OHUPDL Therapeutic Class	Drug	Denial Language: (remove/change anything not related to the specific PA and edit as needed using appropriate verbiage (5th grade reading level) (see Definitions of Terms) Updated 11/30/2022: Increase Text field on PA letters (8000) In reviewing letters that have generated okay, the following symbols are okay 1. (2.) 3. – 4. & 5. Numbers 6. . 7. , Please DO NOT USE BULLETS IN THE DENIAL LANGUAGE
Add to the Denial Language if the terms are clinical and difficult to explain		THE INFORMATION CONTAINED IN THE REMAINING PART OF THIS SECTION IS INTENDED FOR YOUR PROVIDER AND GIVES A MORE DETAILED DESCRIPTION FOR WHY THIS REQUEST WAS NOT APPROVED.
Re-authorization (no documentation submitted to support approval)		Coverage for reauthorization is provided when your provider has submitted documentation (chart notes) showing positive clinical response (outcome) to use of the requested medication as well as documentation (chart notes) that support ongoing safety monitoring while using the requested medication.

Analgesic Agents: NSAIDS	Non-preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: celecoxib, ibuprofen, and meloxicam tablets.
Analgesic Agents: Gout	Non-preferred: febuxostat, probenecid/colchicine	Coverage is provided when the member has had a 30 day trial of at least one preferred (medication covered by the Plan) medication which includes: allopurinol 100 mg and 300 mg, probenecid, colchicine tablets and Colcrys tablets. Please note: Colcrys tablets and colchicine tablets require submission of a prior authorization (approval by your plan).
	Preferred with Clinical Criteria: Colchicine tablets, Colcrys tablets	**ACUTE GOUT DIAGNOSIS** Coverage is provided when the member has had a 30 day trial of BOTH of the following in the last 30 days: 1. A preferred (medications covered by the plan) non-steroidal anti-inflammatory drug (NSAID; a type of medication that treats pain or inflammation) which include but are not limited to indomethacin, naproxen, ibuprofen, sulindac or ketoprofen; AND 2. A preferred oral corticosteroid which includes but is not limited to: prednisone and methylprednisolone **CHRONIC GOUT DIAGNOSIS** Coverage is provided when the member has had a 30 day trial (at maximally tolerated doses) of a preferred xanthine oxidase inhibitor which includes: allopurinol.

	Non-Preferred: Mitigare (BvG)	Coverage is provided when the member has had a 30 day trial of colchicine tablets. Please note: Colchicine tablets require submission of a prior authorization (approval by your plan).
	Non-Preferred: Gloperba	Coverage is provided when the member meets ALL the following requirements: 1. Member is unable to swallow colchicine tablets or capsules; AND 2. Member is using the requested medication for the prevention of gout flares; AND 3. Member has had a 30 day trial of ONE of the following medications: a. A preferred (medications covered by the plan) non-steroidal anti-inflammatory drug (NSAID; a type of medication that treats pain or inflammation) which include but are not limited to indomethacin, naproxen, ibuprofen, sulindac or ketoprofen; OR b. A corticosteroid (a type of medication that treats swelling and inflammation) such as prednisone or dexamethasone.
Analgesic Agents: Opioids	**Preferred: short acting**	Coverage is provided without prior authorization (approval by your plan) when the prescription meets BOTH of the following criteria: 1. Duration of use is no longer than 7 days 2. Prescription does not exceed 30 MED (morphine equivalent dose, used to help prescribers make decisions on the dose) per day dose To exceed acute opioid limits, coverage is provided when the member meets BOTH of the following requirements: 1. Diagnosis of somatic type pain 2. Prescriber attestation that the benefits and risks of opioid therapy have been discussed with patient

		Exemptions: 1. Patients receiving short-acting opioids for: active cancer treatment, palliative care, and end-of-life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, or major orthopedic surgery 2. Prescriber attestation that patient is not opioid naïve (Example, new to Medicaid or was on a higher dose in hospital)
Analgesic Agents: Opioids	**Non-Preferred: short acting**	Coverage is provided when the member has a history of at least 7 days of therapy with TWO unrelated preferred (medication covered by the Plan) medications, which include but are not limited to: Oxycodone, Morphine, Tramadol, Codeine, Hydrocodone IR (all require plan approval if using for longer than 7 days). [For liquid oral dosage form] Coverage is provided when the prescriber has provided documentation of why a patient cannot be changed to a tablet or capsule. [Brand names that have preferred generics] Coverage is provided when the member has a history of a bad reaction to TWO generic drugs (if available).
Analgesic Agents: Opioids	**Preferred: long acting**	Coverage is provided when the member meets ALL the following requirements: Prescription has a daily dose equal to no greater than 80 MED (morphine equivalent dose, used to help prescribers make decisions on the dose) Prescriber has documented an inadequate clinical response (Medications that do not show improvement or causes harm) to

		both non-opioid pharmacologic and non-pharmacologic treatments History of short-acting opioids for greater than or equal to 60 days Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (Baseline urine drug test must be submitted) Pain and function scores at each visit Opioid contract required to be in place and submitted with Prior Authorization (approval by your plan before you can get your medication) form **Exemptions:** Patients receiving long-acting opioids for a catastrophic injury or cancer pain
	SUBSEQUENT AUTHORIZATION CRITERIA	Coverage is provided when the member meets BOTH of the following requirements: Current treatment plan Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed
	Dose escalation requests	Coverage is provided when the member meets BOTH of the following requirements: Prescriber attestation that dose escalation is likely to result in improved function and pain control Requests for a daily dose >100 MED must be prescribed by pain specialist or anesthesiologist consultation

Analgesic Agents: Opioids	**Non-Preferred: Long acting**	Coverage is provided when the member has a history of BOTH requirements: 1. At least 7 days of therapy with TWO unrelated preferred (medication covered by the Plan), **long-acting** opioid medications, which include but are not limited to: Butrans, Morphine ER (extended release). 2. Documentation of an inadequate clinical response (medications that do not show improvement or causes harm) with its immediate release formulation (if available). Please note: Butrans is a preferred medication, however coverage is provided when the prescriber has provided documentation of why the patient cannot be changed to a tablet or capsule form of the preferred (medication covered by the plan) medications and requires documentation of an inadequate clinical response of 60 consecutive days with at least one immediate release opioid formulation.
	For liquid oral dosage form	Coverage is provided when the prescriber has provided documentation of why a patient cannot be changed to a tablet or capsule.
	Brand names that have preferred generics	Coverage is provided when the member has a history of a bad reaction to TWO generic drugs (if available).
	SUBSEQUENT AUTHORIZATION CRITERIA	Coverage is provided when the member meets BOTH of the following requirements: Current treatment plan Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed.

	Dose escalation requests	Coverage is provided when the member meets BOTH of the following requirements: Prescriber attestation that dose escalation is likely to result in improved function and pain control Requests for a daily dose greater than 100 MED (morphine equivalent dose, used to help prescribers make decisions on the dose) must be prescribed by pain specialist (doctor who treats pain caused by disease, disorder, or trauma) or anesthesiologist consultation (monitors pain management).
Analgesic Agents: Opioids	**Transmucosal fentanyl**	Coverage is provided when the member meets ALL the following requirements: Must be prescribed by an oncologist (**doctors who diagnose and treat cancer)**, pain specialist (doctor who treats pain caused by disease, disorder, or trauma), or hospice/palliative prescriber (medical care for people living with a serious illness); and Must currently be taking a long-acting opioid at therapeutic dose of any of the following for at least 7 days without adequate pain relief: - Greater than or equal to 60 mg oral morphine/day - Greater than or equal to 8 mg oral hydromorphone/day - Greater than or equal to 25 mcg/hr transdermal fentanyl - Greater than or equal to 25 mg oral oxymorphone/day - Greater than or equal to 30 mg oral oxycodone/day - Equianalgesic dose of another opioid

	Butrans	Per the Ohio Medicaid Unified Preferred Drug List, Butrans (brand preferred over generic) requires documentation of an inadequate clinical response of 60 consecutive days with at least one immediate release opioid formulation and documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation as well as all of the long acting documentation required on Long-Acting Opioid Medication PA form. If information does exist, please provide documentation with including drug, dosage, duration of therapy, and failure reason.
Blood Agents: Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	Non-Preferred	Coverage is provided when the member has a history of a 14-day trial with one preferred (medication covered by the Plan) medication which includes: Epogen, Mircera and Retacrit (all require submission of a prior authorization (approval by your plan before you can get your medication).
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Non-Preferred	Coverage is provided when the member has a history of a 14-day trial with one preferred (medication covered by the Plan) medication which includes Neupogen, Nivestym, Nyvepria and Ziextenzo (ALL require submission of a prior authorization (approval by your plan before you can get your medication).
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Preferred – Require Clinical PA Neupogen (PA) Nivestym (PA) Nyvepria (PA) Ziextenzo (PA)	Coverage is provided if the medication is FDA (Food and Drug Administration) approved for the diagnosis (disease) and documentation (chart notes from your prescriber) have been submitted documenting the member's diagnosis, patient's weight, and duration of treatment.
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*	Preferred	Coverage is provided if the medication is FDA (Food and Drug Administration) approved for the diagnosis (disease) and documentation (chart notes from your prescriber) have been submitted documenting the member's body weight.

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*	Non-Preferred	Coverage is provided when the member has a history of a 14-day trial of one preferred (medication covered by the Plan) medication which include but are not limited to: **(please insert appropriate preferred medications)**
	For extended half-life factors:	Coverage is provided when the prescribing physician confirms that the member cannot be treated with a shorter-acting half-life product (medication that needs to be taken more often).
Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with one preferred (medication covered by the Plan) medication, which include but are not limited to: Enoxaparin.
	Beyond 35 days: Guidelines from the American College of Chest Physicians limit duration of therapy in the outpatient setting for most indications to less than 35 days. Patients should be transitioned to oral warfarin as soon as possible	Coverage is provided beyond 35 days if the member cannot be changed to oral warfarin and acceptable reasoning is given, which includes but is not limited to: cancer, pregnancy, intolerance, or inability to take warfarin.
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: Eliquis, warfarin, Pradaxa (brand name), and Xarelto.

Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	Non-preferred: Yosprala, Zontivity	Coverage is provided when the member has a history of at least 14 days of therapy with TWO preferred (medication covered by the Plan) medications, which include but are not limited to: aspirin, aspirin/dipyridamole extended release, Brilinta, clopidogrel, and prasugrel.
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Non-Preferred	res
	Preferred: Entresto	Coverage is provided when the member has a diagnosis of chronic heart failure (a progressive heart disease that affects pumping action of the heart muscles) (NYHA Class II-IV or ACC/AHA Stage B-D (a classification of the severity of heart failure).
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Verquvo	Coverage for Verquvo is provided when the member meets ALL the following: 1. The provider has submitted the member's ejection fraction (measurement of how much blood is pumped out of the heart with each heartbeat); 2. Member has been hospitalized for the treatment of heart failure within the previous 180 days or needs treatment with an outpatient intravenous diuretic within the previous 90 days; and 3. Member must be treated with a medication from ALL the following medication classes unless contraindicated: Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, or an angiotensin receptor neprilysin inhibitor, beta-blocker, aldosterone antagonist.
Cardiovascular agents: Angina, Hypertension and Heart Failure, other, non-preferred:	Candesarten, Candesartan/Hydrochlorothiazide, Carospir, Diltiazem 24hr ER Tab, Enalapril solution, Edarbyclor, Hydralazine/Hydrochlorothiazide, Innopran XL, Isradipine, Kapspargo, Katerzia, Kerendia, Nebivolol, Nimodipine, Nymalize, Qbrelis, Sotylize, Telmisartan, Telmisartan/hydrochlorothiazide,	**Non-preferred ACE inhibitors:** Enalapril solution, Qbrelis (brand Lisinopril). Coverage is provided when the member has a history of at least 30 days of therapy with TWO preferred (medication covered by the Plan) medications, in the same class of medication requested, which include but are not limited to: Benazepril, Enalapril, Enalapril/HCTZ, Fosinopril, Fosinopril/HCTZ, Lisinopril, Moexipril, Quinapril, Ramipril.

	Verapamil 200mg, 300mg ER 24hr.	
		Non-preferred ARB: Candesartan, Telmisartan, Telmisartan/hydrochlorothiazide. Coverage is provided when the member has a history of at least 30 days of therapy with TWO preferred (medication covered by the Plan) medications, in the same class of medication requested, which include but are not limited to: irbesartan, irbesartan/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, olmesartan, telmisartan/amlodipine, valsartan.
		Non-preferred beta-blockers: Innopran XL (propranolol), Nebivolol, Sotylize (sotalol), Kapspargo (metoprolol) Coverage is provided when the member has a history of at least 30 days of therapy with TWO preferred (medication covered by the Plan) medications, in the same class of medication requested, which include but are not limited to: acebutolol, atenolol, betaxolol, bisoprolol, carvedilol, labetolol, metoprolol, nadolol, pindolol, propranolol, sotolol, timolol.
		Non-preferred calcium channel blockers: Diltiazem 24hr ER tab, Katerzia (amlodipine), Isradipine, Verapamil 200mg, 300mg ER 24hr. Coverage is provided when the member has a history of at least 30 days of therapy with TWO preferred (medication covered by the Plan)

		medications, in the same class of medication requested, which include but are not limited to: amlodipine, diltiazem, diltiazem 12hour extended-release capsule, diltiazem 24 hour extended-release capsule, felodipine, nicardipine, verapamil, verapamil sustained release.
		Non-preferred Nimodipine: Coverage is provided ONLY when there is a diagnosis of subarachnoid hemorrhage and for 21 days of therapy.
		Non-preferred Aliskiren and Tekturna/HCT: Coverage is provided when the member has a history of at least 30 days of therapy with ONE preferred (medication covered by the Plan) medication, in the same class of medication requested, which include but are not limited to: benazepril, enalapril, enalapril/hydrochlorothiazide, fosinopril, fosinopril/hydrochlorothiazide, irbesartan, irbesartan/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, olmesartan.
Cardiovascular agents: Angina, Hypertension and Heart Failure	Kerendia	Coverage is provided when the member meets ALL the following requirements: 1. Member has been on maximum tolerated dose of an angiotensin-converting enzyme inhibitor (which include but are not limited to benazepril, captopril, lisinopril) or angiotensin receptor blocker (which include but are but are not limited to: losartan, irbesartan, olmesartan); AND 2. Member has an allergy, intolerance (inability to tolerate the side effects of a medication), or inadequate response (medications that do not show improvement or causes harm) to an SGLT2 Inhibitor (which include but are but are not limited to: Invokana, Farxiga, Jardiance).

Cardiovascular agents: Angina, Hypertension and Heart Failure	Camzyos	Coverage is provided when the member meets ALL the following requirements: 1. Medication is being prescribed by or in consultation with a cardiologist (heart doctor); AND 2. Your prescriber has submitted documentation (chart notes) showing you have NYHA Class II-III symptoms (***New York Heart Association Stages of Heart Failure),*** and you have a left ventricular ejection fraction (measurement of how much blood is pumped out of the heart with each heartbeat) greater than or equal to 55%.
Cardiovascular agents: Angina, Hypertension and Heart Failure	Hemangeol	Coverage is provided when the prescriber has submitted documentation of the member's weight.
Cardiovascular Agents: Antiarrhythmics		Coverage is provided when the member has a history of failed therapy with one preferred (medication covered by the Plan) medication which includes but is not limited to: Amiodarone (200mg only), flecainide and dofetilide.
Cardiovascular Agents: Lipotropics	Welchol (Colesevelam) – hyperlipidemia diagnosis	Coverage is provided when the member meets has a history of at least 30 days of therapy with ONE preferred (medication covered by the Plan) medication, in the same class of medication requested, which include but are not limited to: cholestyramine light, colestipol tablet, and Prevalite.
Cardiovascular Agents: Lipotropics	Welchol (Colesevelam) – diabetes diagnosis	Coverage is provided when the member has a diagnosis of Type 2 Diabetes documented in chart notes from your provider.
Cardiovascular Agents: Lipotropics	Non-preferred: Altoprev, Amlodipine/Atorvastatin, Colesevelam, Colestipol granules, Ezetimibe/Simvastatin, Ezallor,	**Non-preferred HMG CoA reductase inhibitors: Altoprev (brand Lovastatin), Amlodipine/Atorvastatin, Ezetimibe/Simvastatin, Livalo (brand Pitavastatin), Fluvastatin, Zypitamag (brand Pitavastatin).**

	Fenofibrate 30, 43, 50, 67, 90, 130, 134 and 150mg Cap, Fenofibrate 40, 54, 120 and 160mg Tab, Fenofibric Acid, Fluvastatin, Juxtapid, Livalo, Nexletol, Nexlizet, Niacin ER Tab, Vascepa (BVG), Zypitamag.	Coverage is provided when the member has a history of at least 30 days of therapy with ONE preferred (medication covered by the Plan) medications, in the same class of medication requested, which include but are not limited to: atorvastatin, lovastatin, pravastatin, rosuvastatin, and simvastatin. **Non-preferred Fibric Acid inhibitors: Fenofibrate 30, 43, 50, 67, 90, 130, 134 and 150mg Cap, Fenofibrate 40, 54, 120 and 160mg Tab, Fenofibric Acid.** Coverage is provided when the member has a history of at least 90 days of therapy with ONE preferred (medication covered by the Plan) medication, in the same class of medication requested, which include but are not limited to: fenofibrate 48 mg and 145 mg tablet, and gemfibrozil tablet.
	Non-preferred (niacin)	**Non-preferred Nicotinic Acid Derivatives**: Niacin ER Tab Coverage is provided when the member has a history of at least 30 days of therapy with ONE preferred (medication covered by the Plan) medication, in the same class of medication requested, which include but are not limited to: niacin over the counter, niacin extended release over the counter.
	Non-preferred (colestipol granules)	**Non-Preferred Bile Acid Sequestrants:** Colestipol Granules

		Coverage is provided when the member has a history of at least 30 days of therapy with ONE preferred (medication covered by the Plan) medication, in the same class of medication requested, which include but are not limited to: cholestyramine Light and regular, colestipol tablets.
	Non-preferred (Vascepa) (Brand preferred over generic)	**Non-Preferred Omega-3 Fatty Acids:** Vascepa Coverage is provided when the member meets the following requirements: 1. Member has a history of at least 30 days of therapy with ONE preferred (medication covered by the Plan) medication, in the same class of medication requested, which include but are not limited to: Omega-3-Acid Ethyl Esters (Lovaza); AND 2. Documentation (chart notes from your provider) must be submitted indicating you have a baseline triglyceride level ≥500mg/dL despite use of fibrates, niacin, and diet/exercise; AND 3. Documentation (chart notes from your provider) must be submitted stating you have discontinued all medications known to increase triglyceride levels (Example- beta blockers, thiazides, and estrogens), if applicable.
	Preferred with Clinical Criteria (Repatha, Praluent)	**Familial hypercholesterolemia (includes heterozygous familial hypercholesterolemia and homozygous familial hypercholesterolemia)** Coverage will be considered for a diagnosis of familial hypercholesterolemia (includes heterozygous familial hypercholesterolemia and homozygous familial hypercholesterolemia) AND must meet all: 1. Provider must submit documentation (chart notes) of baseline labs; AND

		2. Must have documented adherence (chart notes from your provider and paid pharmacy claims) to 90 days of prescribed lipid-lowering medications; AND 3. Unable to reach goal low-density lipoprotein - cholesterol (less than or equal to 100mg/dL for adults or less than 110mg/dL for those less than 18 years of age) with maximally tolerated dose of a high-potency statin (atorvastatin 40mg-80mg and rosuvastatin 20mg-40mg) and ezetimibe (Zetia).
		CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 1. Provider must submit documentation (chart notes) of baseline labs; AND 2. Must have documented adherence (chart notes from your provider and paid pharmacy claims) to 90 days of prescribed lipid-lowering medications; AND 3. Unable to reach goal low-density lipoprotein - cholesterol (less than or equal to 70mg/dL) with maximally tolerated dose of a high-potency statin (atorvastatin 40mg-80mg and rosuvastatin 20mg-40mg) and ezetimibe (Zetia).
Cardiovascular Agents: Lipotropics	Juxtapid, Nexletol, Nexlizet Baseline lab results are required, and initial approval will be for 180 days. Subsequent approvals will require additional levels drawn to assess response to treatment from baseline and/or attestation of medical stabilization and will be for 365 days	Coverage is provided when the member meets ALL the following requirements: 1. Provider must submit documentation (chart notes) of baseline labs; AND 2. Must have documented adherence (chart notes from your provider and paid pharmacy claims) to 90 days of prescribed lipid-lowering medications; AND 3. Member has had least a 90-day trial AND unable to reach goal LDL-C (a type of bad cholesterol or fat in the blood that can lead to heart disease) (LDL is less than or equal to 100mg/dL) with high-potency statin (atorvastatin 40mg-80mg or rosuvastatin 20mg-40mg), ezetimibe and PCSK9 inhibitor (drugs that lower bad cholesterol) (such as Praluent or Repatha).

Cardiovascular Agents: Pulmonary Arterial Hypertension*	Preferred: Clinical Ambrisentan (PA) Sildenafil (PA) Sildenafil Susp (AR) (PA) Tadalafil (PA) Tracleer Tab (BVG) (PA) Tadliq (AR) (PA)	Coverage is provided when the member has a diagnosis of pulmonary arterial hypertension and has documentation of the NYHA Functional Class and any symptoms the patient is experiencing (*New York Heart Association Stages of Heart Failure).*
	Sildenafil Susp (AR) (PA) Tadliq (AR) (PA) Tadliq is designed for patients who have difficulty swallowing tadalafil tablets and is expected to address inconsistencies seen with compounded products. This is the first oral suspension formulation of tadalafil, a phosphodiesterase type 5 (PDE5) inhibitor, approved by the Food and Drug Administration.	Coverage is provided when the member is 6 years of age or younger.
Cardiovascular Agents: Pulmonary Arterial Hypertension*	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with at least two preferred medications (medication covered by the plan), which include but are not limited to: sildenafil and ambrisentan. One of the two trials must be sildenafil or tadalafil.
Cardiovascular Agents: Pulmonary Arterial Hypertension*	Non-Preferred inhalations/IV drugs	For non-preferred inhalation or intravenous medications, the member must have NYHA Functional Class of Pulmonary Hypertension Class 3 or Class 4 symptoms (***New York Heart Association Stages of Heart Failure).***

Central Nervous System (CNS) Agents: Alzheimer's Agents*	Non-preferred: Adlarity, Donepezil 23 mg tab, Galantamine sol, memantine ER, Memantine Sol, Namzaric, ~~Rivastigmine patch~~ (move to preferred on 7/1/2023); Preferred medications are preferred but have other requirements: AR,QL, BvG (refer to the UPDL)	Coverage is provided when the member has a history of at least 30 days of therapy with TWO preferred: (medication covered by the plan) medications, which include but are not limited to: donepezil 5 mg and 10 mg tablet, donepezil oral disintegrating tablet, Exelon patch (brand preferred over generic), galantamine immediate release tablet, galantamine extended-release capsule, memantine tablet, and rivastigmine capsule and patch.
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	Nurtec ODT (Step)	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 14 days of therapy of two preferred (medication covered by the Plan) medications, which include but are not limited to: naratriptan tablets, rizatriptan (oral disintegrating tablets and tablets), and sumatriptan (syringes, spray, and tablets)
	Non-Preferred (Ubrelvy)	Coverage is provided when the member had an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 14 days with at least TWO preferred (medication covered by the Plan) which include but are not limited to: naratriptan tablets, rizatriptan (oral disintegrating tablets and tablets), and sumatriptan (syringes, spray, and tablets) and at least one oral CGRP antagonist (medication used to treat migraine), for example: Nurtec ODT (oral disintegrating tablet) (which requires step therapy of at least 14 days of therapy of two preferred medications).
	Non-Preferred	Coverage is provided when the member has had an inadequate medical response (Medications that do not show improvement or causes harm) to at least 14 days of therapy of two preferred

		(medication covered by the Plan) medications, which include but are not limited to: naratriptan tablets, rizatriptan (oral disintegrating tablets and tablets), and sumatriptan (syringes, spray, and tablets).
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	Non-Preferred Emgality (QL)	Coverage is provided when the member has had a 60 day trial of verapamil (at a titrated dose of at least 480 mg per day).
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	Preferred: Ajovy (QL)(ST)	Coverage is provided when the member meets all the following: 1. Member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try a certain drug(s) before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy of three preferred (medication covered by the Plan) medications, which include but are not limited to: beta-blockers (such as: atenolol, bisoprolol and propranolol), tricyclic antidepressants (such as: amitriptyline and nortriptyline), serotonin-norepinephrine reuptake inhibitors (such as: venlafaxine ER capsules and duloxetine capsules (20, 30 and 60 mg), and anticonvulsants (such as: topiramate) AND 2. Your provider has submitted documentation (chart notes) of severity, frequency, type of migraine, and number of headache days per month (preferably a headache diary); and 3. ***For quarterly requests only*** Member has demonstrated efficacy with use of the requested medication for at least 90 days.
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	Preferred: Aimovig (QL)(ST)	Coverage is provided when the member meets all the following: 1. Member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization

		(approval by your plan) that requires that you try a certain drug(s) before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy of three preferred (medication covered by the Plan) medications, which include but are not limited to: beta-blockers (such as: atenolol, bisoprolol and propranolol), tricyclic antidepressants (such as: amitriptyline and nortriptyline), serotonin-norepinephrine reuptake inhibitors (such as: venlafaxine ER capsules and duloxetine capsules (20,30 and 60mg), and anticonvulsants (such as: topiramate) AND 2. Your provider has submitted documentation (chart notes) of severity, frequency, type of migraine, and number of headache days per month (preferably a headache diary); and 3. ***For dose increases requests only*** Member has had an inadequate response to the use of 70 mg dosing for at least 60 days.
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	Non-Preferred Emgality, Nurtec ODT and Qulipta	Coverage is provided when the member meets the following requirements: 1. The member has a history of at least 30 days of therapy with three preferred (medication covered by the Plan) medications, which include but are not limited to: beta-blockers (such as: atenolol, bisoprolol and propranolol), tricyclic antidepressants (such as: amitriptyline and nortriptyline), anticonvulsants (such as: topiramate, valproate, and gabapentin), and/or serotonin-norepinephrine reuptake inhibitors (such as: venlafaxine ER (extended release) capsules and duloxetine capsules (20, 30 and 60 mg); AND

		2. The member has a history of at least 30 days of therapy of either Aimovig or Ajovy (both require prior authorization (approval by your plan before you can get your medication).
Central Nervous System (CNS) Agents: Anticonvulsants*	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: Carbamazepine, Divalproex, Lamotrigine (IR) immediate release tablet and ODT (oral disintegrating tablet) OR Coverage is provided when the member is being treated under the care of a neurologist (a doctor who specializes in diseases of the brain, spinal cord, and nervous system) with Ohio Medicaid AND has a history of at least 30 days of therapy with one preferred (medication covered by the Plan) medications, which include but are not limited to: Carbamazepine, Divalproex, Lamotrigine (IR) immediate release tablet and ODT (oral disintegrating tablet) (NOTE: This provision applies only to the standard tablet/capsule dosage form and does not apply to brand products with available generic alternatives)
Central Nervous System (CNS) Agents: Anticonvulsants*	Step Therapy	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy of one preferred (medication covered by the Plan) medications, which include but are not limited to: Carbamazepine, Divalproex, and Lamotrigine.
Central Nervous System (CNS) Agents: Anticonvulsants*	Epidiolex	Coverage is provided when the member has had a 30 day trial of any two of the following medications within the past 365 days: clobazam,

		levetiracetam, valproic acid, lamotrigine, topiramate, rufinamide or felbamate.
Central Nervous System (CNS) Agents: Anticonvulsants*	Diacomit	Coverage is provided when the member meets ALL the following requirements: 1. Member's prescriber is a neurologist (a doctor who specializes in diseases of the brain, spinal cord, and nervous system) or is consulting a neurologist; AND 2. Member is taking clobazam (Onfi) at the same time; AND 3. Your provider has submitted documentation (chart notes) addressing any other health concerns as well as baseline blood testing (CBC); AND 4. Your provider has submitted documentation of your weight and the dose requested is appropriate; AND 5. Provider must submit the baseline average number of seizure days per month (this can be measured monthly or quarterly)
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	Preferred Medications: Diastat, Diazepam Gel, Nayzilam (Age Restriction) and Valtoco (Age Restriction)	Valtoco: Coverage is provided when the member is 6 years of age or older. Nayzilam: Coverage is provided when the member is 12 years of age or older.
Central Nervous System (CNS) Agents: Antidepressants*		Coverage is provided when the member has a history of 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: citalopram, bupropion, fluoxetine, sertraline, and venlafaxine ER (extended release) capsules.

	Non-Preferred - Auvelity	Coverage is provided when the member has had an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 30 days with ALL of the following: 1. ONE dopamine/norepinephrine reuptake inhibitor (DNRI) 2. ONE selective norepinephrine reuptake inhibitor (SNRI) 3. TWO selective serotonin reuptake inhibitors (SSRIs) (ONE of which must be either vilazodone (Viibryd) OR vortioxetine (Trintellix))
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: Clozapine, Olanzapine, Quetiapine IR (immediate release) and ER (extended release) and Risperidone.
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	Nuplazid	Coverage is provided when the member meets ALL the following requirements: 1. Member is diagnosed with Parkinson's disease (disorder that causes uncontrollable movements) and has psychotic symptoms (hallucinations and/or delusions) that started after Parkinson's diagnosis; AND 2. The member's symptoms are severe and frequent enough to need treatment with an antipsychotic AND are not related to dementia (loss of memory) or delirium (confused mental state); AND 3. The member's other medications for Parkinson's Disease have been reduced or adjusted and psychotic symptoms

		remain OR member is unable to tolerate adjustment of these other medications; AND 4. There has been inadequate response (medications that do not show improvement or causes harm) to a trial of no less than 30 days of either quetiapine or clozapine OR these medications cannot be used.
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	Lybalvi	Coverage is provided when the member meets ALL the following requirements: 1. Member has had a trial and failure of least 30 days of therapy of two preferred medications (medications covered by the Plan), which include but are not limited to: olanzapine, aripiprazole, quetiapine; **AND** 2. Member must not be using opioids (type of pain medication); **AND** 3. Member must not be undergoing acute opioid withdrawal (symptoms that occur when you stop taking pain medication).
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	Invega, Hayfyra ER	Coverage is provided when the member meets ALL the following requirements: 1. Member has trialed at least 4 months of Invega Sustenna or 3 months of Invega Trinza
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	Step Therapy	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of

		therapy of one preferred medication (medication covered by the plan), which include but are not limited to: clozapine, quetiapine, risperidone.
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	Additional Information	Long-acting injectable antipsychotics may be billed by the pharmacy if they are not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Non-preferred	Coverage is provided when the member has a history of at least 30 days of therapy with three preferred (medication covered by the Plan) medications, which include but are not limited to: amphetamine/dextroamphetamine immediate-release tablets, and methylphenidate tablets and Vyvanse Capsule.
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Step Therapy	Coverage is provided when the member has a history of at least 30 days with atomoxetine OR at least two preferred (medication covered by your Plan) stimulants.
Central Nervous System (CNS) Agents: Fibromyalgia Agents	Savella	Coverage is provided when the member has a history of therapy with no less than two preferred (medication covered by the Plan) medications for at least 14 days each, which include but are not limited to: gabapentin and pregabalin (guidelines suggest use of multiple agents at the same time to manage signs of fibromyalgia).
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	Non-Preferred - Lucemyra (lofexidine): Indicated for Opioid Withdrawal	Coverage is provided when the member has an inadequate clinical response (Medications that do not show improvement or causes

	ADDITIONAL LOFEXIDINE (LUCEMYRA) CRITERIA	harm) of at least 30 days with at least two preferred (medication covered by your Plan) drugs. Coverage is provided when the member meets ALL the following requirements: 1. Medical justification supports why an opioid taper (such as with buprenorphine or methadone) cannot be used; AND Must have had an inadequate clinical response or intolerance to clonidine OR 2. Provide documentation that the drug was initiated (started) in an inpatient setting.
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	Non-Preferred	Coverage is provided when the member has an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 30 days with at least two preferred (medication covered by your Plan) drugs.
	Buprenorphine Mono-Product:	Coverage is provided when the member meets the following requirements: Buprenorphine mono products will be approved for: a. Pregnancy or breastfeeding; b. Contraindication to combo products (documented history of serious adverse reactions that can include moderate/severe hepatic impairment, allergies, anaphylaxis, bronchospasm, angioneurotic edema, anaphylactic shock, hives)

		c. Conversion from mono to combo product (for example was pregnant and is done breast feeding); d. Patients who are being treated for use of long-acting opioids (including conversion from methadone). THE INFORMATION CONTAINED IN THE REMAINING PART OF THIS SECTION IS INTENDED FOR YOUR PROVIDER AND GIVES A MORE DETAILED DESCRIPTION FOR WHY THIS REQUEST WAS NOT APPROVED. Allergy to buprenorphine/naloxone combination product is defined as type I - IgE-mediated hypersensitivity reactions including things such as rash, hives, swelling of the face, wheezing, low blood pressure, and loss of consciousness. Serious adverse reactions do not include symptoms such as: headache, nausea/vomiting, dizziness, and diarrhea.
	Sublocade Drug Utilization Review Criteria **Additional Information** Sublocade and Vivitrol may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered at the pharmacy, the drug must be released only to the administering provider or administering provider's staff, following all applicable regulations.	Dosing schedule will be limited to 300mg/30 days.
Central Nervous System (CNS) Agents: Movement Disorders	Austedo	Coverage is provided when the member meets ALL the following requirements: 1. For the treatment of tardive dyskinesia (movement disorder which causes repeated muscle movements in the face, neck, arms, and legs), the medication must be prescribed by a neurologist (a doctor who specializes in diseases of the brain, spinal cord, and

		nervous system) or psychiatrist (a doctor who specializes in treatment of mental disorders) AND, 2. For the treatment of Huntington's Disease (disorder which causes progressive breakdown of nerve cells in the brain), the medication must be prescribed by a neurologist (a doctor who specializes in diseases of the brain, spinal cord and nervous system); AND the member must have a history of 90 days of tetrabenazine with documented failure to respond at a maximally tolerated dose (highest dose of a drug or treatment that does not cause unacceptable side effects) AND 3. Medication must be prescribed by a neurologist (a doctor who specializes in diseases of the brain, spinal cord, and nervous system) or psychiatrist (a doctor who specializes in treatment of mental disorders).
Central Nervous System (CNS) Agents: Movement Disorders	Ingrezza, tetrabenazine	Coverage is provided when the member meets ALL the following requirements: 1. Medication must be prescribed by a neurologist (a doctor who specializes in diseases of the brain, spinal cord, and nervous system) or psychiatrist (a doctor who specializes in treatment of mental disorders).
Central Nervous System (CNS) Agents: Multiple Sclerosis*		Coverage is provided when the member has had a 30 day trial of one preferred (medication covered by the Plan) medication which include but are not limited to: Aubagio (Brand name is covered by the plan), Avonex, Betaseron, Copaxone (brand name is covered by the plan), dalfampridine, dimethyl fumerate, Fingolimod, Gilenya (Brand name is covered by the plan), and Rebif.
Central Nervous System (CNS) Agents: Narcolepsy	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications listed below: 1. Modafinil or armodafinil; AND 2. Methylphenidate or amphetamine-based drug

Central Nervous System (CNS) Agents: Narcolepsy	Xywav	Coverage is provided when the member meets ALL the following requirements: 1. Sodium restriction with documented adherence to sodium restricted diet; 2. A 30 day trial of TWO preferred medications (medications covered by the plan): a. Modafinil or armodafinil; AND b. Methylphenidate or amphetamine-based drug
Central Nervous System (CNS) Agents: Neuropathic Pain	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: amitriptyline, carbamazepine, oxcarbazepine tablet, duloxetine, gabapentin, and pregabalin.
Central Nervous System (CNS) Agents: Parkinson's Agents	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with one preferred (medication covered by the Plan) medication, which includes but is not limited to: amantadine, carbidopa/levodopa and pramipexole.
Central Nervous System (CNS) Agents: Parkinson's Agents	Non-Preferred (Apokyn, Kynmobi, Inbrija, Nourianz)	Coverage is provided when the member meets the following: 1. The member has a history of at least 30 days of therapy with one preferred (medication covered by the Plan) medication, which includes but is not limited to: amantadine, carbidopa/levodopa and pramipexole; AND 2. Member has had a 30 day trial of one other drug for the treatment of off episodes
Central Nervous System (CNS) Agents: Restless Legs Syndrome	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with one preferred (medication covered by

		the Plan) medications, which include but are not limited to: pramipexole, ropinirole.
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	Non-Preferred	Coverage is provided when the member has a history of at least 10 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: estazolam, temazepam 15 mg and 30 mg, zaleplon, and zolpidem.
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Baclofen solution	Coverage is provided when the member has had at least 30 days of therapy with baclofen tablets or when there is an explanation as to why a liquid dosage form is necessary.
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with one preferred medication (medication covered by the plan), which include but are not limited to baclofen tablets, cyclobenzaprine 5 mg and 10 mg, methocarbamol and tizanidine tablets.
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Non-preferred (carisoprodol)	Coverage is provided when your provider has submitted medical justification via chart notes and or letter of medical necessity indicating that no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition would serve the clinical needs of the patient.
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Non-Preferred extended release	Coverage is provided when the member has had a poor response to the immediate release drug (if available).
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Non-Preferred Brand Name products	Coverage is provided when there has been a poor response or allergy to at least two generic products of the brand medication.
Central Nervous System (CNS) Agents: Smoking Deterrents		All products are covered without a Prior Authorization
Dermatological: Oral Acne Products	Preferred – Clinical PA required	Coverage is provided when the member meets ALL the following requirements:

		1. Requested medication is being used for a Food and Drug Administration (FDA) approved reason; AND 2. Member must be registered and meet all the requirements of the iPLEDGE program (program used to measure the risk of use of the requested medication); AND 3. Member must have had at least a 90 day trial and failure of one preferred (medications covered by the plan) topical (applied to the skin) and one preferred oral antibiotic (taken by mouth) for acne (including but not limited to: doxycycline 50 mg and 100 mg tablet, minocycline Capsule, benzoyl peroxide gel, clindamycin gel) And 4. Must be absent of oral tretinoin in the past 56 days
Dermatological: Oral Acne Products	Non-Preferred	Coverage is provided when the member meets ALL the following requirements: 1. Requested medication is being used for a Food and Drug Administration (FDA) approved reason; AND 2. Member must be registered and meet all the requirements of the iPLEDGE program (program used to measure the risk of use of the requested medication); AND 3. Must be absent of oral tretinoin in the past 56 days And 4. Member must have 90 day trials of TWO preferred (medication covered by the Plan) medications which include but are not limited to: Accutane, Claravis (both require prior authorization (approval by your plan before you can get your medication).
Dermatological: Topical Acne Products	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with three preferred (medication covered by the Plan) medications, which include but are not limited to: Sodium sulfacetamide, benzoyl peroxide and clindamycin gel.

Dermatological: Topical Acne Products	Non-Preferred: Retinoids	Coverage is provided when the member has a history of at least 90 days of therapy with three preferred (medication covered by the Plan) medications, which include but are not limited to: Sodium sulfacetamide, benzoyl peroxide and clindamycin gel.
Endocrine Agents: Androgens	Preferred	Coverage is provided when the member meets ALL the following requirements: 1. Your provider has submitted documentation (chart notes and laboratory values) that support the need for testosterone use.
Endocrine Agents: Androgens	Non-Preferred	Coverage is provided when the member meets ALL the following requirements: 1. Your provider has submitted documentation (chart notes and laboratory values) that support the need for testosterone use; AND 2. Member has had a 90-day trial of ALL preferred (medication covered by the Plan) medications which include but are not limited to: Androderm 2 mg/24HR patch (NDC (National Drug Code): 00023599002) and Androderm 4 mg/24 HR patch (NDC: 00023599204), testosterone gel 1% and testosterone gel 1% pump (all require prior authorization) (approval by your plan before you can get your medication)
Endocrine Agents: Androgens	Subsequent Authorization Criteria	Coverage for reauthorization is provided when your provider has submitted documentation (chart notes) showing positive clinical response (outcome) to use of the requested medication as well as documentation (chart notes) that support ongoing safety monitoring while using the requested medication. (Example-testosterone and hematocrit).
Endocrine Agents: Diabetes – Hypoglycemia Treatments	Non-Preferred	Coverage is provided when the member has completed a trial with a preferred (medication covered by the Plan) medication,

		which include but are not limited to: Baqsimi, Glucagen Hypokit, Gvoke Hypopen, Gvoke PFS (Pre-Filled Syringe), and Zegalogue.
Endocrine Agents: Diabetes – Insulin	Step Therapy	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 120 days of therapy of one preferred (medication covered by the Plan) medication having a similar duration of action) as the requested medication, which include but are not limited to: **[LIST PREFERRED ALTERNATIVES WITH SIMILAR MECHANISM OF ACTION]**
Endocrine Agents: Diabetes – Insulin	Non-Preferred	Coverage is provided when the member has a history of at least 120 days of therapy with two preferred (medication covered by the Plan) medications having a similar duration of action as the requested medication, which include but are not limited to: **[LIST PREFERRED ALTERNATIVES WITH SIMILAR MECHANISM OF ACTION]**
Endocrine Agents: Diabetes – Insulin	Inhaled – Afrezza	Coverage is provided when the member meets ALL the following requirements: 1. Member has a history of at least 120 days of therapy with two preferred (medication covered by the Plan) medications having a similar duration of action as the requested medication, which include but are not limited to: **[LIST PREFERRED ALTERNATIVES WITH SIMILAR MECHANISM OF ACTION];** AND 2. You provider has submitted chart notes showing lung function testing with a FEV1 (the amount of air you can force from your lungs in one second) greater than or equal to 70% predicted; AND 3. Member has been nicotine-free for at least 180 days (supported by chart notes).

Endocrine Agents: Diabetes – Insulin	**Non-Preferred-Additional Criteria**: Basaglar Tempo Pen Humalog U-100 Tempo Pen Lyumjev Tempo Pen	Coverage is provided when the member has had an inadequate clinical response (Medications that do not show improvement or causes harm) or documentation of medical necessity beyond convenience for why the member cannot use the corresponding FlexPens or KwikPens.
Endocrine Agents : Diabetes – Non-Insulin	Non-Preferred	Coverage is provided when the member has a history of at least 120 days of therapy with THREE preferred (medication covered by the Plan) medications, which include but are not limited to: **[LIST APPROPRIATE ALTERNATIVES IN THE SAME DRUG CLASS].**
	Non-Preferred: Mounjaro and Ozempic	Coverage is provided when the member has a history of at least 120 days of therapy with THREE preferred (medication covered by the Plan) medications [ONE of the 120 day trials must be Byetta (5 mcg and 10 mcg), Victoza (18 MG/3 ML PEN) or Trulicity (0.75 mg, 1.5 mg, 3 mg and 4.5 mg)], which include but are not limited to: Farxiga 5 and 10 mg, Invokana 100 mg and 300 mg, Victoza 18 MG/3 ML PEN, and Jardiance 10 and 25 mg. Coverage is provided when the member has had an inadequate clinical response (the inability to reach A1C goal (a test result that shows a three-month average of blood sugars) after at least 120 days of current regimen with documented adherence (taking medications correctly) and appropriate dose escalation.
Endocrine Agents: Endometriosis	Step Therapy	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 84 days of

		therapy with both an NSAID (non- steroidal anti-inflammatory drug) which include but are not limited to: celecoxib, diclofenac, ibuprofen, etodolac, naproxen IR AND an oral contraceptive (birth control) which include but are not limited to: Yasmin, Aviane and Sprintec.
Endocrine Agents: Endometriosis	Non-Preferred	Coverage is provided when the member has a history of at least 84 days of therapy with each of the following: 1. A preferred (medication covered by the Plan) NSAID (non-steroidal anti-inflammatory drug) which includes but are not limited to: celecoxib, diclofenac, ibuprofen, etodolac, naproxen IR (immediate release); AND 2. A preferred oral contraceptive which includes but are not limited to: Yasmin, Aviane, Sprintec; AND 3. A trial of one preferred step therapy (must try one medication before another is covered) medication, which include but are not limited to: Danazol, Depo-Subq Provera 104, Lupron Depot, Myfembree, Orilissa, Zoladex (each require submission of a Prior Authorization by your prescriber (approval by your plan before you can get your medication).
Endocrine Agents: Estrogenic Agents	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: Climara Pro, Estring, Premarin, Prempro and Premphase.
Endocrine Agents: Progestin Agents	Makena has been withdrawn from the market (4/6/2023). Please note, there is 1 generic Hydroxyprogesterone Caproate (not generic Makena) that will be	Makena has been withdrawn from the market, as of 4/6/2023. Use ADMIN DENY.

	active, it now has a **PA required (we suggest RPH-Only review)** to ensure it's an FDA approved Dx, not reducing the risk of pre-term birth.	
Endocrine Agents: Growth Hormone	Non-Preferred: Humatrope, Nutropin, Omnitrope, Seizen, Serostim, Skytrofa, Zomacton	Coverage is provided when the member has a therapeutic failure to no less than a 90-day trial of at least one preferred (medication covered by the Plan) medication which include but are not limited to: Genotropin and Norditropin (both require prior authorization (approval by your plan before you can get your medication).
Endocrine Agents: Growth Hormone	Preferred with Clinical criteria: Genotropin and Norditropin	**PEDIATRIC PATIENTS (UNDER 18 YEARS OLD)** Coverage is provided when the member meets the following: 1. Medication is being prescribed by a pediatric endocrinologist (children's doctor who specializes in hormones), nephrologist (kidney doctor), clinical geneticist (doctor who studies genes), endocrinologist (doctor who specializes in hormones) or gastroenterologist (doctor who specializes in the digestive system); AND 2. Your provider has submitted the following information: height, weight, bone age (children), date and results of most current x-ray, stimulus test results, IGF-1 levels, and a growth chart (children). **ADULTS (18 AND OLDER)** Coverage is provided when the member meets the following: 1. Medication is being prescribed by an endocrinologist (doctor who specializes in hormones); AND 2. Your provider has submitted documentation (chart notes) of growth hormone deficiency by means of negative response to an

		appropriate stimulation test (clonidine testing is not accepted for adults); AND 3. Your provider has submitted baseline evaluation of all the following indicators: a. Insulin-like growth factor (IGF-1) b. Fasting lipid profile c. BUN (blood urea nitrogen) d. Fasting glucose e. Electrolyte levels f. Evaluation of any new osteoarthritis or joint pain g. Bone density testing 4. Your provider has submitted documentation (chart notes) stating that all other hormonal deficiencies have been addressed with adequate replacement therapy.
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	Non-Preferred	Coverage is provided when the member has a history of at least 365 days of therapy with one preferred (medication covered by the Plan) medication within the same drug class, which include but are not limited to: alendronate tablets, Forteo (requires approval by your plan before you can get your medication) and ibandronate.
	Non-Preferred Tymlos (QL): Additional criteria	Must have had an inadequate clinical response of at least 365 days with one bisphosphonate A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	Preferred Forteo (PA) (QL) A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog	Coverage is provided when the member has a history of at least 365 days of therapy with one bisphosphonate (The following are covered by the plan: alendronate tablet and Ibandronate).

Endocrine Agents: Uterine Fibroids	Preferred with clinical criteria	Coverage is provided when the member has had a 90-day trial of one preferred oral contraceptive (birth control) which include but are not limited to: Yasmin, Aviane, Sprintec.
Gastrointestinal Agents: Anti-Emetics	Non-Preferred	Coverage is provided when the member has a history of at least 7 days of therapy with ONE preferred (medication covered by the Plan) medication, which include but are not limited to: Dimenhydrinate, Meclizine, Promethazine, and Ondansetron.
Gastrointestinal Agents: Crohn's Disease	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with TWO preferred (medication covered by the Plan) medications, which include but are not limited to: Azathioprine, Mercaptopurine, and Methotrexate.
Gastrointestinal Agents: Hepatic Encephalopathy	Xifaxan	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication may be approved for monotherapy (one type of treatment) or add-on therapy if there has been a therapeutic failure of being on lactulose therapy for at least 14 days.
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	Xifaxan	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy of one preferred (medication covered by the Plan) medication, which includes but is not limited to: diphenoxylate/atropine or loperamide.

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	Non-preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which includes but is not limited to: diphenoxylate/atropine or loperamide and a trial of Xifaxan which requires Step therapy: Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy of one preferred (medication covered by the Plan) medications, which includes but is not limited to: diphenoxylate/atropine or loperamide.
Gastrointestinal Agents: Pancreatic Enzymes	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with one preferred (medication covered by the Plan) medications, which include but are not limited to: Creon, and Zenpep.
Gastrointestinal Agents: Proton Pump Inhibitors	Non-Preferred ADDITIONAL INFORMATION: Request may be authorized If the drug was initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: lansoprazole capsules, omeprazole capsules, pantoprazole tablets.
Gastrointestinal Agents: Proton Pump Inhibitors	> 1 per day dosing	Coverage is provided when the member meets ALL the following requirements: 1. Member has failed once daily dosing of the requested medication; AND Documentation of one of the following conditions: H. Pylori (bacterial infection in the stomach), Chronic Obstructive Pulmonary Disease (long-

		term lung disease that causes decreased air flow to the lungs), Dyspepsia (pain in the stomach that occurs after eating or drinking), Gastritis (swelling of the lining in the stomach), Gastroparesis (slow stomach emptying), Barrett's Esophagus (condition in which the lining of the throat changes), cancer of the digestive system, Crest Syndrome (condition that causes tightening of skin and connective tissues), Esophageal Varices (abnormal, large veins in the throat), Scleroderma (condition that causes tightening of skin and connective tissues), Systemic Mastocytosis (type of blood disorder), or Zollinger Ellison Syndrome (condition where tumors form in your pancreas or upper part of the small intestine).
Gastrointestinal Agents: Ulcerative Colitis	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: baslsalazide disodium, budesonide ER tab, mesalamine DR cap, mesalamine tab, mesalamine enema, mesalamine ER, Pentasa (brand) and sulfasalazine.
Gastrointestinal Agents: Unspecified GI	Step therapy	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 14 days of therapy of at least two preferred (medication covered by the Plan) medications, which include but are not limited to: bisacodyl EC 5 MG TABLET, loperamide 2 MG CAPSULE, dicyclomine 10 MG CAPSULE and lactulose 10 GM/15 ML SOLUTION.

Gastrointestinal Agents: Unspecified GI	Relistor/Symproic	Coverage is provided when the member meets ALL the following requirements: 1. Patient must be 18 years or older 2. Must have a history of chronic pain requiring continuous opioid therapy for ≥ (greater than or equal to) 84 days.
Gastrointestinal Agents: Unspecified GI	Aemcolo	Coverage is provided when the member meets ALL the following requirements: 1. Patient must be 18 years or older 2. Maximum authorization will be for 3 days 3. Must have the inability to take, or failure of ALL the following: a. Azithromycin b. Ciprofloxacin c. Levofloxacin d. Ofloxacin e. Rifaximin (Xifaxan)
Gastrointestinal Agents: Unspecified GI	Zorbtive/Gattex Subsequent Authorization Criteria	Coverage is provided when the member meets ALL the following requirements: 1. Patient must be 18 years or older 2. Must have evidence of specialized parenteral nutritional support 3. Must have documentation of appropriate lab assessment (bilirubin, alkaline phosphatase, lipase, and amylase) at least 180 days prior to initiation Coverage is provided when the prescriber provides documentation of the member's clinical response to treatment and ongoing safety monitoring (for example: decreased frequency of specialized parenteral nutrition support, improvement in symptoms).

Genitourinary Agents: Benign Prostatic Hyperplasia	Non-Preferred	Coverage is provided when the member has a history of at least thirty (30) days of therapy with two (2) preferred (medication covered by the Plan) medications, which include but are not limited to: alfuzosin, doxazosin, dutasteride, finasteride, prazosin, tadalafil, tamsulosin and terazosin.
Genitourinary Agents: Benign Prostatic Hyperplasia	Tadalafil	Coverage is provided when the member meets ALL the following requirements: 1. Patient must have diagnosis of benign prostatic hyperplasia (enlargement of the prostate); AND 2. Must have a history of at least thirty (30) days of therapy with one of the following preferred (medication covered by the Plan) medications, which include but are not limited to: alfuzosin; doxazosin; prazosin; tamsulosin; terazosin; AND 3. Must have a history of at least ninety (90) days of therapy with finasteride.
Dutasteride/Tamsulosin (Jalyn)		Coverage is provided when documentation is provided for member's inability to use the individual drugs (Dutasteride/Tamsulosin).
Finasteride/Tadalafil (Entadfi)		Coverage is provided when documentation is provided for member's inability to use the individual drugs (Finasteride/Tadalafil).
Genitourinary Agents: Electrolyte Depleter Agents	Non-Preferred	Coverage is provided when the member has a history of at least seven (7) days of therapy with two (2) preferred (medication covered by the Plan) medications, which include but are not limited to: calcium acetate, calcium carbonate, Phoslyra and sevelamer.

Genitourinary Agents: Urinary Antispasmodics	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: Myrbetriq tablets, oxybutynin, solifenacin, and Toviaz.
Immunomodulator Agents for Systemic Inflammatory Disease **Please refer to Evergreen for additional Information on Systemic Immunomodulators**	**Preferred** **Medications Require Clinical PA:** Adbry Enbrel Dupixent Humira Kineret Otezla Taltz (PA and ST) Xeljanz IR	Coverage is provided when the member meets ALL the following requirements: 1. Must have been an inadequate clinical response (medications that do not show improvement or causes harm) of at least 90 days with TWO applicable first-line drugs indicated for diagnosis. 2. Documentation of the requested loading and maintenance dosing on PA (prior authorization) (approval by your plan before you can get your medication) form, if applicable 3. Must not have a current, active infection 4. Must provide evidence of a negative TB test prior to initiation of biologic therapy, if required by labeling.
	Non-Preferred	**[Non-Preferred Criteria]** Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR** **[For liquid oral dosage form]** Coverage is provided when the prescriber has provided documentation of why a patient cannot be changed to a tablet or capsule. Coverage is provided when the member has a history of at least 90 days of therapy with TWO preferred (medication covered by the Plan) medications, if indicated for diagnosis.

		-For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available) -For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)
Immunomodulator Agents for Systemic Inflammatory Disease	ALOPECIA AREATA CRITERIA:	Coverage is provided when a member meets ALL the following requirements: 1. Must be prescribed by or in consultation with a specialist (Example-dermatologist, rheumatologist) AND, 2. Must provide documentation of inadequate clinical response (medications that do not show improvement or causes harm) of at least 90 days with a topical steroid.
	PLAQUE PSORIASIS CRITERIA (receiving phototherapy):	Coverage is provided when a member has a history of an inadequate clinical response (medications that do not show improvement or causes harm) of at least 90 days of phototherapy (treatment that uses radiation or light energy).
	ATOPIC DERMATITIS CRITERIA:	Coverage is provided when the member meets ALL the following requirements: Must have at least 10% body surface area (BSA) involvement Member has a history of TWO of the following: topical (applied to the skin) corticosteroids (medication used to decrease inflammation or swelling that harms your body), topical calcineurin inhibitors [example:

		Elidel] **OR** atopic dermatitis is severe and involves greater than 25% of BSA (body surface area)
	ULCERATIVE COLITIS CRITERIA: (Failed TNF Inhibitors per history and request for another TNF inhibitor)	Coverage will not be provided for the requested medication when a member has a history of an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 90 days with a medication that works the same way, which include but are not limited to: Humira.
	SUBSEQUENT AUTHORIZATION CRITERIA	Coverage is provided when the prescriber provides documentation of patient's clinical response to treatment and ongoing safety monitoring.
Immunomodulator Agents for Systemic Inflammatory Disease	Clinical criteria: Taltz **Taltz requires a PA and ST**	Coverage is provided when the member meets ALL the following requirements: 1. Must have been an inadequate clinical response (medications that do not show improvement or causes harm) of at least 90 days with TWO applicable first-line drugs indicated for diagnosis. 2. Documentation of the requested loading and maintenance dosing on PA (prior authorization) (approval by your plan before you can get your medication) form, if applicable 3. Must not have a current, active infection 4. Must provide evidence of a negative TB test prior to initiation of biologic therapy, if required by labeling
	Step Therapy: Taltz	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 90 days of therapy of ONE preferred (medication covered by the Plan) TNF Inhibitor, which include but are not limited to: Enbrel and Humira.

	SUBSEQUENT AUTHORIZATION CRITERIA	Coverage is provided when the prescriber provides documentation of patient's clinical response to treatment and ongoing safety monitoring.
Infectious Disease Agents: Antibiotics – Cephalosporins	Non-Preferred	Coverage is provided when the member meets ALL the following requirements: 1. Member has an allergy (a sensitive reaction of the body to certain substances), contraindication (a condition that serves as a reason not to take a certain medical treatment) or history of unacceptable/toxic side effects (an unwanted effect that is harmful to the body) to one of the medications listed above; AND 2. Member has an infection that can be treated by the requested medication; OR 3. Member has had a 3-day trial of at least ONE preferred medication such as but not limited to: cefadroxil, cephalexin (250 mg or 500 mg), cefaclor, cefuroxime or cefdinir; OR 4. If the member is completing a course of therapy with a medication requiring a prior authorization (approval by your plan before you can get your medication), which is initiated in the hospital, then may approve the requested medication only to complete the remaining course of therapy.
Infectious Disease Agents: Antibiotics – Macrolides		Coverage is provided when the member meets ALL the following requirements: 1. Member has an allergy (a sensitive reaction of the body to certain substances), contraindication (a condition that serves as a reason not to take a certain medical treatment) or history of unacceptable/toxic side effects (an unwanted effect that is harmful to the body) to one of the medications listed above; AND 2. Member has an infection that can be treated by the requested medication; OR

		3. Member has had a 3-day trial of at least ONE preferred (medications covered by the plan) medication such as but not limited to: Azithromycin or Clarithromycin; OR 4. If the member is completing a course of therapy with a medication requiring a prior authorization (approval by your plan before you can get your medication), which is initiated in the hospital or other similar location or was started before Medicaid eligibility, then may approve the requested medication to complete the course of therapy.
Infectious Disease Agents: Antibiotics – Quinolones	Non-Preferred	Coverage is provided when the member meets ALL the following requirements: 1. Member has an allergy (a sensitive reaction of the body to certain substances), contraindication (a condition that serves as a reason not to take a certain medical treatment) or history of unacceptable/toxic side effects (an unwanted effect that is harmful to the body) to one of the medications listed above; AND 2. Member has an infection that can be treated by the requested medication; OR 3. Member has had a 3-day trial of at least ONE preferred medication (medications covered by the plan) such as ciprofloxacin, ciprofloxacin suspension or levofloxacin; OR 4. If the member is completing a course of therapy with a medication requiring a prior authorization (approval by your plan before you can get your medication), which is initiated in the hospital or other similar location or was started before Medicaid eligibility, then may approve the requested medication to complete the course of therapy.
Infectious Disease Agent: Antibiotics - Inhaled	Preferred - Tobramycin	Coverage is provided when the member meets ALL the following requirements: 1. Member is 6 years of age or older; AND

		2. Member has a diagnosis of Cystic Fibrosis (disease that causes problems with breathing and digestion) WITH a pseudomonas (type of bacteria)-related infection. 3. Documentation must be provided of cultures demonstrating drug is prescribed in alignment with approved indication
	Non-preferred tobramycin agents: (Bethkis, Kitabis, Tobi Podhaler, Arikayce, Cayston) (Please be aware of current UPDL statement - ALL REQUESTS: Must be prescribed in accordance with FDA approved labeling	Coverage is provided when the member meets ALL the following requirements: 1. Member has appropriate age and diagnosis with documentation of cultures demonstrating drug is prescribed in alignment with approved indication Member has had a 28-day trial of at least 1 preferred (medication covered by the Plan) medication which include but are not limited to the following: Tobramycin (requires prior clinical prior authorization) (approval by your plan before you can get your medication)
	Subsequent Authorization Criteria	Coverage for reauthorization is provided when your provider has submitted documentation (chart notes) showing positive clinical response (outcome) to use of the requested medication as well as documentation (chart notes) that support ongoing safety monitoring while using the requested medication such as culture conversion or symptom improvement.
Infectious Disease Agents: Antibiotics – Tetracyclines	Non-Preferred Additional Information: Requests may be authorized if: The infection is caused by an organism resistant to ALL preferred antibiotics (must provide diagnosis and any culture/sensitivity results). The patient is completing a course of therapy that was started in the hospital or other similar location or	Coverage is provided when the member meets ALL the following requirements: 1. Member has an allergy (a sensitive reaction of the body to certain substances), contraindication (a condition that serves as a reason not to take a certain medical treatment) or history of unacceptable/toxic side effects (an unwanted effect that is harmful to the body) to one of the medications listed above; AND 2. Member has an infection that can be treated by the requested medication; OR 3. Member has a history of at least 3 days of therapy with one preferred (medication covered by the plan) medications for acute infection OR at

	was started before Medicaid eligibility, only the remaining course will be authorized.	least 90 days with at least one preferred oral drug for acne, which include but are not limited to: minocycline capsules, doxycycline 50 mg, or doxycycline 100 mg OR 4. If the member is completing a course of therapy with a medication requiring a prior authorization (approval by your plan before you can get your medication), which is initiated in the hospital or other similar location or was started before Medicaid eligibility, then may approve the requested medication to complete the course of therapy.
Infectious Disease Agents: Antifungals	Non-Preferred	Coverage is provided when the member has a history of at least 7 days of therapy with one preferred (medication covered by the Plan) medication, which include but are not limited to: Fluconazole, Ketoconazole, Terbinafine, OR if the member is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized, OR the infection is caused by an organism resistant to all preferred (covered by the plan) antifungals.
	ADDITIONAL OTESECONAZOLE (VIVJOA) CRITERIA:	1. Must provide documentation of at least three symptomatic episodes of vulvovaginal candidiasis in the past 12 months 2. Must provide documentation of non-reproductive potential (for example: post-menopausal) 3. Must have had an inadequate clinical response of at least 180 day maintenance course with oral fluconazole shown by documentation of more than one breakthrough infection
Infectious Disease Agents: Antivirals – Hepatitis C Agents	Clinical Preferred: MAVYRET, SOFOSBUVIR/VELPATASVIR, PEGASYS, RIBAVIRIN	Coverage is provided when the member meets recommendations by the American Association for the Study of Liver Diseases (AASLD). Currently, the patient does not meet the criteria for the following reasons: 1. There is no supporting evidence using the requested medication for the patient's genotype (a strain of virus affecting the liver); AND

		2. There is no supporting evidence using the requested medication for the patient's fibrosis stage (measurement identifying the stiffness/scarring of the liver); AND 3. There is no supporting evidence showing the member has been assessed for a history of decompensated liver disease and liver disease severity; AND 4. The dose, directions, and length of treatment are not listed within the AASLD guidelines; AND 5. The baseline quantitative HCV RNA levels are not drawn within 180 days; AND 6. The prescriber did not discuss with the member the importance of adherence (taking the medication exactly as the doctor wrote it) to the treatment plan, office visits (lab and imaging procedures), and taking medications as prescribed until completion of therapy; AND 7. The member has limited life (< 12 months) expectancy due to non-liver-related conditions
Infectious Disease Agents: Antivirals – Hepatitis C Agents	Clinical non-preferred: Harvoni, Ledipasvir/Sofosbuvir, Solvaldi, Vosevi, Zepatier	Coverage is provided when the member meets recommendations by the American Association for the Study of Liver Diseases (AASLD). Currently, the patient does not meet the criteria for the following reasons: 1. There is no supporting evidence using the requested medication for the patient's genotype (a strain of virus affecting the liver); AND 2. There is no supporting evidence using the requested medication for the patient's fibrosis stage (measurement identifying the stiffness/scarring of the liver); AND 3. There is no supporting evidence showing the member has been assessed for a history of decompensated liver disease and liver disease severity; AND 4. The dose, directions, and length of treatment are not listed within the AASLD guidelines; AND

		5. The baseline quantitative HCV RNA levels are not drawn within 180 days; AND 6. The prescriber did not discuss with the member the importance of adherence (taking the medication exactly as the doctor wrote it) to the treatment plan, office visits (lab and imaging procedures), and taking medications as prescribed until completion of therapy; AND 7. The member has limited life (< 12 months) expectancy due to non-liver-related conditions; AND 8. Must have an inadequate clinical response defined as not achieving sustained virologic response with guideline-recommended preferred drugs.
Infectious Disease Agents: Antivirals – Herpes		Coverage is provided when the member has a history of at least 3 days of therapy with at least ONE preferred (medication covered by the Plan) medications, which include but are not limited to: acyclovir and valacyclovir.
Infectious Disease Agents: Antivirals – HIV*	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with at least one preferred (medication covered by the Plan) medication, which include but are not limited to: Descovy, Juluca, Odefsey, Triumeq.
	Triumeq PD	Coverage is provided when the member meets the following requirement: 1. Chart notes from your provider show your weight is between 10-25kg (kilogram)/22-55lb (pounds).
Ophthalmic Agents: Ophthalmic Steroids	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with two preferred (medication covered by the Plan)

		medications, which include but are not limited to: prednisolone acetate, fluorometholone, and dexamethasone sodium phosphate.
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	ADDITIONAL INFORMATION: Requests may be authorized if: The infection is caused by an organism resistant to ALL preferred antibiotics (must provide diagnosis and any culture/sensitivity results). The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized.	Coverage is provided when the member has an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 3 days with at least two preferred drugs that include but are not limited to: Ofloxacin, Gentamicin, Ciloxan, and Polymyxin/Trimethoprim OR if the member is completing a course of therapy started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized.
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with one preferred (medication covered by the plan) medications, which include but are not limited to: olopatadine, azelastine or cromolyn.
Ophthalmic Agents: Dry Eye Treatments	Non-Preferred: Please note: All drugs in this class require **step therapy** (preferred and non-preferred)	Coverage is provided when the member has a history of at least 14 days of therapy with one preferred (medication covered by the Plan) medication, which includes: Restasis Trays (Brand is preferred by your plan) and a paid pharmacy claim for 14 days of artificial tears or over the counter dry eye drops in the previous 120 days which include but are not limited to: Systane, lubricant eye drops, and Refresh eye drops.
	Step Therapy: Please note: All drugs in this class require **step**	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug

	therapy (preferred and non-preferred)	before you are approved for the drug requested. The requested medication requires the member to have an inadequate response (Medications that do not show improvement or causes harm) of at least 14 days with artificial tears or over-the-counter dry eye drops in the previous 120 days which include but are not limited to: Systane, lubricant eye drops, and Refresh eye drops.
Ophthalmic Agents: Glaucoma Agents	Step Therapy: Alphagan P 0.1%, Azopt (BvG), Combigan (BvG), Travatan Z (BvG)	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy of one preferred (medication covered by the Plan) medication in the same drug class (if available), which include but are not limited to: timolol 0.5% gel and solution, betaxolol, or brimonidine 0.2%.
Ophthalmic Agents: Glaucoma Agents	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with at least two preferred (medication covered by the Plan) medications in the same drug class (if available), which include but are not limited to: dorzolamide, latanoprost, timolol 0.5% gel and solution, Rocklatan, Simbrinza and brimonidine 0.2%.
Ophthalmic Agents: NSAIDs	Non-Preferred	Coverage is provided when the member has a history of at least 3 days of therapy with one preferred (medication covered by the Plan) medications, which include but are not limited to: diclofenac, ketorolac and flurbiprofen. For ketorolac brand-name products, must have tried the generic before brand eligibility is granted.
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	Non-Preferred	Coverage is provided when the member has a history of at least 7 days of therapy with one preferred (medication covered by the Plan) medications, which include but are not limited to: ofloxacin, neomycin/polymyxin B/Hydrocortisone, and Cipro HC.

Oxazolidinone Antibacterial	Zyvox (linezolid)	Coverage is provided when the member meets all the following requirements: 1. Must provide documentation (chart notes) of diagnosis and any culture and sensitivity reports showing the infection is caused by an organism resistant to preferred drugs. 2. For MRSA (methicillin resistant Staphylococcus aureus) (type of bacteria that is resistant to several widely used antibiotics) infections, must have medically valid reason (supported by chart notes) why vancomycin cannot be used.
Respiratory Agents: Antihistamines – Second Generation	Non-Preferred	Coverage is provided when the member has a history of at least 30 days of therapy with TWO preferred (medication covered by the Plan) medications, which include but are not limited to: cetirizine syrup and tablets, loratadine syrup and tablets, or loratadine/pseudoephedrine.
Respiratory Agents: Cystic Fibrosis	Non-preferred: Bronchitol	Coverage is provided for Bronchitol when the member meets ALL the following requirements: 1. Diagnosis of cystic fibrosis (inherited disorder that causes problems with breathing and digestion). 2. The prescriber is, or has consulted with, a pulmonologist (lung doctor) or infectious disease specialist (doctor that treats people with infections). 3. Member meets the Food and Drug Administration (FDA) approved minimum age for Bronchitol (age 6 and older). 4. Must be used as add-on maintenance therapy (used in addition to another medication). 5. Member must pass the Bronchitol Tolerance Test (test given by your provider to determine if you can use Bronchitol). 6. Must have an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 30 days with at least one preferred drug.

Respiratory Agents: Cystic Fibrosis	Preferred: Require PA: Kalydecto, Orkambi, Symdeko, Trikafta	Coverage is provided when the member meets ALL the following requirements: 1. Diagnosis of cystic fibrosis (inherited disorder that causes problems with breathing and digestion). 2. The prescriber is, or has consulted with, a pulmonologist (lung doctor) or infectious disease specialist (doctor that treats people with infections). 3. Patient meets the Food and Drug Administration (FDA) approved minimum age for the requested medication. 4. Provider has submitted documentation of the genetic mutation(s) for cystic fibrosis (lab result(s) showing cystic fibrosis type).
	Criteria for Reauthorization	Continued coverage will be provided if the member meets the following criteria: 1. Member meets all initial criteria for approval. 2. Member's medication adherence (taking medications correctly) is confirmed by pharmacy claim history. 3. Chart notes must be submitted by your provider showing you are stable or have had improvement of Forced Expiratory Volume (amount of air you can force out in one second) AND one or more of the following: a.) Stabilization or improvement of weight gain. b.) Stabilization or improvement in sweat chloride (type of test for cystic fibrosis). c.) Decrease in the number of pulmonary (lung) exacerbations (increase in lung symptoms) or severity. d.) Other chart notes provided by the physician showing ongoing safety monitoring.
Respiratory Agents: Epinephrine Auto-Injectors	Non-Preferred	Coverage is provided if the member has a history of a trial and/or a reason why the member cannot stay on or complete a trial of the

		medication(s) not requiring prior approval, which include but are not limited to: Symjepi, and epinephrine auto-injector (labeler 49502).
Respiratory Agents: Hereditary Angioedema		Please refer to the OHUPDL
	Preferred: All require a PA: Haegarda, Ruconest, Takhzyro Please refer to the OHUPDL	Coverage is provided if the member has documentation of diagnosis (Example- C1-INH deficiency or dysfunction (Type I or II HAE)) and whether the drug will be used for prophylaxis or treatment AND documentation of at-home administration.
	Non-Preferred	Coverage is provided if the member has an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 60 days with at least one preferred drug, which include but not limited to: Haegarda, Ruconest, or Takhzyro (all which require a prior authorization (approval by your plan before you can get your medication).
Respiratory Agents: Inhaled Agents	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with at least two preferred (medication covered by the Plan) that is within the same class and duration of action. Medications include, but not limited to: Advair HFA (Brand name is covered by the plan), Atrovent HFA, Combivent Respimat, Dulera, Serevent Diskus, Spiriva or Symbicort (Brand name is covered by the plan.
	Budesonide and Formoterol (generic Symbicort) ****Is the generic being requested OR is this a Brand Preferred over generic situation******	Coverage is provided when the member has a history of at least 14 days of therapy with one preferred (medication covered by the Plan) medication, which includes but is not limited to: Symbicort (brand name only), Advair Diskus (brand name only) and Advair HFA (brand name only).

	Trelegy Ellipta	Coverage is provided in situations where the member has had a 14-day trial of two medications that are covered by the plan: Anoro Ellipta, Serevent Diskus, Dulera, Advair Diskus (Brand name is covered by the plan), Symbicort (Brand name is covered by the plan), Atrovent HFA, Combivent Respimat, Spiriva Handihaler or Respimat, Asmanex Twisthaler, Flovent Diskus or HFA inhalers (Brand name is covered by the plan), Pulmicort Flexhaler, or Stiolto.
	Breztri Aerosphere	Coverage is provided in situations where the member has had a 14-day trial of two medications that are covered by the plan: Anoro Ellipta, Serevent Diskus, Dulera, Advair Diskus (Brand name is covered by the plan), Symbicort (Brand name is covered by the plan), Atrovent HFA, Combivent Respimat, Spiriva Handihaler or Respimat, Asmanex Twisthaler, Flovent Diskus or HFA inhalers (Brand name is covered by the plan), Pulmicort Flexhaler, or Stiolto.
Budesonide Nebulizer Sol (AR)	Budesonide Nebulizer Sol (AR): a PA is required for patients over 6 years	Coverage is provided when the member is 6 years of age or younger. Preferred (medication covered by the plan) medications include: Pulmicort Flexhaler and Flovent (brand name).
	GLUCOCORTICOIDS <u>Additional Information</u> AR - Albuterol Nebulizer Solution 0.42mg/ml, 0.63mg/ml: a PA is	Coverage is provided if the member has two 30 day trials and/or a reason why the member cannot stay on or complete a trial of the medication(s) not requiring prior approval. Additional criteria to consider: 1. Requested medication may be approved if the patient meets any of the following criteria: a) Under 13 years old and is unable to use an inhaler not requiring prior approval b) Disabled and unable to use a preferred inhaler c) Non-compliant on a preferred inhaler due to taste, dry mouth, or infection

	required for patients over 12 years AR - Budesonide Nebulizer Solution: a PA is required for patients over 6 years	d) Clinically unstable, as defined in current guidelines in terms of oral steroid use or patient's current symptomatology
Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors	Zafirlukast	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 90 days of therapy of one preferred (medication covered by the Plan) medications, which include but are not limited to: montelukast.
	Non-Preferred	Coverage is provided when the member has a history of at least 90 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: montelukast and zafirlukast (requires prior authorization) (approval by your plan before you can get your medication)
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Preferred: Clinical *Initial authorization is limited to 180 days *Re-authorization of up to 365 days granted following demonstration of improvement in patient condition with therapy (e.g., improvement in PFTs)	Coverage for Asthma is provided when the member meets ALL the following requirements: 1. Patient must have a diagnosis of moderate to severe asthma; AND 2. Prescribed by or in consultation with an allergist/immunologist or pulmonologist; AND 3. Prescribed in accordance with its FDA approved labeling; AND 4. Preferred medications (medication the plan prefers the doctor to use; OR medications covered by the plan) will be approved for patients with uncontrolled asthma symptoms and/or exacerbations despite at least 30 days adherence to therapy with:

		Medium dose preferred ICS (inhaled corticosteroid)/LABA (long-acting beta agonist) inhaler (patients 6-11 years old) Medium dose preferred ICS (inhaled corticosteroid)/LABA (long-acting beta agonist) inhaler with tiotropium or high dose preferred ICS/LABA RES (patients 12 years and older).
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Non-Preferred	Coverage is provided when the member has a history of at least 90 days of therapy with one preferred (medication covered by the Plan) medication, which include but are not limited to: Dupixent, Xolair, and Fasenra (all require a prior authorization (approval by your plan before you can get your medication).
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Chronic Rhinosinusitis with Nasal Polyposis	Coverage for Chronic Rhinosinusitis with Nasal Polyposis is provided when the member meets ALL the following requirements: 1. Patient must have a diagnosis of chronic rhinosinusitis with nasal polyposis; AND 2. Prescribed by or in consultation with an allergist/immunologist, pulmonologist, or otolaryngologist; AND 3. Prescribed in accordance with its FDA approved labeling; AND 4. Patient had an inadequate response (medication did not show improvement), could not tolerate the effects of the medication, medication caused harm or patient has a contraindication to one oral corticosteroid (medication used to decrease inflammation or swelling that harms your body); AND 5. 30 day trial to one nasal corticosteroid spray.
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Chronic Urticaria	Coverage for Chronic Urticaria is provided when the member meets ALL the following requirements: 1. Patient must have a diagnosis of chronic (long term) urticaria; AND 2. Prescribed by or in consultation with a dermatologist or allergist/immunologist; AND 3. Prescribed in accordance with its FDA approved labeling; AND

		4. Patient has trial and/or a reason why the patient cannot stay on or complete a trial of TWO 14-day trials with two different antihistamines.
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Moderate to Severe Atopic Dermatitis	Coverage for Moderate to Severe Atopic Dermatitis is provided when the member meets ALL the following requirements: 1. Patient must have a diagnosis of moderate to severe atopic dermatitis; AND 2. Patient has minimum body surface area (BSA) involvement of at least 10%; AND 3. Prescribed by or in consultation with a dermatologist or allergist/immunologist; AND 4. Prescribed in accordance with its FDA approved labeling; AND 5. Patient has had inadequate response (medications do not show improvement or causes harm) or contraindication to two of the following: topical corticosteroids (medication applied to the skin used to decrease inflammation or swelling that harms your body), topical (applied to the skin) calcineurin inhibitors [example: Elidel], unless atopic dermatitis is severe and involves greater than 25% of BSA.
	*Initial authorization is limited to 180 days *Re-authorization of up to 365 days granted following demonstration of improvement in patient condition with therapy (for example: reduced BSA affected).	

Respiratory Agents: Nasal Preparations		Coverage is provided when the member has a history of at least 30 days of therapy with two preferred (medication covered by the Plan) medications in the same class, which include but are not limited to: azelastine, flunisolide and olopatadine nasal spray.
Respiratory Agents: Other Agents	~~Daliresp (Brand preferred over Generic)~~ Non-Preferred: Roflumilast	Coverage is provided when the member meets all the following requirements: 1. Must have had an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 90 days of one preferred long-acting beta agonist (such as Serevent Diskus and Striverdi Respimat) AND one preferred long-acting muscarinic antagonist-containing inhaler (such as Spiriva and Incruse Ellipta). 2. Member is using the requested medication with a long-acting beta agonist AND a long-acting muscarinic antagonist. Documentation must be provided of patient's clinical response to treatment, adherence to maintenance inhaler per pharmacy claims, and ongoing safety monitoring.
Topical Agents: Antifungals	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with two preferred (medication covered by the Plan) medications, which include but are not limited to: clotrimazole, ketoconazole and terbinafine.
	Additional Criteria: Jublia	Coverage is provided when the member had an inadequate clinical response (Medications that do not show improvement or causes harm) of at least 365 days with at least one preferred topical drug AND at least 84 days with at least one preferred oral drug indicated for diagnosis.
Topical Agents: Antiparasitics	Non-Preferred: Eurax Malathion Ivermectin Lotion	Coverage is provided when the member has a history of at least a 14-day trial with ONE preferred (medication covered by the Plan) medication, AND the medication's corresponding generic (if covered) has been attempted. Preferred medications which include but are not limited to:

	Spinosad	Natroba (Brand name is covered by your plan), Permethrin, Piperonyl Butoxide/Pyrethrins.
		Coverage is provided for Lindane lotion and shampoo only for patients who cannot tolerate or who have failed other treatments. **The P&T committee does not recommend the use of Lindane.**
Topical Agents: Corticosteroids	Non-Preferred	Coverage is provided when the member has a history of at least 14 days of therapy with two medications not requiring prior authorization (approval by your plan before you can get your medication) in the same category, which include but are not limited to: triamcinolone, mometasone, desonide cream and ointment, and clobetasol.
Topical Agents: Immunomodulators	Non-Preferred Eucrisa Opzelura Pimecrolimus (AR) Vtama Zoryve **Pimecrolimus (non-preferred): a PA (prior authorization) (approval by your plan before you can get your medication) is required for patients younger than 2 years old. **Opzelura is contraindicated for use in immunocompromised patients.	Coverage is provided when the member has a history of at least 30 days of therapy with at least one preferred (medication covered by the Plan) medications, which include but are not limited to: Elidel and Tacrolimus.
	Preferred:	Step therapy:

	Elidel (AR) (BVG) (ST) Tacrolimus (AR) (ST) AR - pimecrolimus and tacrolimus: a PA is required for patients younger than 2 years old	Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy of two topical corticosteroids (medication used to decrease inflammation or swelling that harms your body). Age Restriction: A PA (prior authorization) (approval by your plan before you can get your medication) is required for patients younger than 2 years old.

Non-preferred testing strips and glucometers		GLUCOMETER The following is a non-preferred (not covered by your plan) glucometer (XXXX), (device used to check blood sugars) please refer to the Ohio Department of Medicaid 2023 Preferred Diabetic Supply List for preferred (covered by your plan) products which include: OneTouch Verio Flex, OneTouch Ultra 2, OneTouch Verio, OneTouch Verio Reflect, TrueMetrix, TrueMetrix Air and Relion TrueMetrix Air. TEST STRIPS The following is a non-preferred (not covered by your plan) test strip (XXXX), please refer to the Ohio Department of Medicaid 2023 Preferred Diabetic Supply List for preferred (covered by your plan) products, which include but are not limited to: OneTouch Ultra Blue, OneTouch Verio, and TrueMetrix test strips.

Dexcom	No PA Required	
Freestyle Libre	No PA Required	

DexCom, Inc.	08627-0016-01	DexCom G6 Transmitter
DexCom, Inc.	08627-0053-03	DexCom G6 Sensor
DexCom, Inc.	08627-0091-11	DexCom G6 Receiver
Dexcom, Inc.	08627-0077-01	DexCom G7 Sensor
DexCom, Inc.	08627-0078-01	DexCom G7 Receiver

Abbott Diabetes Care Sales Corporation	57599-0001-01	FreeStyle Libre 14 Day Sensor
Abbott Diabetes Care Sales Corporation	57599-0002-00	FreeStyle Libre 14 Day Reader
Abbott Diabetes Care Sales Corporation	57599-0800-00	FreeStyle Libre 2 Sensor
Abbott Diabetes Care Sales Corporation	57599-0803-00	FreeStyle Libre 2 Reader
Abbott Diabetes Care Sales Corporation	57599-0818-00	FreeStyle Libre 3 Sensor

Freestyle Precision Neo	Non-Preferred Test Strip • Compatible with the Freestyle Libre CGM system • Deny and Recommend formulary Meters and Test strips	The following is a non-preferred (not covered by your plan) test strip (Freestyle Precision Neo compatible with the Freestyle Libre CGM system), please refer to the Ohio Department of Medicaid 2023 Preferred Diabetic Supply List for preferred (covered by your plan) Blood Glucose Meters and Test Strips, which include but are not limited to: Meters: OneTouch Verio Flex, OneTouch Ultra 2, OneTouch Verio, OneTouch Verio Reflect, TrueMetrix, TrueMetrix Air and Relion TrueMetrix Air and Test Strips: OneTouch Ultra Blue, OneTouch Verio, and TrueMetrix test strips.

Diabetic Insulin Pump	Omnipod	Coverage is provided when the member meets ALL the following requirements: Member has a diagnosis of Type 1 or 2 Diabetes Must require insulin injections greater than or equal to 3 times a day and self-home glucose monitoring greater than or equal to 4 times a day Must be adherent to the insulin therapy recommended by an endocrinologist (*doctor who has special training in diagnosing and treating disorders of the endocrine system* (the glands and organs that make hormones) as demonstrated by monitoring logs and claims history maintained for at least 3 months Must meet ONE of the following criteria while compliant with insulin regimen: a. HgA1C>7% (a test result that shows a three-month average of blood sugars) b. History of recurrent hypoglycemia (low blood sugar) c. Wide fluctuations in blood glucose before mealtime d. A marked early morning increase in fasting blood sugar (dawn phenomenon-glucose level exceeds 200mg/dL) e. History of ketoacidosis (body produces high levels of blood acids called ketones) f. A history of severe glycemic excursions Must be capable of managing the pump and that the desired improvement in metabolic control can be achieved (or someone assisting the individual)
	Subsequent authorizations require documentation of objective evidence of improvement in control of diabetes relative to baseline	Must have completed a comprehensive diabetes education program within the previous 365 days Must submit a letter or documentation indicating patient regularly works with a certified diabetes educator

First-Products	First-Omeprazole; First-Lansoprazole, First-Mouthwash BLM, First-Metronidazole, First-Progesterone VGS and First-Baclofen	The coverage request cannot be approved because the information provided shows this medication (First-XXXX suspension) is not Food and Drug Administration (FDA) approved. Medications that are not FDA approved are not covered by your plan. Please consider the following alternatives: Nexium granules (brand name), Protonix Pak (brand name), XXXX suspension (compounded by your pharmacy, may require prior authorization (approval by your plan before you can get your medication), Protonix suspension (prior authorization required), Prilosec suspension (prior authorization required), lansoprazole orally disintegrating tablets (prior authorization required) and esomeprazole granules (prior authorization required).

Missing clinical information		The coverage request cannot be approved because there is a lack of clinical information provided including, but not limited to XXXXXX.

Missing signatures on Prior Authorizations	ODM has clearly stated that the prior authorizations must come from the prescriber or staff of the prescriber.	A prior authorization has been submitted for this member and medication, but the origin of the prior authorization request cannot be determined at this time. Per Rule 5160-9-03(C)(3) of the Ohio Administrative Code, prior authorizations may only be submitted by a prescriber or prescriber's staff. "Please see attached orders" or "See attached signed prescription" is not considered attestation by prescriber or prescriber's agent. Pharmacists or pharmacy technicians, working in community, long term care, specialty, or infusion locations are not considered prescriber's agents or staff member unless specifically designated by the prescriber or pursuant to Ohio Revised Code Section 4729.39. Please have prescriber or prescriber's staff member sign and submit the prior authorization form.

Requested Information Not Received	denying for requested information not received	Coverage is provided when provider notes indicate that the member has tried the covered medications or given a medical reason why the covered medications will not work or may cause harm and criteria has been met. The following information is required: **xxxxxx.** Due to lack of information, an outreach was made to the providers office and the requested information was not received. The Gainwell Policy for Medical Necessity and Ohio Unified Preferred Drug List criteria were reviewed and per Ohio Administrative Code Rule 5160-1-01 (C) and 5160-26-03 (B), a medically necessary service must include: generally accepted standards of medical practice, be clinically appropriate in administration, treatment & outcome and be the lowest cost alternative to effectively treat the condition. Please contact your provider to assist you with other treatment options that might be covered under your benefit package, or other services that might be available through the community.

OFF LABEL	Indication	Please use the Admin Denial Letter Process – To select the ADMIN DENIAL LETTER, select Status of DENIED, then instead of selecting DENIAL LETTER, select ADMIN DENIAL LETTER. Do not add any additional information in the letter text portion.

DAW 1 (Dispense as Written)	Refer to Medical Necessity Policy and Procedures Additional Information: Type I-IgE-mediated hypersensitivity reactions may include the following items: rash, hives, swelling of the face, wheezing, low blood pressure, and loss of consciousness.	Coverage is provided when the member has had a trial and failure of TWO generic manufacturers (makers) (if available) of the requested brand name medication AND is unable to continue due to a documented adverse event OR allergic reaction OR Coverage is provided for situations where the member had a serious adverse event (unexpected or harmful event) with BOTH generic version(s) AND the provider has provided a copy and confirmation of a MedWatch form (used to report an adverse event) submission to the FDA (Food and Drug Administration) documenting the adverse outcome experienced by the member that includes one of the following: a) was life threatening; b) required hospitalization; c) caused disability or permanent damage; or d) required intervention to prevent permanent impairment/damage OR Coverage is provided when the Member has a documented allergic reaction (sensitivity) to an inactive ingredient (non-active parts) in the generic product and the prescriber has documented the inactive ingredient, the reaction (dates and clinical details), and the manufacturer of the generic product(s) trialed.

Missing Diagnosis		Coverage is provided in situations where the medication requested is being prescribed for a FDA (Food and Drug Administration) approved indication. Approved indications include but are not limited to the following: (fill in the blank with approved indications (fifth grade reading level). **For example: Diabetic Neuropathy (type of nerve damage that can occur if you have diabetes)

Non-Covered Services	**Admin denials are performed for non-covered services which include:** • **Drugs that are not payable/rebate** • **Obesity** • **Infertility** • **ED** • **DESI drugs** • **Drugs covered by Part D** • **Non-covered OTC's (non-payable/non-rebate)** • **Off-label use of medication (off label indication, dosing, age, etc.)**	Please use the Admin Denial Letter Process – To select the ADMIN DENIAL LETTER, select Status of DENIED, then instead of selecting DENIAL LETTER, select ADMIN DENIAL LETTER. Do not add any additional information in the letter text portion.
Quantity Limits		The coverage request cannot be approved because the amount of medication ordered (XX dose form (48 tablets) for XX days) by your provider is above the amount allowed by your plan (XX tablets for XX days). This is called a Quantity Limit. The information provided by your provider does not support a reason to exceed the amount of medication covered by your plan.

Brand Preferred over Generic Template	Brand Preferred over Generic Template Enter in the information: Add to the Notes section of the PA, Cancel the PA and Add to the Additional Info Chat	Auth ID Cancelled: Drug/strength: Reason for fax: Brand Preferred over Generic The following medication [xxxx] has been requested for your patient. The plan covers the brand name medication [xxxx] without a prior authorization. Please have the pharmacy process the brand name medication using a DAW 9 when processing the prescription. If the non-preferred medication (the medication that is NOT covered by the plan) is required, please re-submit the prior authorization request for review with a statement that the non-preferred medication is being requested and include the clinical reasons that the preferred medication cannot be used.
PA Examples Format	***Non-preferred*:** **Step Therapy:**	(Non-preferred blank template) Coverage is provided when the member has a history of at least XXX days of therapy with XXXX preferred (medication covered by the Plan) medications, which include but are not limited to: XXXXXXXXXXX, XXXXXXXXXXX. (Topical Retinoids example) Coverage is provided when the member has a history of at least 90 days of therapy with three preferred (medication covered by the Plan) medications, which include but are not limited to: benzoyl peroxide and clindamycin gel. ***Step Therapy*:** (Step Therapy blank template) Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least XXXX days

	Clinical:	of therapy of XXX preferred (medication covered by the Plan) medications, which include but are not limited to: XXXX, XXXX, XXXX. (Qelbree example) Coverage is provided when the member has met the step therapy requirement for this medication. Step therapy is a type of prior authorization (approval by your plan) that requires that you try one drug before you are approved for the drug requested. The requested medication requires the member to have a history of at least 30 days of therapy with atomoxetine OR at least two preferred (medication covered by the Plan) stimulants, which include but are not limited to: Dextroamphetamine-Amphetamine XR (extended release), Methylphenidate ER tablet (Concerta, Methylin ER, and Ritalin SR), and Vyvanse capsule. ***Clinical*:** (Clinical blank template) Coverage is provided when the member meets ALL the following requirements: 1. XXXXX; AND 2. XXXX; AND 3. XXXX. (Elidel example) Coverage is provided when the member meets ALL the following requirements: 1. Member has had a 30 day trial of TWO preferred topical (apply to the skin) corticosteroids (medication used to decrease

		inflammation or swelling that harms your body) which include but are not limited to: Amcinonide, Desonide, Diflorasone, Hydrocortisone and Mometasone; OR if topical corticosteroids are unable to be used due to potential risk to the member; AND 2. Member has a diagnosis of Atopic dermatitis (a condition that causes dry, itchy, and swollen skin); AND 3. Member is 2 years of age and older.
OHIO MEDICAID GAINWELL POLICY AND RULE LANGUAGE		
Reason for Denial	**Policy**	**Rule**
Non-Preferred or Lower Cost Medications	Medical Necessity Policy	The Gainwell Policy for Medical Necessity and Ohio Unified Preferred Drug List criteria were reviewed and per Ohio Administrative Code Rule 5160-1-01 (C) and 5160-26-03 (B), a medically necessary service must include: generally accepted standards of medical practice, be clinically appropriate in administration, treatment & outcome and be the lowest cost alternative to effectively treat the condition. Please contact your provider to assist you with other treatment options that might be covered under your benefit package, or other services that might be available through the community.

Medical Necessity for DAW	Medical Necessity Policy - Dispense as Written (DAW)	The Gainwell Policy for Medical Necessity Dispense as Written (DAW) and Ohio Unified Preferred Drug List criteria were reviewed and per Ohio Administrative Code Rule 5160-1-01 (C) and 5160-26-03 (B), a medically necessary service must include: generally accepted standards of medical practice, be clinically appropriate in administration, treatment & outcome and be the lowest cost alternative to effectively treat the condition. Please contact your provider to assist you with other treatment options that might be covered under your benefit package, or other services that might be available through the community.
Medical Necessity Newly Available Drugs Not on the UPDL OR Drugs Not on the UPDL	Medical Necessity Policy	The Gainwell Policy for Medical Necessity was reviewed and per Ohio Administrative Code Rule 5160-1-01 (C) and 5160-26-03 (B), a medically necessary service must include: generally accepted standards of medical practice, be clinically appropriate in administration, treatment & outcome and be the lowest cost alternative to effectively treat the condition. Please contact your provider to assist you with other treatment options that might be covered under your benefit package, or other services that might be available through the community.
Experimental Use	Medical Necessity Policy – Cancer Drugs, Non-Cancer Drugs, Orphan Drug Use	The Gainwell Policy for Medical Necessity and Ohio Unified Preferred Drug List were reviewed and per Ohio Administrative Code Rule 5160-9-03 (B)-(D), drugs that fall into specific categories may be considered non-covered by the Ohio Department of Medicaid (ODM) pharmacy program. Please contact your provider to assist you with other treatment options that might be covered under your benefit package, or other services that might be available through the community.
Compounds	Medical Necessity Policy - Multi-Ingredient Compounds	Your request for MULTI-INGREDIENT COMPOUND cannot be approved and is denied because the information provided (including chart notes to support need for therapy) does not meet the following medical necessity coverage requirements: The active ingredients must be prescribed in therapeutic amounts based on

		Food and Drug Administration approved indications; If a compound is similar to a commercially available product but differs in dosage, dosage form, or inert ingredient (such as flavoring, dye, or preservative), clinical documentation is required from the prescriber supporting the need for the compound; If any ingredient in the compound, active or inactive, otherwise requires prior authorization, you must meet criteria established for medical necessity for that ingredient. Member has had a trial or a reason why the member cannot have a 30 day trial with ALL covered medications that can be used to treat the member's condition. The Gainwell Policy for Medical Necessity was reviewed and per Ohio Administrative Code Rule 5160-1-01 (C) and 5160-26-03 (B), a medically necessary service must include: generally accepted standards of medical practice, be clinically appropriate in administration, treatment & outcome and be the lowest cost alternative to effectively treat the condition. Please contact your provider to assist you with other treatment options that might be covered under your benefit package, or other services that might be available through the community.

Excluded Coverage for Compounded Preparations:	Medical Necessity Policy - Multi-Ingredient Compounds	The coverage request cannot be approved and is denied due to the following: 1. The compound does not contain a federal legend drug covered by the plan 2. The compound is being used for obesity, sexual dysfunction, infertility, investigational or experimental use 3. The compound is for a product that is commercially available 4. The compound is for convenience purposes only 5. The compound is for implantable hormone replacement pellets or granules (such as: estrogen-based implantable pellets) 6. The compound contains one or more of the following ingredients: baclofen, gabapentin, and ketamine 7. The compound is for a bioidentical hormone The Gainwell Policy for Medical Necessity was reviewed and per Ohio Administrative Code Rule 5160-1-01 (C), 5160-9-03 (E) and 5160-26-03 (B), a medically necessary service must include: generally accepted standards of medical practice, be clinically appropriate in administration, treatment & outcome and be the lowest cost alternative to effectively treat the condition. Please contact your provider to assist you with other treatment options that might be covered under your benefit package, or other services that might be available through the community.

Updates to the Denial Language	***Date:*** ***1/1/2023 JC and CR*** ***1/10/2023 RC RPH*** ***1/19/2023 RC RPH*** ***02/06/2023 RC RPH*** ***02/22/2023 RC RPH*** ***04/01/2023 RCRPH*** ***04/25/2023 RCRPH*** ***6/13/2023 RCRPH*** ***06/21/2023 RCRPH***	**Information:** Changes made for the OHUPDL 1/1/2023 (30 day change notice) Trelegy, Breztri, Respiratory Agents: Antihistamines-Second Generation and Respiratory Agents: Inhaled Agents and Immunomodulator Agents: Systemic Inflammatory Disease. Removed Denial Language for Off-Label Dose/QTY Updates to: Ubrelvy, Test Strips/Glucometers, Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE for the Non-preferred Updates to Dermatological: Oral Acne Products: Preferred and Non-Preferred Added/Updated denial language for 4/1/2023 changes Added Policy Rule to the end of Denial Language Document Updated DL: • Opioids – long acting • Dermatologic Agents: Oral Acne Products • Aimovig and Ajovy • Buprenorphine Mono-Product • Removed Dexcom 5 • Added Dexcom and Freestyle Libre • Removed Protopic • Added Freestyle Precision Neo Added denial language for Omnipod and Central Nervous System (CNS) Agents: Atypical Antipsychotics Non-Preferred **Updated Compound Denial Language** **Updated DAW Denial Language**

		Updated Lipotropics **Updated Proton Pump Inhibitors** **Updated Denial Language applicable to 7/1/2023 UPDL changes (currently in ORANGE)**