes		8/7/2026	Yes	
		8/7/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/7/2026	No	
Yes		8/7/2026	Yes	
	Yes	8/7/2026	Yes	
	Yes	8/7/2026	Yes	
Yes	Yes	8/7/2026	Yes	
	Yes	8/7/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		4/8/2026	No	
Yes		1/21/2026	Yes	
Yes		1/26/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		7/28/2026	No	
Yes		7/28/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		1/1/2026	No	
Yes		7/6/2026	Yes	
		7/6/2026	Yes	
Yes		7/6/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		12/5/2025	Yes	
		1/5/2026	No	
		3/19/2026	Yes	
		7/22/2026	No	
		7/22/2026	No	
		10/7/2025	No	
		10/15/2025	Yes	
Yes		10/21/2025	No	
Yes		10/21/2025	Yes	
Yes		10/21/2025	Yes	
		10/21/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/21/2025	Yes	
Yes		10/21/2025	Yes	
Yes		10/21/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF 7/1/2022		N/A	No	
		2/23/2026	No	
Yes		2/2/2026	Yes	
		2/2/2026	Yes	
Yes		2/2/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/18/2026	No	
Yes		12/17/2025	No	
Yes		1/1/2026	No	
1 year		1/1/2026	No	
Yes		1/7/2026	No	
		1/7/2026	No	
Yes		1/16/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		5/13/2026	No	
Yes		5/15/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		3/11/2026	No	
Yes		3/11/2026	No	
		1/16/2026	No	
		3/18/2026	No	
		10/10/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		12/8/2025	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes - not brand		1/7/2026	No	
Yes		1/7/2026	No	
Yes		1/21/2026	No	
		1/21/2026	No	
Yes - Primlev only		2/2/2026	No	
		2/2/2026	No	
Yes - Primlev only		2/2/2026	No	
Yes - Primlev only		2/2/2026	No	
Yes		2/4/2026	No	
		2/4/2026	No	
Yes		4/14/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/5/2026	No	
		8/12/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		2/2/2026	No	
Yes		1/21/2026	Yes	
		6/26/2026	No	
Yes		2/23/2026	Yes	
		2/23/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		3/13/2026	No	
		5/8/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/22/2026	No	
		5/22/2026	No	
		5/22/2026	No	
Yes		7/9/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		1/26/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		2/2/2026	Yes	
		2/2/2026	Yes	
Yes		2/2/2026	Yes	
		2/2/2026	Yes	
		7/22/2026	No	
		9/19/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		4/29/2026	No	
	Yes	9/8/2025	No	
		2/4/2026	No	
Yes	Yes	8/11/2025	No	
		8/12/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes - only authorized generic		12/5/2025	Yes	
Yes		12/5/2025	Yes	
Yes		12/5/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		5/12/2026	No	
		5/12/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/30/2025	No	
		1/21/2026	No	
		12/8/2025	No	
		6/18/2026	No	
		9/8/2025	Yes	
		1/7/2026	Yes	
Yes		12/16/2025	Yes	Yes
Yes		2/16/2026	No	
		1/7/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		9/8/2025	No	
Yes		1/7/2026	No	
Yes		2/4/2026	No	
Yes		2/4/2026	No	
		7/11/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	1/26/2026	No	
	Yes	1/26/2026	No	
		6/10/2026	No	
	Yes	7/24/2026	No	
Yes		3/18/2026	No	
		3/18/2026	Yes	
Yes - brand only		7/15/2026	Yes	Yes- brand only

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		9/16/2025	No	
Yes		9/16/2025	No	
Yes Authorized generic only		7/15/2026	Yes	
Yes		7/15/2026	Yes	
Yes		7/15/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/15/2026	Yes	
		7/15/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
	Yes	1/30/2026	No	
		6/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	6/18/2026	No	
	Yes	1/21/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
	Yes	7/1/2025	No	
	Yes	8/11/2025	No	
	Yes	8/11/2025	No	
	Yes	8/11/2025	No	
		10/15/2025	No	
	Yes	1/21/2026	No	
	Yes	6/29/2026	Yes	
	Yes	6/29/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/25/2025	No	
Yes	Yes	8/25/2025	No	
	Yes	10/7/2025	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	Yes	
	Yes	1/5/2026	No	
		8/20/2025	No	
		8/5/2026	No	
		2/19/2026	No	
	Yes	12/4/2025	Yes	
	Yes	12/4/2025	Yes	
		1/5/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		5/19/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes -authorized generic only		10/8/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/8/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		10/8/2025	Yes	
Yes		10/8/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		7/6/2026	Yes	
Yes		7/6/2026	Yes	
		7/6/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/6/2026	Yes	
		7/6/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/11/2026	No	
		8/11/2026	No	
		6/9/2025	No	
Yes		8/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/11/2026	No	
		8/11/2026	No	
Yes		8/11/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/11/2026	No	
Yes		8/11/2026	No	
MSB Exclusion *This criteria applies only to the NPF		7/15/2025	No	
MSB Exclusion *This criteria applies only to the NPF		1/1/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		6/2/2026	Yes	
		6/2/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		9/8/2025	No	
		5/22/2026	No	
Yes		5/22/2026	No	
		7/28/2026	Yes	
		7/28/2026	Yes	
Yes		7/28/2026	No	
		1/7/2026	No	
		1/7/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		11/20/2025	No	
		10/15/2025	No	
Yes		2/23/2026	No	
Yes		12/8/2025	No	
Yes		3/19/2026	Yes	
Yes		3/19/2026	Yes	
		3/19/2026	Yes	
Yes		3/19/2026	Yes	
Yes		9/8/2025	No	
		10/21/2025	Yes	
		11/17/2025	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		2/4/2026	Yes	
Yes		2/4/2026	No	
		2/23/2026	No	
		10/10/2025	No	
		10/10/2025	No	
Yes		12/4/2025	No	
		1/23/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		10/7/2025	Yes	
		10/7/2025	Yes	
		10/7/2025	No	
Yes	Yes	10/10/2025	No	
		9/8/2025	Yes	
Yes		2/23/2026	No	
		9/8/2025	No	
		9/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		3/11/2026	No	
Yes		10/10/2025	No	
Yes		10/28/2025	No	
Yes		1/21/2026	No	
		1/23/2026	No	
	Yes	2/23/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		7/11/2025	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
	Yes	8/25/2025	Yes	
Yes		8/25/2025	No	
	Yes	8/25/2025	Yes	
Yes	Yes	12/8/2025	No	
		7/13/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		7/11/2025	Yes	
Yes		7/11/2025	Yes	
Yes		7/11/2025	Yes	
Yes		7/11/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		1/1/2026	No	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		2/5/2026	No	
		2/19/2026	No	
		7/17/2026	No	
		1/5/2026	Yes	
Yes		1/5/2026	Yes	
Yes		3/11/2026	No	
		N/A	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		1/9/2026	No	
		6/3/2025	Yes	
		12/2/2025	No	
Yes		12/2/2025	Yes	
Yes		12/10/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/30/2025	No	
Yes		8/12/2026	No	
		8/12/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		12/2/2025	No	
		7/29/2026	No	
		7/29/2026	No	
	Yes	7/29/2026	No	
	Yes	7/29/2026	No	
Yes		2/23/2026	No	
Yes		5/15/2026	No	
Yes		1/9/2026	Yes	
Yes		1/9/2026	No	
		1/9/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/9/2026	Yes	
Yes - Kyzatrex only		12/5/2025	No	
		1/21/2026	No	
Yes		1/21/2026	No	
Yes		12/8/2025	No	
		12/8/2025	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes - brand only		1/21/2026	No	
Yes		1/21/2026	No	
Yes		8/11/2026	No	
Yes		7/6/2026	No	Yes
Yes		7/6/2026	No	Yes
		6/10/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		7/6/2026	No	
	Yes	10/21/2025	No	
	Yes	10/21/2025	No	
	Yes	10/21/2025	No	
	Yes	10/21/2025	No	
Yes	Yes	10/21/2025	No	
Yes	Yes	12/8/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		1/1/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes	Yes	4/30/2026	No	
Yes		3/18/2026	No	
Yes		5/21/2026	Yes	
Yes		5/21/2026	Yes	
Yes		5/21/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		7/11/2025	No	
		7/11/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/14/2025	No	
		10/30/2025	Yes	
MSB Exclusion *This criteria applies only to the NPF		10/7/2025	No	
Yes		10/28/2025	No	
		7/6/2026	Yes	
		7/6/2026	Yes	
Yes		7/6/2026	Yes	
		7/22/2026	Yes	

Data Class: **Confidential**

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/11/2026	Yes	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
Yes		8/25/2025	No	
		12/8/2025	No	
Yes		12/26/2025	No	
		12/29/2025	Yes	
Yes- brand only		12/29/2025	No	Yes
Yes		4/8/2026	Yes	Yes
		4/8/2026	Yes	Yes
		4/8/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/10/2025	No	
Yes		1/21/2026	No	
Yes		2/4/2026	No	
Yes		6/1/2026	No	
		8/15/2025	No	
		6/18/2026	No	
Yes		1/21/2026	No	
		7/21/2025	No	
		10/14/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/31/2026	No	
		1/21/2026	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
Yes		12/4/2025	No	
	Yes	2/18/2026	Yes	
		3/11/2026	No	
		12/8/2025	No	
		9/11/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		9/11/2025	No	
		1/21/2026	No	
		1/21/2026	Yes	
		1/21/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/21/2026	Yes	
		1/21/2026	Yes	
		1/21/2026	Yes	
		1/21/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/21/2026	Yes	
		1/21/2026	Yes	
		1/21/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		2/25/2026	No	
		10/7/2025	No	
		2/25/2026	Yes	
		2/25/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		2/25/2026	Yes	
		1/9/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/21/2026	Yes	
		1/21/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/21/2026	Yes	
		1/21/2026	Yes	
		1/21/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		1/21/2026	No	
		1/21/2026	No	
		8/11/2026	Yes	
		8/11/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/11/2026	Yes	
		1/21/2026	Yes	
		8/4/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/4/2025	No	
		1/21/2026	Yes	
		12/8/2025	No	
		1/7/2026	No	
		1/21/2026	No	
		7/28/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/7/2025	No	
		10/7/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		8/5/2026	No	
		8/5/2026	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		7/9/2025	Yes	
		7/9/2025	Yes	
		7/9/2025	Yes	
		6/1/2026	Yes	
		6/1/2026	Yes	
		8/11/2026	Yes	
		3/27/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		3/27/2026	Yes	
		1/21/2026	Yes	
		1/21/2026	Yes	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		9/8/2025	No	
		9/8/2025	No	
		9/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		9/8/2025	No	
		9/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		9/8/2025	No	
		9/8/2025	No	
		9/8/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
		10/7/2025	No	
		2/23/2026	No	
		12/8/2025	No	
		12/8/2025	No	
	Yes	7/16/2025	No	
Yes		1/9/2026	No	Yes
		7/9/2025	No	

Data Class: Confidential

Formulary Exception Criteria

2026 NPF Excluded Medicaiton	Continuation of Therapy Required?	Date Last Reviewed	Utilizes Pref Alts to Operationalize Criteria	Expendable List
Yes		8/29/2025	No	
Yes		8/29/2025	No	
MSB Exclusion *This criteria applies only to the NPF		N/A	No	
		4/8/2026	No	
		4/8/2026	No	
		7/6/2026	Yes	
MSB Exclusion *This criteria applies only to the NPF		7/1/2025	No	
Yes		4/8/2026	No	
		12/29/2025	No	

Data Class: Confidential