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| Criteria 1 | Hemangeol (P, PA) |
| Criteria 2 | Entresto (P, PA) |
| Criteria 3 | Kerendia (NP) |
| Criteria 4 | Camzyos (NP) |
| Criteria 5 | Verquvo (NP) |
| Criteria 6 | Sotylize Soln (NP, AR) |
| Criteria 7 | Non-Dihydropyridines: Diltiazem 24HR ER Tabs (NP, QL), Verapamil 200, 300mg ER 24HR (NP, QL) |
| Criteria 8 | NP Agents: Aliskiren, Aspruzyo Sprinkle, Candesartan, Candesartan/HCTZ, Carospir, Carvedilol ER, Clonidine ER (generic of Nexicon XR), Corlanor, Edarbi, Edarbyclor, Hydralazine/HCTZ, Innopran XL, Israpidine, Kapspargo, Katerzia, Levamlodipine, Nebivolol (BvG), Nisoldipine, Norliqva, Nymalize, Qbrelis, Tekturna/HCTZ, Telmisartan, Telmisartan/HCTZ |
| Criteria 9 | Nimodipine (NP) |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Hemangeol | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| HEMANGEOL | 072352 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1233 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted documentation of the patient’s weight?    If yes, please submit documentation. | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 4 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 | |
| N | 1235 | |
| 5 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s weight?    If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Entresto | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ENTRESTO | 074408 | GCNSeqNo |
| ENTRESTO | 074409 | GCNSeqNo |
| ENTRESTO | 074410 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1233 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the provider submitted documentation of chronic heart failure classified as either New York Heart Association (NYHA) Class II-IV  or American College of Cardiology (ACC)/American Heart Association (AHA) Stage B-D? | Y | END (Approve x 365 days) | |
| N | 1235 | |
| 4 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 | |
| N | 1235 | |
| 5 | 1234 |  | Select and Free Text | Has the provider submitted documentation of chronic heart failure classified as either New York Heart Association (NYHA) Class II-IV  or American College of Cardiology (ACC)/American Heart Association (AHA) Stage B-D? | Y | END (Approve x 365 days) |
| N | 1235 |
| 6 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Kerendia | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| KERENDIA | 082499 | GCNSeqNo |
| KERENDIA | 082500 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis?    If yes, please submit the medication trials and dates. | Y | 1003 | |
| N | 1002 | |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted 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)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 | |
| N | 1236 | |
| 5 | 1003 |  | Select | Does the provider attest that the patient is on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker? | Y | 1004 | |
| N | 1235 | |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of an inadequate clinical response to a SGLT2 Inhibitor? | Y | 1006 | |
| N | 1005 | |
| 7 | 1005 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the  patient cannot try a SGLT2 inhibitor (i.e., chronic kidney disease diagnosis)? | Y | 1006 | |
| N | 1235 | |
| 8 | 1006 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1007 | |
| N | END (Pending Manual Review) | |
| 9 | 1007 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 10 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Camzyos | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| CAMZYOS | 083317 | GCNSeqNo |
| CAMZYOS | 083318 | GCNSeqNo |
| CAMZYOS | 083319 | GCNSeqNo |
| CAMZYOS | 083320 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis?    If yes, please submit the medication trials and dates. | Y | 1003 | |
| N | 1002 | |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted 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)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 | |
| N | 1236 | |
| 5 | 1003 |  | Select | Is the medication being prescribed by or in consultation with a cardiologist? | Y | 1004 | |
| N | 1235 | |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of New York Heart Association (NYHA) Class II-III symptoms and left ventricular  ejection fraction greater than or equal to 55 percent?  If yes, please submit documentation. | Y | 1005 | |
| N | 1235 | |
| 7 | 1005 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1006 | |
| N | END (Pending Manual Review) | |
| 8 | 1006 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Verquvo | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| VERQUVO | 081858 | GCNSeqNo |
| VERQUVO | 081859 | GCNSeqNo |
| VERQUVO | 081860 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis?    If yes, please submit the medication trials and dates. | Y | 1003 | |
| N | 1002 | |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted 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)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 | |
| N | 1236 | |
| 5 | 1003 |  | Select and Free Text | Has the provider submitted documentation of the patient’s ejection fraction? | Y | 1004 | |
| N | 1235 | |
| 6 | 1004 |  | Select | Has the patient been hospitalized for the treatment of heart failure in the previous 180 days? | Y | 1006 | |
| N | 1005 | |
| 7 | 1005 |  | Select | Has the patient needed treatment with an outpatient intravenous diuretic in the previous 90 days? | Y | 1006 | |
| N | 1235 | |
| 8 | 1006 |  | Select and Free Text | Has the patient been treated with an agent from ALL the following unless contraindicated:  1.Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, OR an angiotensin receptor neprilysin inhibitor  2.Beta-blocker  3.Aldosterone antagonist and/or SGLT2 inhibitor as appropriate for renal function  If yes, please submit documentation. | Y | 1007 | |
| N | 1235 | |
| 9 | 1007 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1008 | |
| N | END (Pending Manual Review) | |
| 10 | 1008 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 11 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 12 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 13 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Sotylize Soln | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| SOTYLIZE SOLN | 073475 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis?    If yes, please submit the medication trials and dates. | Y | 1003 | |
| N | 1002 | |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted 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)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 | |
| N | 1236 | |
| 5 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 | |
| N | 1005 | |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1005 | |
| N | 1235 | |
| 7 | 1005 |  | Select | Is the patient 6 years of age and older? | Y | 1006 | |
| N | END (Pending Manual Review) | |
| 8 | 1006 |  | Select and Free Text | Is the patient unable to swallow a tablet and/or capsule formulation?  If yes, please submit documentation. | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Non-Preferred Non-Dihydropyridines | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| DILTIAZEM 24 HR ER TABS | 051802 | GCNSeqNo |
| DILTIAZEM 24 HR ER TABS | 051803 | GCNSeqNo |
| DILTIAZEM 24 HR ER TABS | 051804 | GCNSeqNo |
| DILTIAZEM 24 HR ER TABS | 051805 | GCNSeqNo |
| DILTIAZEM 24 HR ER TABS | 051806 | GCNSeqNo |
| DILTIAZEM 24 HR ER TABS | 051801 | GCNSeqNo |
| VERAPAMIL 200, 300 mg ER 24 HR | 041652 | GCNSeqNo |
| VERAPAMIL 200, 300 mg ER 24 HR | 041653 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis?    If yes, please submit the medication trials and dates. | Y | 1003 | |
| N | 1002 | |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted 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)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 | |
| N | 1236 | |
| 5 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 | |
| N | END (Pending Manual Review) | |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ALISKIREN | 062288 | GCNSeqNo |
| ALISKIREN | 062289 | GCNSeqNo |
| ASPRUZYO SPRINKLE | 083128 | GCNSeqNo |
| ASPRUZYO SPRINKLE | 083129 | GCNSeqNo |
| CANDESARTAN | 037015 | GCNSeqNo |
| CANDESARTAN | 037016 | GCNSeqNo |
| CANDESARTAN | 037017 | GCNSeqNo |
| CANDESARTAN | 040659 | GCNSeqNo |
| CANDESARTAN/HCTZ | 045425 | GCNSeqNo |
| CANDESARTAN/HCTZ | 046624 | GCNSeqNo |
| CANDESARTAN/HCTZ | 064285 | GCNSeqNo |
| CAROSPIR | 046605 | GCNSeqNo |
| CARVEDILOL ER | 061811 | GCNSeqNo |
| CARVEDILOL ER | 061812 | GCNSeqNo |
| CARVEDILOL ER | 061813 | GCNSeqNo |
| CARVEDILOL ER | 061814 | GCNSeqNo |
| CLONIDINE HCL ER | 066917 | GCNSeqNo |
| CORLANOR | 060186 | GCNSeqNo |
| CORLANOR | 060187 | GCNSeqNo |
| CORLANOR | 079666 | GCNSeqNo |
| EDARBI | 067113 | GCNSeqNo |
| EDARBI | 067115 | GCNSeqNo |
| EDARBYCLOR | 068389 | GCNSeqNo |
| EDARBYCLOR | 068390 | GCNSeqNo |
| INNOPRAN XL | 033370 | GCNSeqNo |
| INNOPRAN XL | 051907 | GCNSeqNo |
| ISRADIPINE | 015888 | GCNSeqNo |
| ISRADIPINE | 015889 | GCNSeqNo |
| KAPSPARGO | 078119 | GCNSeqNo |
| KAPSPARGO | 078120 | GCNSeqNo |
| KAPSPARGO | 078121 | GCNSeqNo |
| KAPSPARGO | 078122 | GCNSeqNo |
| KATERZIA | 079995 | GCNSeqNo |
| LEVAMLODIPINE | 080610 | GCNSeqNo |
| LEVAMLODIPINE | 080611 | GCNSeqNo |
| NEBIVOLOL | 036654 | GCNSeqNo |
| NEBIVOLOL | 063510 | GCNSeqNo |
| NEBIVOLOL | 063511 | GCNSeqNo |
| NEBIVOLOL | 064945 | GCNSeqNo |
| NISOLDIPINE | 024499 | GCNSeqNo |
| NISOLDIPINE | 024500 | GCNSeqNo |
| NISOLDIPINE | 024501 | GCNSeqNo |
| NISOLDIPINE | 063730 | GCNSeqNo |
| NISOLDIPINE | 063731 | GCNSeqNo |
| NISOLDIPINE | 063732 | GCNSeqNo |
| NISOLDIPINE | 063733 | GCNSeqNo |
| NORLIQVA | 080176 | GCNSeqNo |
| NYMALIZE | 080991 | GCNSeqNo |
| NYMALIZE | 080992 | GCNSeqNo |
| NYMALIZE | 082451 | GCNSeqNo |
| QBRELIS | 076442 | GCNSeqNo |
| TEKTURNA/HCTZ | 063589 | GCNSeqNo |
| TEKTURNA/HCTZ | 063590 | GCNSeqNo |
| TEKTURNA/HCTZ | 063591 | GCNSeqNo |
| TEKTURNA/HCTZ | 063592 | GCNSeqNo |
| TELMISARTAN | 040910 | GCNSeqNo |
| TELMISARTAN | 040911 | GCNSeqNo |
| TELMISARTAN | 047126 | GCNSeqNo |
| TELMISARTAN/HCTZ | 047324 | GCNSeqNo |
| TELMISARTAN/HCTZ | 047326 | GCNSeqNo |
| TELMISARTAN/HCTZ | 057690 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis?    If yes, please submit the medication trials and dates. | Y | 1003 | |
| N | 1002 | |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted 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)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 | |
| N | 1236 | |
| 5 | 1003 |  | Select | Is the request for generic nebivolol? | Y | 1004 | |
| N | 1005 | |
| 6 | 1004 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | 1005 | |
| N | 1235 | |
| 7 | 1005 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1006 | |
| N | END (Pending Manual Review) | |
| 8 | 1006 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/16/2023 |
| **Other** |  |

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| **Criteria Title** | Cardiovascular Agents: Angina, Hypertension & Heart Failure | | |
| **Criteria Subtitle** | Nimodipine | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| NIMODIPINE | 000579 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** | |
| 1 | 0009 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1000 | |
| Continuation (re-authorization request) | 1234 | |
| 2 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 | |
| N | 1235 | |
| 3 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis?    If yes, please submit the medication trials and dates. | Y | 1003 | |
| N | 1002 | |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted 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)?    If yes, please submit the medication name and reason for inability to use. | Y | 1003 | |
| N | 1236 | |
| 5 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 | |
| N | END (Pending Manual Review) | |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) | |
| N | 1235 | |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 21 Days

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| --- | --- |
| **Last Approved** | 5/16/2023 |
| **Other** |  |