**Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)**

**June 1, 2025**

**Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.**

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|  | **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Agents for Dependency** | | |  |
| Lucemyra® | P | **Initial Criteria:**   * Must be ≥ 18 years of age; **AND** * Patient is not pregnant or breast feeding; **AND** * Attestation that if patient is at risk for QT interval prolongation (congestive heart failure, bradyarrhythmia, hepatic impairment, renal impairment, or taking other medicinal products that lead to QT prolongation), baseline electrocardiogram (ECG) has been performed; **AND** * Patient has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to clonidine; **AND** • Prescriber to provide verbal attestation of a comprehensive treatment plan between provider and patient; **AND** * In the case of opioid use disorder (OUD), provide verbal attestation that patient:   + Has a referral to **OR** active involvement in substance abuse counseling; **OR**   + Is unable to have counseling **AND** provides verbal attestation that patient has been offered medication-assisted treatment (MAT) as part of a comprehensive treatment plan; **AND** * Provide verbal attestation that patient is NOT prescribed concurrent opioid medication without explanation (verified by state opioid database, if available); **AND** * Provide verbal attestation that the patient is capable of and instructed how to self-monitor for hypotension, orthostasis, bradycardia, and associated symptoms; **AND** * Provide verbal attestation that the patient has been provided with a tapering schedule and instructions on when to contact their healthcare provider for further guidance.   **Renewal Criteria:**   * Patient continues to meet initial criteria; **AND** * If the renewal is a continuation of the initial approval because additional therapy is needed, approve up to 7 additional days (for a total of 14 days of treatment, including days of treatment received as inpatient, if any) | 16/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vivitrol®injection | P |  | 1 vial per 28 days |
| lofexidine | NP | See Lucemyra® prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to preferred Lucemyra® | 16/day |



Please use Google Chrome, Microsoft Edge, or Firefox as your browser to access the files on the TennCare site.

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|  | **Buprenorphine and Buprenorphine/Naloxone** | | |  |
|  | **Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) Network Provider only:** | | |  |
| buprenorphine/ naloxone tablets | P |  | 8/2 mg: 3/day;  2/0.5 mg: 3/day ^ | [Buprenorphine](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/Buprenorphine-Products-PA-Form.pdf)  [Products PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/Buprenorphine-Products-PA-Form.pdf) |
| buprenorphine/ naloxone film | P |  | 12/3 mg: 2/day;  8/2 mg: 3/day;  4/1 mg: 2/day;  2/0.5 mg: 3/day ^ |
| buprenorphine | NP | **Criteria:**   * Diagnosis of opiate addiction; **AND** * Prescriber is enrolled and in good standing in the BESMART program; **AND** • Buprenorphine will not be approved for treatment of depression or pain; **AND** * ONE of the following:   + Patients is actively pregnant (must provide estimated due date) o Patient is actively breastfeeding (must provide delivery date)   + Request is for a two-day induction for patients transitioning off of Methadone   + Patient is unable to take naloxone containing products due to a contraindication, drug to drug interaction, or history of toxic side effects that caused immediate or long-term damage (DOCUMENTATION REQUIRED). **Note**: Mild rash, itching, and GI intolerance are not accepted as intolerance to naloxone.   **PA Approval durations**:  ­ Pregnancy: 3 months past due date;  ­ Breastfeeding: 6 months (maximum 4 approvals);  ­ Contraindication to Naloxone: Initial Authorization 6-months, Reauthorization 12 months  **Note**: The PA for buprenorphine monotherapy sublingual tablets in pregnant or breastfeeding patients diagnosed with opioid use disorder can be bypassed using Professional Pharmacy Service (PPS) Codes. | 8 mg: 3/day;  2 mg: 3/day ^ |
| Suboxone® film | NP | **Criteria:** (6-month duration for initial request; 12-month duration for reauthorization)   * Diagnosis of opiate addiction; **AND** * Prescriber is enrolled and in good standing in the BESMART program; **AND** * Buprenorphine will not be approved for treatment of depression or pain; **AND** * Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product   (DOCUMENTATION REQUIRED) | 12/3 mg: 2/day;  8/2 mg: 3/day;  4/1 mg: 2/day;  2/0.5 mg: 3/day^ |
| Zubsolv® | NP | See Suboxone film prior authorization criteria | 11.4/2.9 mg: 1/day  8.6/2.1 mg: 2/day;  5.7/1.4 mg: 3/day;  2.9/0.71 mg: 2/day;  1.4/0.36 mg: 3/day;  0.7/0.18 mg: 3/day |

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| ***\**** *For children, larger quantities may be approved as medically necessary.*  ***^*** *Requests for 4/day will only be approved if dose is being titrated or patient’s condition is too unstable to attempt to change to a higher strength.*  ***Note****: Nurse Practitioner (NP) , Physician Assistant (PA) and other mid-level prescribers in the BESMART network are limited to MDD 16mg/day per TN state law.* | | | |  |
| **All other TennCare Providers:** | | | |  |
| buprenorphine/ naloxone tablets | P | **Criteria:** (6-month duration for initial request; 12-month duration for reauthorization)   * Diagnosis of opiate addiction; **AND** * Prescriber is NOT a nurse practitioner or physician assistant; **AND** * Physician attests they have reviewed the Tennessee Controlled Substances Database for this patient on the date of the prior authorization request to ensure that concomitant narcotic or benzodiazepine use is not occurring. Additional Information: * Buprenorphine will not be approved for treatment of depression or pain. * Buprenorphine will not be approved for recipients whose medication history indicates use of concomitant narcotics or benzodiazepines without a clinically valid reason and drug tapering plan. * Quantity limit is as a single daily dose. Twice daily dosing may be approved as clinically necessary. * Physicians will be asked to provide an anticipated treatment plan for the patient (including anticipated dosing for induction & maintenance phases, anticipated frequency of office visits, & anticipated plan for psychosocial counseling). * The “Here to Help” program as an exclusive provider of counseling will not be accepted. * Prior Authorizations will be assigned to the prescribing physician. * Requests for buprenorphine from a different physician will require a new prior authorization request and documentation that the previous prescribing physician has communicated transfer of care. | 8/2 mg: 2/day for  6 months then 1/day\*;  2/0.5 mg: 3/day\* ^ | [Buprenorphine](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/Buprenorphine-Products-PA-Form.pdf)  [Products PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/Buprenorphine-Products-PA-Form.pdf) |
| buprenorphine | NP | **Criteria:**  See buprenorphine/naloxone tabprior authorization criteria; **AND**  • ONE of the following:   * Patients is actively pregnant (must provide estimated due date) o Patient is actively breastfeeding (must provide delivery date) * Request is for a two-day induction for patients transitioning off of Methadone * Patient is unable to take naloxone containing products due to a contraindication, drug to drug interaction, or history of toxic side effects that caused immediate or long-term damage (DOCUMENTATION REQUIRED). **Note**: Mild rash, itching, and GI intolerance are not accepted as intolerance to naloxone.   **PA Approval Durations**:  ­ Pregnancy: 3 months past due date;  ­ Breastfeeding: 6 months (maximum 4 approvals);  ­ Contraindication to Naloxone: Initial Authorization 6-months, Reauthorization 12 months | 8 mg: 2/day for  6 months then 1/day\*; 2 mg: 3/day\* ^ |
| buprenorphine/ naloxone film | NP | See buprenorphine/naloxone tab prior authorization criteria; **AND**  • Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product  (DOCUMENTATION REQUIRED) | 12/3mg & 8/2 mg:  2/day for 6 months then 1/day\*;  4/1 mg: 2/day  2/0.5 mg: 3/day\* ^ |
| Suboxone® film | NP | See buprenorphine/naloxone tab prior authorization criteria; **AND**  • Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product  (DOCUMENTATION REQUIRED) |

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| Zubsolv® | NP | See buprenorphine/naloxone tab prior authorization criteria  • Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product  (DOCUMENTATION REQUIRED) | 11.4/2.9 & 8.6/2.1 mg:  1.day;  5.7/1.4mg :2/day for 6 months then 1/day\*;  2.9/0.71 mg: 2/day;  1.4/0.36 mg: 3/day;  0.7/0.18 mg:3/day\* |  | |
| ***\**** *For children, larger quantities may be approved as medically necessary.*  ***^*** *Requests for 4/day will only be approved if dose is being titrated or patient’s condition is too unstable to attempt to change to a higher strength* | | | |  | |
| **Transmucosal Fentanyl Products** | | | |  | |
| fentanyl lozenge | NP | * Medication is ordered for the treatment of breakthrough cancer pain * Recipient must be receiving around-the-clock scheduled long-acting opioids * Recipient must be tolerant to opioids, defined as one of the following:   o ≥ 60 mg oral morphine per day for at least one week without adequate pain relief o ≥ 25 mcg/hr transdermal fentanyl for at least one week without adequate pain relief o ≥ 30 mg oral oxycodone/day for at least one week without adequate pain relief o ≥ 8 mg oral hydromorphone/day for at least one week without adequate pain relief o ≥ 25 mg oral oxymorphone/day for at least one week without adequate pain relief o Equianalgesic dose of another opioid for at least one week without adequate pain relief   * Trial and failure, contraindication, intolerance, or drug-to-drug interaction with at least 2 immediate release opioid products   **Note**: Prescription should be written by or in consultation with an oncologist or pain management specialist unless patient is enrolled in or eligible for hospice care. | 4/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | |
| Fentora® | NP | See fentanyl lozenge prior authorization criteria | 4/day |
| Subsys® | NP | See fentanyl lozenge prior authorization criteria | 4/day |
| **Naloxone Products** | | | |  | |
| Kloxxado® | P |  | 2 sprayers/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | |
| naloxone injection | P |  | 2 injections/30 days |
| naloxone nasal spray (Rx [& OTC)](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | P |  | 2 sprayers/30 days |
| Narcan® | P |  | 2 sprayers/30 days |
| Opvee® | P |  | 2 sprayers/30 days |
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|  | | **Narcotic Agonist/Antagonists** | | |  |
| nalbuphine | P | * Trial and failure of at least 2 short acting narcotics; **OR** * Documented contraindication, or intolerance to short acting narcotics; **AND** • Unable to swallow, OR Unable to absorb medications through the GI tract. | 10 mg/mL: 4 mL/day  20 mg/mL: 8 mL/day | | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| butorphanol nasal spray | NP | * Documented inability to swallow or absorb PO narcotics, **OR** * For the treatment of migraines; **AND** o Recipient MUST be receiving prophylactic therapy for migraines, **AND** o Trial and failure, intolerance, or contraindication to at least **ONE** agent in EACH of the following categories: * 5-HT1 receptor antagonist (triptans) * Anti-migraine combinations * NSAIDs | 2.5 mL/30 days | |
| pentazocine/ naloxone | NP | * Contraindication, or intolerance to ALL short acting narcotics * Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 30 days | 12/day | |

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| **Narcotics, Long-Acting**  **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/preferred-drug-list/Opioid%20Criteria%20-%20Acute,%20Chronic,%20and%20Exceptions.pdf)**\*\*** | | | | |
| fentanyl patch 12, 25, 50, 75, &  100 mcg | P | See morphine ER tablets prior authorization criteria | 10 patches/30 days; \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |  |

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| morphine ER tablets | P | * Management of severe pain with need for around-the-clock analgesia for an extended period; **AND** * Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND** * Requests for strengths ≥ 90mg: (Please refer to the TennCar[e MME Conversion Chart)](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/MME%20Conversion%20Chart.pdf)o Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine > 60 mg/day, oral oxycodone > 30 mg/day, oral hydromorphone > 8 mg/day, or an equianalgesic dose of another opioid); **AND** * If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND** o Using contraception; **OR**    + Has an intrauterine device (IUD) or implant; **OR**   + Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** * The provider attests to investigating ALL of the following before submitting a PA:   + History of substance abuse o Frequent requests for early refills o Reported frequent instances of lost tablets o Requests for odd quantities which requires fractional dosing o Requests for short-term or prn usage   + Medication history indicates concurrent use of other extended-release opioids   **Note**: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome.  Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 1/day;    \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| tramadol ER | P | See morphine ER prior authorization criteria | 1/day; \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| Belbuca® | NP | * Management of severe pain with need for around-the-clock analgesia for an extended period; **AND** * Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND** * Patients who have not been titrated down to no more than 30 mg morphine (or morphine equivalents) per day will NOT be approved; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND** * If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND** o Using contraception; **OR**    + Has an intrauterine device (IUD) or implant; **OR**   + Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** * The prescriber attests to investigating all of following before submitting a PA:   + History of substance abuse o Frequent requests for early refills o Reported frequent instances of lost tablets o Requests for odd quantities which requires fractional dosing o Requests for short-term or prn usage o Medication history indicates concurrent use of other extended-release opioids; **AND** * Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage   (this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated  **Note**: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 2/day;    \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| buprenorphine patch | NP | See Belbuca® prior authorization criteria  Additionally, Butrans® 7.5, 10, 15, and 20 mcg/hr will be approved for opioid-experienced patients only. | 4 patches/28 days; \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Butrans® | NP | See Belbuca® prior authorization criteria  Additionally, Butrans® 7.5, 10, 15, and 20 mcg/hr will be approved for opioid-experienced patients only. | 4 patches/28 days;  \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| **Narcotics, Long-Acting**  **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/preferred-drug-list/Opioid%20Criteria%20-%20Acute,%20Chronic,%20and%20Exceptions.pdf)**\*\*** | | | | |
| ConZip® | NP | * Management of severe pain with need for around-the-clock analgesia for an extended period; **AND** * Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND** * If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND** o Using contraception; **OR**    + Has an intrauterine device (IUD) or implant; **OR**   + Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** * The prescriber attests to investigating ALL of the following before submitting a PA:   + History of substance abuse o Frequent requests for early refills o Reported frequent instances of lost tablets   + Requests for odd quantities which requires fractional dosing o Requests for short-term or prn usage o Medication history indicates concurrent use of other extended-release opioids; **AND** * If patient is 12 to 18 years of age: (For patients less than 12 years of age, approval will not be granted) o Patient does not have any of the following:   ­ Obesity (BMI ≥ 30)  ­ Obstructive Sleep Apnea  ­ Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, pulmonary hypertension, etc.)  ­ Recent adenectomy/tonsillectomy; **AND** o Trial and failure or contraindication to acetaminophen; **AND** o Trial and failure or contraindication to ALL NSAIDs; **AND**   * Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage   (this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated  **Note**: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 1/day;    \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
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**Clinical Criteria, Step Therapy, and**

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| **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Long-Acting**  **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/preferred-drug-list/Opioid%20Criteria%20-%20Acute,%20Chronic,%20and%20Exceptions.pdf)**\*\*** | | | | |
| fentanyl patch  37.5, 62.5, &  87.5 mcg | NP | See hydromorphone ER prior authorization criteria | 10 patches/30 days; \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |  |
| hydrocodone  ER | NP | * The prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider * If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND** o Using contraception; **OR**    + Has an intrauterine device (IUD) or implant; **OR**   + Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** * Approval of non-preferred agents requires: Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated. * The following should be investigated before a PA is granted:   + History of substance abuse o Frequent requests for early refills o Reported frequent instances of lost tablets o Requests for odd quantities which requires fractional dosing o Requests for short-term or prn usage   + Medication history indicates concurrent use of other extended-release opioids * Requests for strengths ≥ 90mg: (Please refer to the TennCar[e MME Conversion Chart)](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/MME%20Conversion%20Chart.pdf)o Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine > 60 mg/day, oral oxycodone > 30 mg/day, oral hydromorphone > 8 mg/day, or an equianalgesic dose of another opioid) | Tabs: 1/day;  Caps: 2/day;    \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Long-Acting**  **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/preferred-drug-list/Opioid%20Criteria%20-%20Acute,%20Chronic,%20and%20Exceptions.pdf)**\*\*** | | | | |
| hydromorphone ER | NP | * Management of severe pain with need for around-the-clock analgesia for an extended period; **AND** * Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND** * Requests for strengths ≥ 90mg: (Please refer to the TennCar[e MME Conversion Chart)](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/MME%20Conversion%20Chart.pdf)o Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine > 60 mg/day, oral oxycodone > 30 mg/day, oral hydromorphone > 8 mg/day, or an equianalgesic dose of another opioid); **AND** * If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND** o Using contraception; **OR**    + Has an intrauterine device (IUD) or implant; **OR**   + Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** * The provider attests to investigating ALL of the following before submitting a PA:   + History of substance abuse o Frequent requests for early refills o Reported frequent instances of lost tablets o Requests for odd quantities which requires fractional dosing o Requests for short-term or prn usage o Medication history indicates concurrent use of other extended-release opioids; **AND** * Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage   (this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated  **Note**: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | Tablet: 1/day;    \*^Max Total:  Non-Chronic: 60  [MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf)  Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| Hysingla® ER | NP | See hydromorphone ER prior authorization criteria | 1/day;  \*^Max Total:  Non-Chronic: 60[MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| **Narcotics, Long-Acting**  **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/preferred-drug-list/Opioid%20Criteria%20-%20Acute,%20Chronic,%20and%20Exceptions.pdf)**\*\*** | | | | |
| methadone | NP | * One of the following:   + Diagnosis of Metastatic Neoplasia   + Infants up to 1 year of age who are discharged from hospital on a methadone taper will be approved for up to 30 days o Management of severe pain with need for around-the-clock analgesia for an extended period AND patient has contraindication to all other long-acting opioids; **AND** * Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * Concomitant use of benzodiazepines & opioids will only be approved under the care of, or referral to, a mental health provider; **AND** * Requests for strengths ≥ 90mg: (Please refer to the TennCar[e MME Conversion Chart)](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/MME%20Conversion%20Chart.pdf)o Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine > 60 mg/day, oral oxycodone > 30 mg/day, oral hydromorphone > 8 mg/day, or an equianalgesic dose of another opioid); **AND** * If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND** o Using contraception; **OR**    + Has an intrauterine device (IUD) or implant; **OR**   + Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** * The following should be investigated before a PA is granted:   + History of substance abuse o Frequent requests for early refills o Reported frequent instances of lost tablets o Requests for odd quantities which requires fractional dosing o Requests for short-term or prn usage o Medication history indicates concurrent use of other extended-release opioids; **AND**   **Note**: TennCare does not cover any form of methadone for the treatment of opioid addiction.  **Note**: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 5 mg: 8/day;  10 mg: 4/day;  5 mg/5 mL: 40mL/day; 10 mg/5 mL: 20 mL/day;  10 mg/mL: 4 mL/day;    \*^Max Total:  Non-Chronic:  6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf)  Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| Methadose® | NP | See methadone prior authorization criteria | See methadone |
| morphine ER capsules | NP | See hydromorphone ER prior authorization criteria | Beads Caps: 1/day; Caps: 2/day  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Long-Acting**  **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/preferred-drug-list/Opioid%20Criteria%20-%20Acute,%20Chronic,%20and%20Exceptions.pdf)**\*\*** | | | | |
| MS Contin® | NP | See hydromorphone ER prior authorization criteria | 15, 30, 60 mg: 3/day;  100 mg: 2/day;  200 mg: 1/day; \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)    [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf) [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)      [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| oxycodone ER | NP | See hydromorphone ER prior authorization criteria | 2/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Oxycontin® | NP | See hydromorphone ER prior authorization criteria |
| Oxymorphone  ER | NP | See hydromorphone ER prior authorization criteria  **Note**: Due to cross-reactivity with morphine, oxymorphone SR will not be approved for patients with immune-mediated morphine allergy. |
| **\*^Morphine Milligram Equivalent (**[MME**)**](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) **Criteria:**   * Indication or diagnosis is Cancer pain or Hospice   − ***Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); AND***  − Document prescriber’s specialty; **AND**  − Patient has a written treatment plan with established objectives; **AND**  − ***Patient has a signed Pain Management Agreement; AND***  − If request is for a female of child-bearing age (14-44 years), patient is not pregnant**; AND**   * Using contraception (e.g., barrier, oral contraceptive, rhythm method); **OR** * Has an intrauterine device (IUD) or implant; **OR** * Has history of hysterectomy, tubal ligation, or endometrial ablation | | | | |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| codeine/APAP | P | * Patient is > 12 years of age and < 18 years of age; **AND** * Trial and failure of acetaminophen; **AND** * Contraindication to ALL NSAIDs; **AND** * Patient does not have any of the following:   + Obesity   + Obstructive Sleep Apnea   + Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, etc.) o Recent adenectomy/tonsillectomy | 12/day:  \*^Max Total:  Non-Chronic: 60 [MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| Endocet® | P |  | 2.5/325 mg tab: 12/day; All other tabs: 8/day; \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| hydrocodone/ APAP 325 mg | P |  | 5/325 mg tab: 12/day;  7.5/325 & 10/325 mg tabs:  8/day; soln: 120 mL/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| hydrocodone/ ibuprofen | P |  | 5/200 mg tab: 12/day;  7.5/200 mg tab: 8/day;  10/200 mg tab: 6/day;  \*^Max Total:  Non-Chronic:6[0 MME/day;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| hydromorphone tabs | P |  | 2 mg: 7/day;  4 mg: 3/day;  8 mg: 1/day;  \*^Max Total:  Non-Chronic:6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| morphine IR tabs | P |  | 6/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| morphine solution | P | * Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); OR request is for a hospice patient, HIV/AIDS patient, active cancer patient, OR long-term care facility resident (document name of facility); **AND** * Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * If patient is females and of child-bearing age (14-44 years), patient is not pregnant; **AND** o One of the following:   ­ Using contraception  ­ Has an intrauterine device (IUD) or implant  ­ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**   * Recipient must be opioid tolerant (as demonstrated by >1 week history of morphine > 60 mg/day, oral oxycodone > 30 mg/day, oral hydromorphone > 8 mg/day, or an equianalgesic dose of another opioid) | \*^Max Total:  Non-Chronic: 60 [MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| oxycodone/ APAP 325mg | P |  | 2.5/325 mg tab: 12/day;  All other tabs: 8/day; soln: 40 mL/day  \*^Max Total:  Non-Chronic: 60 [MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| oxycodone concentrate | P | See morphine solution prior authorization criteria | \*^Max Total:  Non-Chronic: 60 [MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/MME%20Conversion%20Chart.pdf) |
| oxycodone tabs | P |  | 5 & 10 mg: 8/day; 15, 20, & 30 mg: 4/day; \*^Max Total:  Non-Chronic: 60 [MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| oxycodone soln | P |  | \*^Max Total:  Non-Chronic: 60 [MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| tramadol | P | * Patient is > 12 years of age and < 18 years of age; **AND** * Patient does not have any of the following:   + Obesity (BMI ≥ 30) o Obstructive Sleep Apnea   + Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, etc.) o Recent adenectomy/tonsillectomy; **AND** * Trial and failure or contraindication to acetaminophen; **AND** * Trial and failure or contraindication to ALL NSAIDs   **Note:** Patients 18 years and older will only be subject to the quantity limit and opioid criteria | 8 tabs/day;  80 mL/day  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| tramadol/APAP | P | See tramadol prior authorization criteria | 12/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Apadaz® | NP |  | 6.12/325 mg tab: 8/day; 8.16/325 mg tab: 6/day;  4.08/325 mg tab: 12/day  Max: 4 g APAP/day |
| benzhydrocodone/ APAP | NP |  | See Apadaz® |
| butalbital/APAP/ caffeine/codeine | NP | * Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long- term damage (NOTE: this does not include GI intolerance) with ALL preferred short-acting narcotic agents; **AND** * One of the following:   + Patients ≥ 18 years of age   + Patient is > 12 years of age and < 18 years of age; **AND**   ­ Trial and failure of acetaminophen; **AND**  ­ Contraindication to ALL NSAIDs; **AND** ­ Patient does not have any of the following:   * Obesity * Obstructive Sleep Apnea * Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, etc.) * Recent adenectomy/tonsillectomy | Butalbital-containing products: 20/30 days\*\*  Max: 4 g APAP/day |
| butalbital/ASA/ caffeine/codeine | NP | See butalbital/APAP/caffeine/codeine prior authorization criteria | Butalbital-containing products: 20/30 days\*\* |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| codeine | NP | See butalbital/APAP/caffeine/codeine prior authorization criteria | 15 mg & 30 mg: 12/day; 60 mg: 6/day; \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| dihydrocodeine/ APAP/caffeine | NP | See butalbital/APAP/caffeine/codeine prior authorization criteria | 8 tabs/day;  Max: 4 g APAP/day |
| Dilaudid® | NP | * Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents; **AND** * Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND** * Pain agreement required. Please refer to th[e Opioid and Controlled Substance Agreement;](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Patient%20Medication%20Management%20Agreement.pdf) **AND** * Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider. * If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND** o Using contraception; **OR**    + Has an intrauterine device (IUD) or implant; **OR**   + Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** * Has history of hysterectomy, tubal ligation, or endometrial ablation   **Note**: Use of opioids during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 2 mg: 7/day;  4 mg: 3/day;  8 mg: 1/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Fioricet® with codeine | NP | See butalbital/APAP/caffeine/codeine prior authorization criteria | Butalbital-containing products: 20/30 days\*\*  Max: 4 g APAP/day |
| hydrocodone/ APAP 300 mg | NP | See Dilaudid® prior authorization criteria | 5/300 mg tab: 12/day;  10/300 mg tab: 6/day; Soln: 89 mL/day; \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| hydromorphone  liquid | NP | See Dilaudid® prior authorization criteria | 15 mL/day; \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| hydromorphone suppositories | NP | See Dilaudid® prior authorization criteria | 5/day; \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| levorphanol | NP | See Dilaudid® prior authorization criteria | 6/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| Lortab® | NP | See Dilaudid® prior authorization criteria | 5/325 mg tabs: 8/day;  All other tabs: 8/day; soln: 89 mL/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| meperidine | NP | See Dilaudid® prior authorization criteria | tabs: 12/day;  soln: 60 mL/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| morphine suppositories | NP | See Dilaudid® prior authorization criteria | 5 mg: 12/day;  All others: 6/day; \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Nalocet® | NP | See Dilaudid® prior authorization criteria | 12/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Oxaydo® | NP | See Dilaudid® prior authorization criteria | 8/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| oxycodone/ APAP 300 mg | NP | See Dilaudid® prior authorization criteria | 2.5/325 mg tab: 12/day;  All other tabs: 8/day; soln: 40 mL/day  \*^Max Total:  Non-Chronic: 60 [MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| oxycodone caps | NP | See Dilaudid® prior authorization criteria | 8/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| oxymorphone | NP | See Dilaudid® prior authorization criteria | 4/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Percocet® | NP | See Dilaudid® prior authorization criteria | 2.5/325 mg: 12/day;  All others: 8/day; \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Prolate® | NP | See Dilaudid® prior authorization criteria | tabs: 8/day;  soln: 40 mL/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 200 |
| Qdolo® | NP |  | \*^Max Total:  Non-Chronic: 60 MME/day Chronic: 200 |
| Roxicodone® | NP | See Dilaudid® prior authorization criteria | 4/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| Roxybond® | NP | See Dilaudid® prior authorization criteria | 4/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |

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| **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| Seglentis® | NP | * Patient is > 12 years of age and < 18 years of age; **AND** o Patient does not have any of the following:   ­ Obesity (BMI ≥ 30)  ­ Obstructive Sleep Apnea  ­ Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, pulmonary hypertension, etc.)  ­ Recent adenectomy/tonsillectomy; **AND** o Trial and failure or contraindication to acetaminophen; **AND** o Trial and failure or contraindication to ALL NSAIDs**; AND**   * + Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents; **AND** * Patient is > 18 years of age:   + If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**   ­ Using contraception; **OR**  ­ Has an intrauterine device (IUD) or implant; **OR**  ­ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND** o Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents; **AND**  **Note**: Use of opioids during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 12/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) | [Acute Opioid](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)  [PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Acute-Opioid-PA-Form.pdf)        [Chronic](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Chronic-Opioid-PA-Form.pdf)        [Exceptions](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Opioid PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Opioid%20Exceptions%20PA%20Form.pdf) |
| Ultracet® | NP | See Seglentis® prior authorization criteria | 12/day;  \*^Max Total:  Non-Chronic: 6[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) Chronic: 20[0 MME/day](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) |
| **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Narcotics, Short-Acting**  **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.**  **\*\*\* Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit**[**:** Acute Use Opioid Criteria **\***](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/TennCare%20acute%20opioid%20criteria%2015%20day%20supply.pdf***)**\*\*** | | | | |
| **\*\**Quantity Limit Override Criteria for Butalbital-Containing Products:***  Requests for butalbital-containing products for quantities greater than 20 per 30 days will be approved for patients meeting the following criteria:   * Trial and failure of at least 2 prophylactic headache treatments: a tricyclic antidepressant (unless contraindicated) PLUS at least one of the following: divalproex sodium, sodium valproate, topiramate, frovatriptan or beta-blocker   **\*^Morphine Milligram Equivalent (**[MME**)**](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/MME-Conversion-Chart-New.pdf) **Criteria:**   * Indication or diagnosis is Cancer pain or Hospice   − ***Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); AND***  − Document prescriber’s specialty; **AND**  − Patient has a written treatment plan with established objectives; **AND** − ***Patient has a signed Pain Management Agreement; AND*** − Female of child-bearing age (14-44 years):   * Is not pregnant; **AND** * Using contraception; **OR** * Has an intrauterine device (IUD) or implant; **OR** * Has history of hysterectomy, tubal ligation or endometrial ablation | | | | |

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|  | **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indica*** | | ***ted.*** |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **NSAIDs** | |  |  |
| celecoxib | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| diclofenac 1% gel | P |  | 10 g/day |
| ketorolac tabs | P |  | 20/60 days |
| Pennsaid | P | • Diagnosis of osteoarthritis pain of the knee |  |
| Voltaren® gel | P |  | 10 g/day |
| Celebrex® | NP |  | 2/day |
| diclofenac caps, |  |  |  |
| packet, and solution | NP | • Clinically valid reason why the preferred NSAIDs cannot be used |  |  |
| diclofenac patch | NP | • Clinically valid reason why the preferred NSAIDs cannot be used | 2 patches/day |
| diclofenac potassium 25 mg tabs |  | • Clinically valid reason why the preferred diclofenac products cannot be used |  |
|  |  | **ANALGESICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Elyxb® | NP | * Diagnosis of migraine; **AND** * Patient is unable to swallow solid dosage forms | 120 mg/day |  |
| Lofena® | NP | • Clinically valid reason why the preferred diclofenac products cannot be used |  |
| ketorolac spray | NP | Trial and failure, contraindication, or intolerance of oral ketorolac; **OR** Patient is unable to swallow solid dosage forms | 5 bottles/60 days |
| Flector® | NP | Clinically valid reason why the preferred NSAIDs cannot be used | 2 patches/day |
| meloxicam caps | NP | • Clinically valid reason why the preferred meloxicam tablets cannot be used | 1/day |
| Sprix® | NP | * Trial and failure, contraindication, or intolerance of oral ketorolac; **OR** * Patient is unable to swallow solid dosage forms | 5 bottles/60 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Toradol® | NP |  | 20/60 days |
| Zorvolex® | NP | • Clinically valid reason why the preferred NSAIDs cannot be used |  |
|  |  | **NSAID/Anti-Ulcer Agents** | |  |
| diclofenac/ misoprostol | P | * Patient is > 60 years old; **OR** * Patients < 60 years old and is at high risk for GI side effects as indicated by ANY of the following:   o History of peptic ulcer disease/GI bleed/NSAID gastropathyo GERD (gastroesophageal reflux disease) due to conventional NSAIDSo Patient on anticoagulantso Patient on chronic corticosteroidso History of platelet dysfunction or coagulopathy, including use of clopidogrel or aspirino Patient on methotrexate | 50 mg/200 mcg: 4/day; 75 mg/200 mcg: 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ibuprofen/ famotidine | P | • Patient is at high risk for GI side effects as indicated by ANY of the following:History of peptic ulcer disease/GI bleed/NSAID gastropathy  GERD (gastroesophageal reflux disease) due to conventional NSAIDS  Patient on anticoagulants  Patient on chronic corticosteroids  History of platelet dysfunction or coagulopathy, including use of clopidogrel or aspirinPatient on methotrexate | 3/day |
| Vimovo® | P | • See Duexis® prior authorization criteria | 2/day |
| Arthrotec® | NP |  | 50 mg/200 mcg: 4/day; 75 mg/200 mcg: 2/day |
| Duexis® | NP |  | 3/day |
| naproxen/ esomeprazole | NP |  | 2/day |
|  |  | **Salicylates** | |  |
| salsalate | P |  | 500 mg: 6/day; 750 mg: 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| diflunisal | NP |  | 3/day |

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|  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antibiotics: Agents for Diarrhea** | |  |  |
| vancomycin soln | P | * Patient is unable to swallow sold dosage forms; **OR** * Patient is < 12 years of age | 2,000 mg/day |  |
| Aemcolo® | NP | * Patient is being treated for traveler’s diarrhea; **AND** * Trial and failure, contraindication, intolerance, drug-drug interaction or resistance to a fluoroquinolone or azithromycin | 12 tabs/Rx; max 24 tabs/year |
| Firvanq® | NP | • Trial and failure, contraindication, or intolerance to generic vancomycin solution | 2,000 mg/day |
| Vancocin® | NP | • Trial and failure, contraindication, or intolerance to vancomycin capsules |  |
|  | **Antibiotics: Aminoglycosides, Oral** | |  |  |
| Arikayce® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following:   + Chest radiography or high-resolution computed tomography (HRCT) scan; **AND** o At least two positive sputum cultures; **AND**   + Other conditions such as tuberculosis and lung malignancy have been ruled out; **AND** * Patient has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. (Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6-months); **AND** * Prescribed in conjunction with a multi-drug antimycobacterial regimen **Renewal Criteria:** * Patient has demonstrated response to therapy defined as having three consecutive monthly negative sputum cultures by month six of treatment; **AND** * Patient has not experienced toxicity to amikacin treatment (e.g., ototoxicity, renal toxicity, neuromuscular blockade) | 8.4 mL/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Antibiotics: Anti-Tuberculosis, Oral** | |  |  |
| Sirturo® | NP | **Criteria: (9-month approval duration)**   * Patient is ≥ 5 years of age and weighs ≥ 15 kg; **AND** * Patient has a diagnosis of pulmonary multi drug-resistant tuberculosis (MDR-TB); **AND** * Sirturo is prescribed as part of a combination regimen with at least 3 other drugs to which the patient’s MDR-TB isolate has been shown to be susceptible; **AND**   Sirturo is prescribed by, or in consultation with, an infectious disease specialist |  |  |
|  | **Antibiotics: Cephalosporins Third Generation** | |  |  |
| cefpodoxime suspension | NP | * Patient less than 12 years of age and treatment is for genitourinary infection; **OR** * Patient is unable to swallow solid dosage forms |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Antibiotics: Lincosamides, Oral** | |  |  |
| clindamycin pediatric solution | P | * Patient less than 12 years of age; **OR** * Patient is unable to swallow solid dosage forms |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cleocin® Pediatric granules | NP | • Patient is unable to swallow solid dosage forms |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antibiotics: Macrolides** | |  |  |
| azithromycin packet | P |  | 2 g/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| azithromycin suspension | P |  |  |
| azithromycin tablets | P |  | 250, 500 mg: 12/Rx 600 mg: 8/month |
| clarithromycin ER/XL | NP |  | 2/day |
| Dificid® tablets & suspension | NP | • Diagnosis of *Clostridium difficile (C. diff)* associated diarrhea  **Note**: Individuals started on Dificid® therapy in the hospital will be approved for this agent following hospital discharge to allow for completion of the course of therapy. | Tabs: 2/day Susp: 1 bottle/Rx |
| Zithromax® packet | NP |  | 2 g/Rx |
| Zithromax® susp | NP |  |  |
| Zithromax® tablet | NP |  | 250, 500 mg: 12/Rx 600 mg: 8/month |
|  | **Antibiotics: Nitrofurans, Oral** | |  |  |
| nitrofurantoin suspension | P | • Patient is unable to swallow solid dosage forms  **Note**: PA not required for patients less than 12 years of age. |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Antibiotics: Oxazolidinones** | |  |  |
| linezolid tablets | P | • Treatment is for ONE of the following:   * Vancomycin Resistant Enterococcus faecalis infections * Healthcare-associated Methicillin-Resistant Staph Aureus (MRSA) infections or community-acquired MRSA with polyresistance * Community-acquired pneumonia (CAP) caused by S. pneumoniae or S. aureus (MSSA) o Nosocomial pneumonia caused by S. pneumoniae or S. aureus (including MSSA and MRSA) o Complicated skin and skin structure infections (SSSI) caused by S. aureus (MSSA and MRSA), S. pyogenes, or S.   agalactiae.   * Uncomplicated SSTI caused by S. aureus (MSSA only) or S. pyogenes * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| linezolid suspension | P | • One of the following:   * Patient is less than 12 years of age * Patient is unable to swallow oral dosage forms * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) |  |
| Sivextro® | NP | * Diagnosis of acute bacterial skin and skin structure infection; **AND** o Patient must be resistant to or have a contraindication, or intolerance, to all other treatment options; **OR** * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) | 1/day |
| Zyvox® suspension | NP |  | 60 mL/day |
| Zyvox®tablets | NP |  | 2/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Antibiotics: Quinolones, Oral** | | |  |  |
| Baxdela® | NP | * Patient age ≥ 18 years of age; **AND** * ONE of the following:   + Diagnosis of acute bacterial skin and skin structure infection (ABSSSI); **AND**   ­ Trial and failure to, contraindication, or resistance to ONE preferred standard of care agents for ABSSSI (e.g., linezolid, clindamycin, doxycycline, SMX-TMP, vancomycin, cephalosporin, a preferred fluoroquinolone)   * + Diagnosis of community-acquired bacterial pneumonia (CABP); **AND**   ­ Trial and failure to, contraindication, or resistance to TWO preferred standard of care agents for CABP (e.g., macrolide, doxycycline, a preferred fluoroquinolone, beta-lactam, linezolid) o Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) | 2/day;  Max 14-day supply | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cipro® suspension | NP | • Patient is unable to swallow solid dosage forms |  |
| ciprofloxacin suspension | NP | • Patient is unable to swallow solid dosage forms |  |
| Levofloxacin solution | NP | • Patient is unable to swallow solid dosage forms |  |
| moxifloxacin | NP | * Trial and failure, contraindication, or intolerance to 2 preferred agents; **OR** * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) |  |
| **Antibiotics: Tetracyclines** | | |  |  |
| doxycycline hyclate caps | P |  | 50 mg: 3/day;  All others: 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| doxycycline hyclate tabs 50, 100 mg |  |  | 50 mg: 3/day;  All others: 2/day |
| doxycycline monohydrate caps 50, 100 mg | P |  | 50 mg: 3/day;  All others: 2/day |
| demeclocycline | NP | * Trial and failure of 2 preferred agents; **OR** * Treatment is for syndrome of inappropriate antidiuretic hormone secretion (SAIDH) |  |
| Doryx® | NP |  | 50 mg: 3/day;  All others: 2/day |
| doxycycline DR | NP |  | 50 mg: 3/day;  All others: 2/day |
| doxycycline hyclate tabs 20, 75, 150 mg | NP | • Agent is used as an adjunct to scaling and root planting to promote attachment level gain and to reduce pocket depth for adult periodontitis | 2/day |
| doxycycline monohydrate caps 75, 150 mg | NP |  | 2/day |
| doxycycline suspension | NP | • Patient is unable to swallow solid dosage forms |  |

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| **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| minocycline ER | NP | * Patient is < 21 years old; **AND** * Diagnosis of non-nodular moderate to severe acne vulgaris with inflammatory lesions; **AND** * Patient requires long-term therapy with an oral tetracycline; **AND** * Trial and failure, contraindication, or intolerance of TWO of the following topical agents:   o Metronidazole (Metrogel®) o Azelaic acid (Azelex®, Finacea®) o Erythromycin (A/T/S® solution, gel) o Clindamycin (Cleocin T®) o Topical keratolytic agents (such as benzoyl peroxide, salicylic acid preparations); **AND**   * Clinically valid reason why the preferred minocycline capsules cannot be used | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Minolira® ER | NP | See minocycline ER prior authorization criteria | 1/day |
| Nuzyra® | NP | **Criteria:** **(approval duration: 14 days)** • Patient is ≥ 18 years of age; **AND**  • One of the following:  o Community-acquired bacterial pneumonia (CABP); **AND**  ­ Trial and failure to, contraindication, or resistance to TWO preferred standard of care agents for CABP (e.g., macrolide, doxycycline, a preferred fluoroquinolone, beta-lactam, linezolid) o Diagnosis of acute bacterial skin and skin structure infections (ABSSSI); **AND**  ­ Trial and failure to, contraindication, or resistance to ONE preferred standard of care agents for ABSSSI (e.g., linezolid, clindamycin, doxycycline, SMX-TMP, vancomycin, cephalosporin, a preferred fluoroquinolone) o Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) | 3/day;  Max 14-day supply |
| Oracea® | NP | * Diagnosis of inflammatory lesions (papules and pustules) of rosacea; **AND** * Patient is < 21 years of age; **AND** * Patient requires long-term therapy (greater than 3 months) with an oral antibiotic; **AND** * Trial and failure, contraindication, or intolerance to ONE of the following topical agents:   o Metronidazole (e.g., MetroGel®, MetroCream®) o Azelaic Acid (e.g., Azelex®, Finacea®) o Erythromycin gel or solution | 2/day |
| Solodyn® | NP | See minocycline ER prior authorization criteria | 1/day |
| Targadox® | NP |  | 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vibramycin® | NP |  | 50 mg: 3/day;  All others: 2/day |
| Ximino® | NP | See minocycline ER prior authorization criteria | 1/day |
| **Antibiotics: UTI Agents, Miscellaneous** | | | | |
| fosfomycin | NP | • Trial and failure, contraindication, intolerance, or resistance to at least 2 of the following agents:  o Sulfamethoxazole/trimethoprim o Quinolones o Nitrofurantoin | 1 packet (3 g) per course of therapy | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antibiotics, Vaginal** | |  |  |
| Cleocin® cream | P |  | 40 g/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| metronidazole 0.75% vaginal gel | P |  | 70 g/Rx |
| Nuvessa® | P |  | 5 g/Rx |
| Vandazole® | P |  | 70 g/Rx |
| clindamycin phos 2% cream | NP |  | 40 g/Rx |
| Clindesse® vaginal cream | NP |  | 5 g/Rx |
|  | **Antifungals, Oral** | |  |  |
| fluconazole suspension | P | • Patient is unable to swallow solid dosage forms; **OR** Patients < 20 years of age |  |  |
| fluconazole tablets | P |  | 150 mg: 4/28 days |  |
| Sporanox® capsules | P |  | 4/day |  |
| Sporanox® solution | P | • Patient is unable to swallow sold dosage forms | 40 mL/day |
| terbinafine tablets | P |  | 84/year |
| Ancobon® | NP | * Diagnosis of systemic candidiasis or cryptococcosis; **OR** * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) |  |
| Brexafemme® | NP | * Diagnosis of vulvovaginal candidiasis; **AND** * One of the following:   + Patient is > 18 years of age   + Patient is a post-menarchal female; **AND** * Patient is not pregnant; **AND** * Trial and failure, contraindication, or intolerance to 1 preferred oral agent (fluconazole tablets) OR 1 preferred topical agent (miconazole-3 kit or terconazole) | 4 tabs/Rx |
| Cresemba® oral | NP | * Patient is > 6 years of age; **AND** o Diagnosis of one of the following: ­ Invasive aspergillosis; **AND** * Trial and failure, contraindication, or intolerance to voriconazole OR posaconazole   ­ Invasive mucormycosis; **AND** o A fungal culture and relevant laboratory study (including histopathology) has been obtained to isolate and identify the causative organism(s); **OR**   * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) |  |
| Diflucan® susp | NP | • Patient is unable to swallow solid dosage forms |  |
| Diflucan® tablets | NP |  | 150 mg: 4/28 days |

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| **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| flucytosine | NP | * Diagnosis of systemic candidiasis or cryptococcosis; **OR** * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) |  |  |
| itraconazole caps | NP | • Trial and failure of preferred Sporanox® capsules | 4/day |
| itraconazole soln | NP | * Patient is unable to swallow solid dosage forms; **AND** * Trial and failure of preferred Sporanox® solution | 40 mL/day |  |
| ketoconazole | NP | * Trial and failure, contraindication, or intolerance to TWO preferred agents; **OR** * Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Noxafil® | NP | • ONE of the following:   * As indicated for the prophylaxis of invasive *aspergillus* and/or *candida* in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with Graft versus Host Disease (GVHD), recipients with hematologic malignancies (leukemia, lymphoma, myelodysplastic syndromes) with prolonged neutropenia from chemotherapy, or recipients with AIDS. * Treatment of Fusariosis disease o Treatment of Zygomycetes disease * Treatment of other fungal infections or molds that are refractory or resistant to, or in patient who have a contraindication, or intolerance to itraconazole or voriconazole o Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) |  |
| Oravig® | NP | * Patient is 18 years of age or older; **AND** * Patient has a diagnosis of oropharyngeal candidiasis; **AND** * Patient has a contraindication, allergic reaction, or drug-drug interaction to clotrimazole troche and nystatin | 1/day |
| posaconazole | NP | See Noxafil® prior authorization criteria |  |
| Tolsura® | NP | * Diagnosed of ONE of the following:   o Aspergillosis (pulmonary and extrapulmonary) o Blastomycosis (pulmonary and extrapulmonary) o Histoplasmosis (including chronic cavitary pulmonary disease, disseminated, or nonmeningeal); **AND**   * Clinically valid reason why the patient cannot use the other itraconazole capsules or solution | 4/day |
| Vfend® | NP | • Treatment is for ONE of the following:   * Candidemia (in non-neutropenic patients) o Esophageal candidiasis o Invasive aspergillosis * Serious fungal infections caused by *S. apiospermum* and *Fusarium* species including *F. solani*  o Part of standard anti-fungal regimen in febrile neutropenic patients o Other fungal infections that are refractory or resistant to other oral triazole agents (i.e., fluconazole, ketoconazole); **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy) | 18/84 days |
| Vivjoa® | NP | * Diagnosis of recurrent vulvovaginal candidiasis (RVCC); **AND** * Provider attests patient is NOT of reproductive potential; **AND** * The member has experienced ≥ 3 episodes of VVC in less than one year; **AND** * Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6-months |  |
| voriconazole | NP | See Vfend prior authorization criteria |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antifungals, Vaginal** | |  |  |
| Gynazole-1 | P |  | 5 gm/day |  |
| miconazole-3 kit | P |  | 1 box/Rx |  |
| miconazole-3 vaginal supp | P |  | 1 box/Rx |  |
| terconazole | P |  | 1 box/Rx |  |
|  | **Anti-Infectives: Anthelmintics** | |  |  |
| albendazole | P | * Treatment of neurocysticercosis caused by *Taenia solium*; **AND** o Prescribed by, or in consultation with, an Infectious Disease specialist; **OR** * Treatment of cystic hydatid disease caused by *Echinococcus granulosus*; **OR** • Treatment of hookworm |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| ivermectin tablets | P |  | 20/90 days |
| Emverm® | NP | * Treatment of *Enterobius vermicularis* (pinworm) in single or mixed infections; **AND** o Recipient has tried and failed, has an intolerance, OR contraindication to pyrantel pamoate; **OR** * Treatment of *Ancylostoma duodenale* (common hookworm) or *Necator americanus* (American hookworm); **AND** o Recipient has tried and failed, has an intolerance, OR contraindication to albendazole; **OR** * Treatment of *Trichuris trichiura* (whipworm) or *Ascaris lumbricoides* (common roundworm); **AND** o Recipient has tried and failed, has an intolerance, OR contraindication to ivermectin  **Length of authorization**: Will be based on FDA indication |  |
| Stromectol® | NP |  | 20/90 days |
|  | **Anti-Infectives: Antiprotozoals, Oral** | |  |  |
| atovaquone | P | * Treatment is for Pneumocystis pneumonia (PCP) prevention or treatment; **AND** o Trial and failure, contraindication, intolerance to sulfamethoxazole/trimethoprim; **OR** * Diagnosis of Toxoplasmosis gondii encephalitis; **AND** o Trial and failure, contraindication, intolerance to sulfamethoxazole/trimethoprim; **OR** Diagnosis of Babesiosis |  |  |
| benznidazole | NP | Diagnosis of American trypanosomiasis (Chagas disease) caused by Trypanosoma cruzi | 12.5 mg: 6/day 100 mg: 4/day |  |
| Lampit® | NP | • Diagnosis of American trypanosomiasis (Chagas disease) caused by Trypanosoma cruzi |  |  |
| Likmez® |  | * Patient is unable to swallow solid dosage forms; **OR** * Patients less than 12 years of age |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Mepron® | NP | See atovaquone prior authorization criteria: **AND**  • Trial and failure, contraindication, intolerance, or drug-drug interaction to sulfamethoxazole/trimethoprim |  |

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|  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| nitazoxanide tablets | NP | * Patient is > 12 years of age or older; **AND** * One of the following:   + Treatment of diarrhea caused by *Cryptosporidium parvum* (Note: Will not be approved for the treatment of diarrhea caused by C. parvum in HIV-infected or immunodeficient patients); **OR**   + Treatment of diarrhea caused by *Giardia lamblia*; **AND**   ­ Patient has failed and failed, or has a contraindication, intolerance, or adverse drug reaction to tinidazole and metronidazole | 6/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| pyrimethamine | NP | Treatment of toxoplasmosis when used in combination with a sulfonamide |  |  |
| Solosec® | NP | * Patient is 12 years of age or older; **AND** * One of the following: * Diagnosis of bacterial vaginosis; **AND** * Trial and failure, contraindication, or intolerance to one of the following: * Cleocin® vaginal cream * Cleocin® vaginal suppository * clindamycin capsules * metronidazole tablets * metronidazole vaginal gel * Diagnosis of trichomoniasis caused by *Trichomonas vaginalis* (*T. vaginalis*); **AND** * Trial and failure, contraindication, or intolerance to preferred metronidazole tablets | 1 pack/month | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| sulfadiazine | NP | * Treatment of *Toxoplasma gondii* encephalitis in combination with pyrimethamine; **OR** * Rheumatic fever prophylaxis in patients who have a contraindication or intolerance to penicillin |  |  |
|  | **Antivirals: COVID Treatment** | |  |  |
| Lagevrio® | P | • Patient is > 18 years of age and older | 40/5 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Paxlovid® | P | • Patient is > 12 years of age and older | 30/5 days |
|  | **Antivirals: Cytomegalovirus Agents** | |  |  |
| Livtencity® | NP | * Patient is > 12 years of age and weighs > 35kg; **AND** * Diagnosis of post-transplant cytomegalovirus (CMV) infection; **AND** * Infection is refractory to prior treatment with at least one of the following:   o Ganciclovir, valganciclovir, cidofovir or foscarnet | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Prevymis® | NP | * Patient is > 18 years of age and older; **AND** * One of the following:   o Patient is scheduled or has received an allogeneic hematopoietic stem cell transplant (HSCT) and ONE of the following:  ­ Patient is seropositive for CMV; **OR**  ­ Treatment is for prophylaxis against CMV disease; **OR** o Patient is a kidney transplant recipient and **BOTH** of the following:  ­ Patient is 12 years of age and older and weighs at least 40 kg; **AND**  ­ Patient is high risk of CMV Disease (e.g., Donor CMV seropositive/Recipient CMV seronegative [D+/R-]); **AND**   * Must beprescribed by, or in consultation with, an oncology, hematology, infectious disease, or transplant specialist; **AND** * Patient is NOT receiving concurrent therapy with pimozide, ergot alkaloids, or cyclosporine in conjunction with either pitavastatin or simvastatin   **Note:** When co-administered with cyclosporine the recommended dose of Prevymis is 240 mg daily. | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| **Antivirals: Hepatitis B** | | | | |
| entecavir | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| lamivudine-HBV | P |  | 1/day |
| tenofovir | P |  | 1/day |  |
| adefovir | NP |  | 1/day |  |
| Baraclude® solution | NP | * Diagnosis of chronic hepatitis B virus infection with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease; **AND** • Patient is unable to swallow tablets; **AND** * Prescriber will monitor hepatic function closely for at least several months in patients who discontinue therapy **Note**: Prior authorization is not required for patients 2 through 11 years of age | 20 ml/day |  |
| Baraclude® tablets | NP |  | 1/day |  |
| Vemlidy® | NP | * Patient is 6 years of age and older; **AND** * Diagnosis of Chronic Hepatitis B virus (HBV) infection in adults with compensated liver disease; **AND** * Inadequate treatment response (detectable HBV DNA level after 24 weeks of therapy), virologic breakthrough, resistance, intolerance, or contraindication to entecavir; **AND** * Patient has ONE of the following:   + History of osteoporosis or osteopenia o Renal impairment defined by CrCL <50 mL/min   + Clinically valid reason as to why the preferred tenofovir disoproxil fumarate (TDF) cannot be used; **AND** * Patient is not using Vemlidy® as monotherapy if (HIV)-1 positive (must have additional antiviral therapy if HIV-1 positive for coverage of both disease states); **AND** * Prescriber will monitor hepatic function closely at repeated intervals for at least several months in patients who discontinue therapy | 1/day |  |
| Viread® powder | NP | * Patient has had a trial and failure, contraindication, or intolerance to 2 preferred agents; **OR** * Patient is 6 years of age or younger and being treated for post-exposure prophylaxis (PEP) |  |  |
| Viread® tablets | NP |  | 1/day |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Antivirals: Hepatitis C Antivirals** |  |  |
| Epclusa® tablet | P | • One of the following:  o **Diagnosis of Chronic Hepatitis C, Genotype 1, 2, 4, 5, and 6**  ­ Treatment naïve patients with OR without compensated cirrhosis (Child-Pugh A) (Total duration – 12 weeks); **OR** o **Diagnosis of Chronic Hepatitis C, Genotype 3**  ­ Treatment naïve patient without cirrhosis (Total Duration-12 weeks)  ­ Treatment naïve patient with compensated cirrhosis (Child-Pugh A) without baseline NS5A RAS Y93H (Total duration – 12 weeks);  ­ Treatment naïve patient with compensated cirrhosis (Child-Pugh A) with baseline NS5A RAS Y93H AND given in combination with ribavirin (Total duration – 12 weeks); o **Diagnosis of Chronic Hepatitis C, Genotype 1, 2, 3, 4, 5, and 6**  ­ Patients with decompensated cirrhosis (Child-Pugh B or C) AND given in combination with ribavirin (Total duration – 12 weeks); **OR**  ­ Patients with decompensated cirrhosis (Child-Pugh B or C) who are ribavirin ineligible (Total duration – 24 weeks); **AND**   * If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease, or Gastroenterology); **AND** * Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following:   + Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients   [(HCV Guidance - Treatment Experienced)](https://www.hcvguidelines.org/treatment-experienced) o Current quantitative HCV RNA levels   * + Quantitative HCV RNA level measured 12 weeks after completion of previous treatment o Previous treatment history o Genotype testing from current and previous infections; **AND** * Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  **Note:** Patients previously treated with one of the following are considered treatment-naïve: sofosbuvir+ daclatasvir, peginterferon alfa + ribavirin, paritaprevir/ritonavir/ombitasvir/dasabuvir, and telaprevir or boceprevir + pegylated interferon, ribavirin | 1/day | [Epclusa PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Epclusa%20PA%20Form.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Harvoni® tablet | P | * One of the following:   o **Diagnosis of Chronic Hepatitis C, genotype 1** ­ Patients without cirrhosis:   * Treatment naïve patients with documentation of pre‐treatment HCV RNA < 6 million IU/mL (Total duration – 8 weeks) * Treatment naïve patients with documentation of pre‐treatment HCV RNA > 6 million IU/mL (Total duration – 12 weeks) * Liver or kidney transplant patient (Total duration – 12 weeks); **OR** ­ Patients with compensated cirrhosis (Child-Pugh A): * Treatment naïve patients (Total duration – 12 weeks) * Liver or kidney transplant patient (Total duration – 12 weeks); **OR** ­ Patients with decompensated cirrhosis (Child-Pugh B or C): * Given in combination with ribavirin (Total duration – 12 weeks) * If ribavirin ineligible, may take as monotherapy (Total duration – 24 weeks); **OR** * **Diagnosis of Chronic Hepatitis C, genotype 4, 5, 6**   ­ Treatment naïve patients with OR without compensated cirrhosis (Child-Pugh A) (Total Duration- 12 weeks)  ­ Liver or kidney transplant patient with or without compensated cirrhosis (Child-Pugh A) (Total duration – 12 weeks)  ­ Patients with decompensated cirrhosis (Child-Pugh B or C)   * + Given in combination with ribavirin (Total duration – 12 weeks)   + If ribavirin ineligible, may take as monotherapy (Total duration – 24 weeks); **AND**   + If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); AND   + Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following: * Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients   [(HCV Guidance - Treatment Experienced)](https://www.hcvguidelines.org/treatment-experienced) o Current quantitative HCV RNA levels   * Quantitative HCV RNA level measured 12 weeks after completion of previous treatment o Previous treatment history * Genotype testing from current and previous infections; AND o Patient has been screened for Hepatitis B prior to treatment with a direct-acting antiviral agent for Chronic Hepatitis C **Note:** Patients previously treated with one the following are considered treatment-naïve: sofosbuvir+ daclatasvir, peginterferon alfa + ribavirin, paritaprevir/ritonavir/ombitasvir/dasabuvir, and telaprevir or boceprevir + pegylated interferon, ribavirin | 1/day | [Harvoni PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Harvoni%20PA%20Form.pdf) |
| ledipasvir/sofosbuvir | P | See Harvoni®tablet prior authorization criteria | 1/day | [Harvoni PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Harvoni%20PA%20Form.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Mavyret® | P | **Diagnosis of Chronic Hepatitis C, allgenotypes**   * Patients with or without cirrhosis:   + Treatment naïve patients (Total authorization 8 weeks); **OR**   + Liver or kidney transplant recipients (Total duration – 12 weeks); **OR** * If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); **AND** * Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following:   + Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients   [(HCV Guidance - Treatment Experienced)](https://www.hcvguidelines.org/treatment-experienced) o Current quantitative HCV RNA levels   * + Quantitative HCV RNA level measured 12 weeks after completion of previous treatment o Previous treatment history o Genotype testing from current and previous infections; **AND** * Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C **Note:** Patients previously treated with one the following are considered treatment-naïve: sofosbuvir+ daclatasvir, peginterferon alfa + ribavirin, paritaprevir/ritonavir/ombitasvir/dasabuvir, and telaprevir or boceprevir + pegylated interferon, ribavirin | 3/day | [Mavyret PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Mavyret%20PA%20Form.pdf) |
| Mavyret® pellet | P | See Mavyret® prior authorization criteria; **AND** Patient is unable to swallow tablets | 5/day |  |
| sofosbuvir/ velpatasvir | P | See Epclusa® tablet prior authorization criteria | 1/day | [Epclusa PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Epclusa%20PA%20Form.pdf) |
| Epclusa® pellet | NP | See Epclusa® tablet prior authorization criteria; **AND** Patient is unable to swallow tablets | 150 mg: 1/day  200 mg: 2/day |
| Harvoni® pellet | NP | See Harvoni® tablet prior authorization criteria; **AND** Patient is unable to swallow tablets | 1 pak/28 days | [Harvoni PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Harvoni%20PA%20Form.pdf) |

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| **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Sovaldi® tablets | NP | • One of the following:  o **Diagnosis of Chronic Hepatitis C,** **genotype 1 or 4** (Total duration – 12 weeks)  ­ Used in combination with ribavirin and peginterferon alfa; **OR**  ­ Patient must have a contraindication or drug‐drug interaction with two preferred agents; **OR**  ­ Patients must be treatment naïve to all HCV therapy (including therapies with pegylated interferon or ribavirin); **OR**  ­ If patient has a documented contraindication to interferon; may use in combination with ribavirin alone (Total duration – 24 weeks); **AND** o **Diagnosis of Chronic Hepatitis C,** **genotype 2** (Total duration – 12 weeks):  ­ Treatment-naïve and treatment-experienced with or without cirrhosis (Child-Pugh A); **AND**  ­ Requires contraindication or drug‐drug interaction with two preferred agents; **AND**  ­ Used in combination with ribavirin o **Diagnosis of Chronic Hepatitis C,** **genotype 3** (Total duration – 24 weeks):  ­ Treatment-naïve and treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A); **AND** ­ Requires contraindication or drug‐drug interaction with Mavyret and Epclusa; **AND** ­ Used in combination with ribavirin   * If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease, or Gastroenterology); **AND** * Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following:   + Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients   [(HCV Guidance - Treatment Experienced)](https://www.hcvguidelines.org/treatment-experienced) o Current quantitative HCV RNA levels   * + Quantitative HCV RNA level measured 12 weeks after completion of previous treatment o Previous treatment history o Genotype testing from current and previous infections; **AND** * Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C;   **AND**   * If request is for diagnosis of Hepatocellular Carcinoma awaiting liver transplant (Length of authorization: 48 wks), must be used in combination with ribavirin; **AND** o Must meet ALL Milan criteria, defined as:   ­ The presence of a tumor 5 cm or less in diameter in subjects with single hepatocellular carcinoma  ­ No more than three tumor nodules, each 3 cm or less in diameter, in subjects with multiple tumors ­ No extrahepatic manifestations of the cancer and no evidence of vascular invasion of the tumor; **AND**   * If request is for Sovaldi pellet, patient must be unable to swallow tablets. | 1/day | [Sovaldi PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Sovaldi%20PA%20Form.pdf) |
| Sovaldi® pellet | NP | See Sovaldi® tablet prior authorization criteria; **AND**  • Patient is unable to swallow tablets | 1 pack/28 days |

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| **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Vosevi® | NP | * **Diagnosis of chronic Hepatitis C, genotype 1–6**  o Sofosbuvir- based treatment failures, with or without compensated cirrhosis (Total duration – 12 weeks); **OR** o Glecaprevir/Pibrentasvir treatment failure with or without compensated cirrhosis (Total duration – 12 weeks); **OR** o Multiple Direct-Acting Antiviral (DAA) treatment failures in combination with weight-based ribavirin (Total duration- 24 weeks); **AND** * If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); **AND** * Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of all the following:   + Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients   [(HCV Guidance - Treatment Experienced)](https://www.hcvguidelines.org/treatment-experienced) o Current quantitative HCV RNA levels   * + Quantitative HCV RNA level measured 12 weeks after completion of previous treatment o Previous treatment history o Genotype testing from current and previous infections; **AND** * Patient does not have, nor has ever had, decompensated cirrhosis [Child-Pugh score greater than 6 (class B or C)]; **AND** * Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C | 1/day | [Vosevi PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Vosevi%20PA%20Form.pdf) |
| Zepatier® | NP | * One of the following:   + **Diagnosis of Chronic Hepatitis C, genotype 1*a*** **without NS5A polymorphism, genotype 1b, genotype 4** (Total duration   – 12 weeks);  ­ Patient must have a contraindication or drug-drug interaction with two preferred agents o **Diagnosis of Chronic Hepatitis C, genotype 1a WITH NS5A polymorphism** (Total duration – 16 weeks);  ­ Patient must have a contraindication or drug‐drug interaction with two preferred agents; **OR** o **Diagnosis of Chronic Hepatitis C, genotype 4** (Total duration – 16 weeks)  ­ Patient failed prior treatment with peginterferon alfa + ribavirin; **AND**  ­ Patient must have a contraindication or drug‐drug interaction with two preferred agents; **AND**   * If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); **AND** * Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:   + Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients   [(HCV Guidance - Treatment Experienced)](https://www.hcvguidelines.org/treatment-experienced) o Current quantitative HCV RNA levels   * + Quantitative HCV RNA level measured 12 weeks after completion of previous treatment o Previous treatment history o Genotype testing from current and future infections; **AND** * Patient does not have decompensated cirrhosis (defined as a Child-Pugh score > 6 [class B or C]); **AND** * Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C | 1/day | [Zepatier PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Zepatier%20PA%20Form.pdf) |

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|  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antivirals: Hepatitis C Pegylated Interferons** | |  | |
| Pegasys® syringes | P | Diagnosis of ONE of the following:   * Chronic Hepatitis C and one of the following:   + Adult Patients: In combination therapy with other hepatitis C virus drugs for adults with compensated liver disease. Pegasys monotherapy is indicated only if patient has contraindication or significant intolerance to other Hepatitis C drugs   + Pediatric Patients: In combination with ribavirin for pediatric patients 5 years of age and older with compensated liver disease * Chronic Hepatitis B and one of the following: * Adult Patients: Treatment of adults with HBeAg-positive and HBeAg-negative chronic hepatitis B (CHB) infection who have compensated liver disease and evidence of viral replication and liver inflammation; **OR** * Pediatric Patients: Treatment of non-cirrhotic pediatric patients 3 years of age and older with HBeAg-positive CHB and evidence of viral replication and elevations in serum alanine aminotransferase (ALT)   **Note**: Prior authorization will be required after 24 weeks of therapy | 4/24 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Pegasys® vials | P | See prior authorization criteria for Pegasys® syringes | 4/24 days |
|  | **Antivirals: Herpes Agents, Oral** | |  | |
| famciclovir | P |  | 125 mg: 20/30 days;  250 mg: 60/30 days;  500 mg: 3/day & 21/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| valacyclovir | P |  | 500 mg: 60/30 days 1000 mg: 30/Rx |
| Sitavig® buccal tabs | NP |  | 2/Rx |
| Valtrex® | NP |  | See valacyclovir |
|  | **Antivirals: HIV Attachment Inhibitors** | |  | |
| Rukobia® | NP | **Initial Criteria:**   * Diagnosis of treatment-experienced multidrug-resistant HIV-1 infection; **AND** * HIV-1 RNA levels > 200 copies/mL; **AND** * Prescriber attests that the patient lacks sufficient treatment options due to resistance, intolerability, contraindication, or other safety concerns to construct a fully suppressive antiretroviral regimen; **AND** * Will not be used with strong cytochrome P450 (CYP)3A inducers * Prescribed by, or in consultation with or by an infectious disease specialist **Renewal Criteria:** * Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remain virologically suppressed) | 2/day |  |

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|  |  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Antivirals: HIV Capsid Inhibitors** |  |  |
| Sunlenca® | P | * Diagnosis of treatment-experienced multidrug-resistant HIV-1 infection; **AND** * HIV-1 RNA levels > 200 copies/mL; **AND** * Prescriber attests that the patient lacks sufficient treatment options due to resistance, intolerability, contraindication, or other safety concerns to construct a fully suppressive antiretroviral regimen; **AND** * Agentwill be used in combination with *an optimized* antiretroviral *regimen;* **AND** * Prescriber attests the patient has received or will receive the subcutaneous dose; **AND** * Prescribed by, or in consultation with or by an infectious disease specialist | 1 pack/year | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **Antivirals: HIV CCR5 Antagonists** |  |  |
| maraviroc tablets | P | * Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; **AND** * Verification that agent will be administered in combination with other antiretroviral agents | 150 mg: 2/day; 300 mg: 4/day |  |
| Selzentry® tablets | NP | * Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; **AND** * Verification that agent will be administered in combination with other antiretroviral agents; **AND** • Trial and failure, contraindication, or intolerance to maraviroc tablets | 150 mg: 2/day; 300 mg: 4/day |
| Selzentry® solution | NP | * Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; **AND** * Verification that agent will be administered in combination with other antiretroviral agents; **AND** * Patient is 11 years of age or younger OR patient is unable to swallow tablets |  |
|  |  | **Antivirals: HIV Fusion Inhibitors** |  |  |
| Fuzeon® | P | **Initial Criteria:**   * Diagnosis of treatment-experienced multidrug-resistant HIV-1 infection; **AND** * HIV-1 RNA levels > 200 copies/mL; **AND** * Prescriber attests that the patient lacks sufficient treatment options due to resistance, intolerability, contraindication, or other safety concerns to construct a fully suppressive antiretroviral regimen; **AND** * Agent will be used in combination with an optimized antiretroviral regimen therapy (ART); **AND** • Prescribed by, or in consultation with or by an infectious disease specialist **Renewal Criteria:** * Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remain virologically suppressed) | 1 kit/30 days (2 vials/day) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antivirals: HIV Integrase Inhibitors** | |  |  |
| Isentress® | P |  | tabs: 2/day;  chews: 6/day;  granules: 2 packs/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Tivicay® | P |  | 2/day |
| Tivicay PD® | P | * Patient is < 6 years of age; **OR** * Patient is unable to swallow solid dosage forms; **OR** * Clinically valid reason why the patient cannot use Tivicay tablets | 3 bottles/30 days |
| Isentress® HD | NP | • Verification that agent will be administered in combination with other antiretroviral agents; **AND** • Clinically valid reason why the patient cannot use the preferred agents | 2/day |
| Juluca® | NP | * Patient has a diagnosis of HIV; **AND** * Patient does not have any prior history of treatment failure to other HIV agents **OR** known resistance to the individual components (dolutegravir/rilpivirine); **AND** * Patient is virologically suppressed (HIV-1 RNA < 50 copies/mL) on a current ART regimen for ≥ 6-months | 1/day |
|  | **Antivirals: HIV NNRTIs** | |  |  |
| efavirenz | P |  | 50 mg: 7/day;  200 mg: 2/day;  600 mg: 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Intelence® | P | * Patient is treatment-experienced; **AND** * Patient will concomitantly take at least two additional antiretroviral agents; **AND**   Patient has documented non-nucleoside reverse transcriptase inhibitor (NNRTI) resistance | 2/day |  |
| nevirapine | P |  | 200 mg 2/day;  Susp: 40 mL/day |  |
| Pifeltro® | P |  | 1/day |  |
| etravirine | NP | See Intelence prior authorization criteria | 2/day |  |
| nevirapine ER | NP |  | 1/day |  |
|  | **Antivirals: HIV NRTIs** | |  |  |
| abacavir | P |  | tabs: 2/day soln: 30mL/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| emtricitabine | P |  | 1/day |
| lamivudine | P |  | 100 & 300 mg:  1/day;  150 mg: 2/day; soln: 30 mL/day |
| stavudine | P |  | caps: 2/day; soln: 80 mL/day |

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| **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| zidovudine | P |  | 100 mg: 6/day;  300 mg: 2/day; syrup: 60 mL/day |  |
| Emtriva® | NP |  | caps: 1/day; soln: 24 mL/day |
| Epivir® | NP |  | 150 mg: 2/day;  300 mg: 1/day; soln: 30 mL/day |
| Retrovir® | NP |  | 100 mg: 6/day; syrup: 60 mL/day |
| Ziagen® | NP |  | tabs: 2/day; soln: 30 mL/day |
| **Antivirals: HIV NRTI Combos** | | | | |
| abacavir/ lamivudine | P |  | 1/day |  |
| Biktarvy® | P |  | 1/day |  |
| Complera® | P |  | 1/day |
| Delstrigo® | P |  | 1/day |
| Descovy® | P |  | 1/day |
| Dovato® | P |  | 1/day |
| emtricitabine/ tenofovir | P |  | 1/day |
| efavirenz/emtricitabine/tenofovir | P |  | 1/day |
| Genvoya® | P |  | 1/day |
| lamivudine/ zidovudine | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Odefsey® | P |  | 1/day |
| Stribild® | P |  | 1/day |
| Symtuza® | P | **Initial Criteria:**   * Patient has a diagnosis of HIV-1; **AND** * Patient has no known substitutions associated with resistance to darunavir or tenofovir; **AND** * One of the following:   o Patient is ARV treatment-naïve; **OR**  o Patient is ARV treatment-experienced and meets the following requirements:  ­ Virologically suppressed (HIV-1 RNA < 50 copies/mL) on a stable ARV regimen for ≥ 6-months; **OR**  ­ Patient is switching medication due to adverse effects or documented compliance issues due to pill burden or dose frequency **Renewal Criteria:**   * Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remaining virologically suppressed) | 1/day |

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|  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Triumeq® | P |  | 1/day |  |
| Trizivir® | P |  | 2/day |
| Cimduo® | NP |  | 1/day |
| efavirenz/lamivudin e/tenofovir | NP |  | 1/day |
| Epzicom® | NP |  | 1/day |
| Symfi® | NP |  | 1/day |
| Symfi® Lo® | NP |  | 1/day |
| Triumeq PD® | NP |  | 6/day |
| Truvada® | NP |  | 1/day |
|  | **Antivirals: HIV Pharmacokinetic Enhancers** | |  |  |
| ritonavir tablet | P |  |  |  |
| Norvir® pack | NP | * Patient has a diagnosis of HIV-1; **AND** * The requested will be used in combination with other antiretroviral agents; **AND** * One of the following:   o Patient is ≤ 18 years of age; **OR** o Clinically valid reason why the preferred ritonavir tablets cannot be used  **Note**: Norvir oral powder is dosed in increments of 100 mg; prescription should not be written for <100 mg increments | 12/day |
| Norvir® tablet | NP |  | 12/day |
| Tybost® | NP | * Verification that agent will be administered in combination with Prezista® (darunavir) **OR** atazanavir; **AND** * Patient has a contraindication or intolerance to ritonavir; **AND** * Patient is not pregnant; **AND** * Patient does not have renal impairment | 1/day |
|  | **Antivirals: HIV Protease Inhibitors** | |  |  |
| atazanavir caps | P |  | See Reyataz® |  |
| darunavir | NP |  | 800 mg: 1/day;  All other strengths:  2/day; susp: 12 mL/day |
| Evotaz® | P |  | 1/day |
| fosamprenavir | P |  | 4/day |
| lopinavir/ritonavir | P |  | soln: 6 mL/day tabs: 1/day |
| Prezcobix® | P |  | 1/day |
| Prezista® suspension | P |  | 12 mL/day |
| Reyataz® powder | P |  | 5/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Viracept® | P |  | tabs: 4/day |
|  | **ANTI-INFECTIVES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Aptivus® | P | • Confirmation that patient has had previous exposure to at least one PI indicated for first line therapy. | caps: 4/day; soln: 10 mL/day |  |
| Kaletra® | NP |  | soln: 15 mL/day tabs: 6/day |
| Prezista® tabs | NP |  | 800 mg: 1/day;  All other strengths: 2/day |
| Reyataz® caps | NP |  | 300 mg: 1/day;  150, 200 mg: 2/day |
|  | **Antivirals: Influenza** | |  |  |
| oseltamivir capsules and suspension | P |  | caps: 20/180 days;  susp: 300 mL/180  days | [Influenza](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Influenza%20Antiviral%20PA%20Form.pdf)  [Antiviral PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Influenza%20Antiviral%20PA%20Form.pdf) |
| Relenza® | P |  | 40/180 days |
| Tamiflu® capsules and suspension | NP |  | See oseltamivir |
| Xofluza® | NP | * Agent is being used for treatment of influenza OR post-exposure prophylaxis of influenza; **AND** * Treatment is being used for ONE of the following:   + Acute uncomplicated influenza in patients > 5 years of age who have been symptomatic for no more than 48 hours and who are otherwise healthy   + Acute uncomplicated influenza in patients > 5 years of age who are at high risk of developing influenza-related complications   + Post-exposure prophylaxis of influenza in patients > 5 years of age; **AND** * One of the following:   + Contraindication to both Relenza® and Tamiflu® that is not associated with requested agento Area surveillance data that indicates an oseltamivir resistant strain   + Recurrent documented influenza in the same flu season that was previously treated with a preferred agent | 2/Rx |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **ACE Inhibitors (AEIs)** | |  |  |
| ramipril | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Altace® | NP |  | 2/day |
| captopril | NP | • Trial and failure, contraindication, or intolerance of TWO preferred agents **Note**: PA is not required for members 18 years of age and younger |  |
| Epaned® | NP | • Patient is unable to swallow solid dosage forms  **Note**: PA is not required for members 8 years of age and younger |  |
| enalapril suspension | NP | See Epaned® prior authorization criteria  **Note**: PA is not required for members 8 years of age and younger |  |
| moexipril | NP |  | 7.5 mg: 1/day; 15 mg: 2/day |
| perindopril | NP |  | 2 mg, 4 mg: 1/day; 8 mg: 2/day |
| Qbrelis® solution | NP | • Patient is unable to swallow solid dosage forms  **Note**: PA is not required for members 7 years of age and younger |  |
| trandolapril | NP |  | 1/day |
|  | **ACEIs + Calcium Channel Blockers** | |  |  |
| benazepril/ amlodipine | P |  | 5/40 mg: 2/day; All others: 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Lotrel® | NP | • Patient is unable to take the two components separately | 5/40 mg: 2/day; All others: 1/day |
| Prestalia® | NP | • Patient is unable to take the two components separately | 1/day |
| trandolapril/ verapamil | NP | • Patient is unable to take the two components separately | 1/day |
|  | **ACEIs + Diuretics** | |  |  |
| benazepril/HCTZ | NP | • Patient is unable to take the two components separately |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Alpha-Beta Blockers** | |  |  |
| carvedilol | P |  | 2/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| carvedilol ER | NP |  | 1/day |
| Coreg® | NP |  | 2/day |
| Coreg CR® | NP |  | 1/day |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Angiotensin II Receptor Antagonists (ARBs)** | |  |  |
| irbesartan | P |  | 1/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| losartan | P |  | 25 mg, 100 mg:  1/day;  50 mg: 2/day |
| olmesartan | P |  | 1/day |
| valsartan | P |  | 1/day |
| Atacand® | NP |  | 1/day |
| Avapro® | NP |  | 1/day |
| Benicar® | NP |  | 1/day |
| candesartan | NP |  | 4 & 32 mg: 1/day;  8 mg & 16 mg: 2/day |
| Cozaar® | NP |  | 25 mg, 100 mg:  1/day;  50 mg: 2/day |
| Diovan® | NP |  | 1/day |
| Edarbi™ | NP |  | 1/day |
| Micardis® | NP |  | 1/day |
| telmisartan | NP |  | 1/day |
| valsartan solution | NP | • Patient is unable to swallow solid dosage forms | 80 mL/day |  |
|  | **ARB + Calcium Channel Blocker** | |  |  |
| valsartan/ amlodipine | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| valsartan/ amlodipine/HCTZ | P | • Patient is unable to take the components separately | 1/day |
| Azor® | NP |  | 1/day |
| Exforge® | NP |  | 1/day |
| Exforge HCT® | NP | • Patient is unable to take the components separately | 1/day |
| olmesartan/ amlodipine | NP |  | 1/day |
| olmesartan/ amlodipine/HCTZ | NP | • Patient is unable to take the components separately | 20/5/12.5 mg: 2/day; All others: 1/day |
| telmisartan/ amlodipine | NP |  | 1/day |

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|  |  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tribenzor® | NP | • Patient is unable to take the components separately | 20/5/12.5 mg: 2/day; All others: 1/day |  |
|  |  | **ARB + Diuretic** |  | |
| irbesartan/HCTZ | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| losartan/HCTZ | P |  | 1/day |
| olmesartan/HCTZ | P |  | 1/day |
| valsartan/HCTZ | P |  | 1/day |
| Atacand HCT® | NP |  | 1/day |
| Avalide® | NP |  | 1/day |
| Benicar HCT® | NP |  | 1/day |
| candesartan/HCTZ | NP |  | 1/day |
| Diovan HCT® | NP |  | 1/day |
| Edarbyclor® | NP |  | 1/day |
| Hyzaar® | NP |  | 1/day |
| Micardis HCT® | NP |  | 1/day |
| telmisartan/HCTZ | NP |  | 1/day |
|  |  | **ARB + Neprilysin Inhibitor** |  | |
| Entresto® tablets | P | • Diagnosis of chronic heart failure (NYHA Class II-IV) | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Entresto® sprinkles | NP | * Diagnosis of chronic heart failure (NYHA Class II-IV); **AND** * Clinically valid reason why Entresto tablets cannot be used | 8/day |
|  |  | **Antianginals: Nitrates** |  | |
| Rectiv® | P | * Diagnosis of history of anal fissure; **AND** * Patient is a candidate for surgery |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| GoNitro® powder | NP | * Clinically valid reason why the preferred agents cannot be used; **OR** * Patient is unable to swallow solid dosage forms or sublingual formulations (e.g., spray, tablet) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| nitroglycerin spray | NP | * Trial and failure, contraindication, or intolerance of TWO preferred agents; **OR** * Clinically valid reason why the preferred agent cannot be used |  |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antiarrhythmics, Oral** | |  |  |
| dofetilide | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Multaq® | NP | * Not on concurrent Class I or III anti-arrhythmic agent; **AND** * Not hospitalized for exacerbation of heart failure in past 30 days; **AND** * Patient does not have NYHA class IIIb or IV heart failure; **AND** * Trial and failure, contraindication, or intolerance of TWO of the following preferred antiarrhythmic agents: (Note:   Requirement is waived if patient has structural heart disease) o amiodarone o flecainide o propafenone o sotalol |  |
| Sotylize® | NP | • Patient is unable to swallow tablets and capsules  **Note**: PA is not required for patients 8 years of age and younger |  |
| Tikosyn® | NP |  | 2/day |
|  | **Anticoagulants, Injectable** | |  |  |
| enoxaparin | P |  | 2 injections/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| fondaparinux | P |  | 1 injection/day |
| Arixtra® | NP |  | 1 injection/day |
| Lovenox® | NP |  | 2 syringes/day |
|  | **Anticoagulants, Oral** | |  |  |
| Eliquis® | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Pradaxa® caps | P |  | 2/day |
| Xarelto® | P |  | 2.5 & 15 mg: 2/day  10 & 20 mg: 1/day; |
| dabigatran | NP | • Clinically valid reason why the preferred Pradaxa cannot be used | 2/day |
| Pradaxa® packs | NP | * Patient is unable to swallow sold dosage forms; **OR** * Clinically valid reason why the patient cannot use Pradaxa oral pellets | 2/day |  |
| Savaysa® | NP | * One of the following:   o Diagnosis of non-valvular atrial fibrillation; **AND**  ­ Documentation that CrCl NOT ≥ 95 mL/min as calculated by Cockcroft-Gault equation o Diagnosis of deep vein thrombosis or pulmonary embolism; **AND**   * Trial and failure, intolerance, or contraindication to Xarelto® and Pradaxa® | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Xarelto® suspension | NP | • Patient is unable to swallow solid dosage forms |  |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antihypertensives, Miscellaneous** | |  |  |
| clonidine weekly patch | P |  | 0.1, 0.2 mg: 4/28 days;  0.3 mg:  pt ≤21: 4/28 days pt >21: 8/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| clonidine 24hr ER | NP |  | 1/day |
| minoxidil | NP | * Diagnosis of severe hypertension (symptomatic or associated with target organ damage only); **AND** * Trial and failure, contraindication, or intolerance to TWO of the following:   + ACEI or ARBs o Beta-blocker   + Calcium channel blocker~~s~~ o Methyldopa o Clonidine; **AND** * Patient is concomitantly taking a diuretic (e.g., hydrochlorothiazide, chlorthalidone, furosemide, etc.); **AND** * Patient does not have diagnosis of pheochromocytoma (minoxidil may stimulate secretions of catecholamines from the tumor)   **Note**: Minoxidil will not be approved for alopecia |  |
| Vecamyl® | NP | * Diagnosis of Essential Hypertension or Malignant Hypertension, **AND** * Trial and failure, contraindication, or intolerance to **ALL** the following:   + ACE inhibitororARB o Beta blocker   + Calcium Channel Blocker o Clonidine o Hydralazine; **AND** * Patient is concomitantly taking a diuretic (e.g., hydrochlorothiazide, chlorthalidone, furosemide) | 10/day |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Beta Blockers** | |  |  |
| metoprolol succinate ER | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Hemangeol® | NP | * Diagnosis of Infantile Hemangioma; **AND** * Clinically valid reason why the preferred propranolol solution cannot be used |  |
| InnoPran XL® | NP |  | 80 mg: 2/day; 120 mg: 1/day |
| Kapspargo Sprinkle® | NP | * Diagnosis of ONE of the following:    + Heart Failure or LVEF ≤ 40%   + Hypertensiono Angina Pectoris; **AND** * Patient is unable to swallow tablets and capsules | 1/day |
| Toprol XL® | NP | • Diagnosis of one of the following: o Heart Failure or LVEF ≤ 40% o Paroxysmal Atrial Fibrillation | 1/day |
|  | **Calcium Channel Blockers (DHP)** | |  |  |
| amlodipine | P |  | 2.5 & 5 mg (1.5/day); 10 mg (1/day) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| nifedipine ER/SA/XL | P |  | 1/day |
| Norliqva® | P | * Diagnosis of one of the following:   + Hypertension   + Chronic stable angina or treatment   + Vasospastic Angina (Prinzmetal’s or Variant Angina) o Confirmed or suspected vasospastic angina o Angiographically documented Coronary Artery Disease in patients without heart failure and an ejection fraction ≥ 40%; **AND** * One of the following:   + Patient is unable to swallow solid dosage forms; **OR**   + Clinically valid reason why nimodipine capsules cannot be used | 10 mL/day |
| isradipine | NP |  | 2.5 mg (2/day); 5 mg (4/day) |
| Katerzia® | NP | See Norliqva prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to Norliqva® | 10 mL/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| nimodipine | NP | • Diagnosis of subarachnoid hemorrhage (SAH) |  |
| nisoldipine | NP |  | 1/day |
| Norvasc® | NP |  | See amlodipine |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nymalize® | NP | * Diagnosis of Subarachnoid Hemorrhage; **AND** * One of the following:   + Patient is unable to swallow solid dosage forms   + Clinically valid reason why nimodipine capsules cannot be used | 120 mL/day |  |
| Procardia® XL | NP |  | 1/day |
| Sular® | NP |  | 1/day |
|  | **Calcium Channel Blockers (Non-DHP)** | |  |  |
| verapamil ER/SR | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cardizem LA® | NP |  | 1/day |
| diltiazem ER caps | NP |  | 1/day |
|  | **Cardiac Agents, Miscellaneous** | |  |  |
| ranolazine ER | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| ivabradine | P | * Diagnosis of Congestive Heart Failure (NYHA class II to IV) and documentation of the following:   + Left ventricular ejection fraction ≤ 35%; **AND** o In sinus rhythm with resting heart rate ≥ 70 beats per minute; **AND** o One of the following:   ­ Currently taking a maximum tolerated dose of a beta-blocker and still experiencing heart failure symptoms; **OR**  ­ Patient has a contraindication, adverse reaction, or drug-drug interaction to a beta-blocker; **OR**   * Diagnosis of Congestive Heart Failure (NYHA class II to IV) due to dilated cardiomyopathy (DCM); **AND** o Left ventricular ejection fraction ≤ 45%; **AND**   + Patient is in sinus rhythm with elevated heart rate; **AND** * Will **NOT** be approved for patients with any of the following:   + Concomitant use of potent CYP3A inhibitors or inducers o Acute decompensated heart failure   + Clinically significant hypotension or bradycardia   + Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present o Severe hepatic impairment   + Pacemaker dependence (heart rate maintained exclusively by the pacemaker) | 2/day |
| Aspruzyo Sprinkle® | NP | * Diagnosis of chronic angina; **AND** * Failure to achieve an adequate response, or intolerance to, at least ONE agent from TWO of the following classes:   + Beta-blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)   + Long-acting nitrate (e.g., nitroglycerin, isosorbide dinitrate, isosorbide mononitrate) o Non-DHP calcium channel blocker (e.g., diltiazem, verapamil); **AND** • Patient is unable to swallow solid dosage form | 2/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Camzyos® | NP | **Initial Criteria:**   * Diagnosis of obstructive hypertrophic cardiomyopathy (HCM); **AND** * Left ventricular hypertrophy (LVH) confirmed by cardiac imaging (i.e., echocardiography, cardiac MRI); **AND** * Heart failure is classified New York Heart Association (NYHA) class II or III Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain); **AND** * Patient has left ventricular outflow tract (LVOT) peak gradient > 50 mmHg at rest or with provocation; **AND** * Patient has a left ventricular ejection fraction > 55% (for initiation of therapy); **AND** * Prescribed by or in consultation with a cardiologist; **AND** * Trial and failure, contraindication, or intolerance to TWO of the following at a maximally tolerated dose:   o Non-vasodilating beta blocker (e.g., bisoprolol, propranolol) o Calcium channel blocker (e.g., verapamil, diltiazem) o Disopyramide **Renewal Criteria:**   * Documentation of positive clinical response to therapy (e.g., NHYA class remains stable or improves improved symptom relief, improvement of LVOT gradient); **AND** * Patient has a left ventricular ejection fraction > 50%; **AND** * Prescribed by, or in consultation with, a cardiologist | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Corlanor® | NP | See ivabradine prior authorization criteria; **AND**  • Clinically valid reason why ivabradine cannot be used | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ranexa® | NP | * Diagnosis of chronic angina; **AND** * Failure to achieve an adequate response, or intolerance to, at least ONE agent from TWO of the following classes:   + Beta-blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)   + Long-acting nitrate (e.g., nitroglycerin, isosorbide dinitrate, isosorbide mononitrate) o Non-DHP calcium channel blocker (e.g., diltiazem, verapamil); **AND** * Clinically valid reason why the patient cannot use generic ranolazine ER | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tryvio® | NP | **Initial Criteria: (6-month duration)**   * Diagnosis of resistant hypertension; **AND** * Patient is 18 years of age or older; **AND** * Submission of medical records (e.g. chart notes) documenting patient has not achieved target blood pressure (e.g. systolic <130/80) following concurrent maximumly toleratedtreatment with at least THREE of the following antihypertensive classesunless contraindicated or intolerance:   + ACE inhibitors or Angiotensin II receptor blockers (ARBs) o Beta blockers o Calcium channel blockers   + Mineralocorticoid Receptor Antagonists o Thiazide diuretics; **AND** * Tryvio will be used in combination with at least one other hypertensive drug   **Renewal Criteria**   * Submission of medical records (e.g. chart notes) documenting a positive clinical response to therapy (e.g. decrease of systolic blood pressure from baseline); **AND** * Patient is receiving concomitant therapy with other hypertensive drugs (documented by claims or medical records) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Verquvo® | NP | * Diagnosis of symptomatic chronic heart failure (NYHA class II-IV) with reduced ejection fraction (≤45%); **AND** * Prescribed by, or in consultation with, a cardiologist (initial approval only); **AND** * Patient has had a heart failure hospitalization in the last 6-months **OR** has received outpatient IV diuretics for heart failure in the last 3 months; **AND** * Patient is 18 years of age or older; **AND** * Patient is currently being treated with an ACEI, ARB, or Entresto; **AND** * Patient is currently being treated with a beta blocker; **AND** * Patient is not pregnant or breastfeeding; **AND** * Female patients of reproductive potential will be counseled to use effective contraception during treatment with therapy and for at least one month after the last dose; **AND** * Patient does not meet any of the following:   o Concomitant use with another soluble guanylate cyclase (sGC) stimulator (e.g., Adempas) o Concomitant use with a PDE-5 inhibitor (e.g., tadalafil, sildenafil) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Direct Renin Inhibitors** | |  |  |
| aliskiren | NP | Patient has a diagnosis of hypertension; **AND**  Trial and failure, contraindication, or intolerance to an agent from at least TWO of the following drug classes:  ACEI/ARB  Calcium channel blocker  Thiazide diuretic | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Tekturna® | NP | See aliskiren prior authorization criteria | 1/day |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tekturna HCT® | NP | * Trial and failure, contraindication, or intolerance to an agent from at least TWO of the following drug classes: * ACEI/ARB * Calcium channel blocker * Thiazide diuretic * Patient is unable to take the individual components | 1/day |  |
|  | **Diuretics: Carbonic Anhydrase** | |  |  |
| dichlorphenamide | NP | See Keveyis criteria**; AND** • Trial and failure of Keveyis® | 2/day |  |
| Keveyis® | NP | **Initial Criteria: (2-month duration)**   * Diagnosis of Primary Hypokalemic/Hyperkalemic Periodic Paralysis, and related variants; **AND** * Patient does not have any of the following:   + Hepatic insufficiency o Severe pulmonary disease   + Hypersensitivity to dichlorphenamide or other sulfonamides * Avoid concomitant use with high dose aspirin **Renewal Criteria:** * Clinical documentation that patient has exhibited a reduction in symptoms or attacks; **AND** * Patient’s serum potassium and bicarbonate levels are being monitored | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Diuretics: Loop** | |  |  |
| Furoscix® | NP | * Diagnosis of chronic heart failure; **AND** * Patient has signs and symptoms of congestive heart failure due to fluid overload; **AND** * The patient is currently receiving maximal oral diuretic therapy; **AND** * Prescriber attests that additional oral diuretic therapy would be ineffective; **AND** * Prescribed by, or in verbal consultation with, a cardiologist; **AND** * Prescriber has demonstrated appropriate administration use of the On-Body Infusor® | 4 devices/month |  |
|  | **Diuretics: Potassium Sparing** | |  |  |
| CaroSpir® | NP | * One of the following:   o Diagnosis of hypertension o Diagnosis of heart failure o Diagnosis of edema associated with hepatic cirrhosis; **AND**   * Patient is unable to swallow solid dosage forms   **Note:** PA not required for patients < 6 years of age | 15 mL/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| eplerenone | NP | * One of the following:   + Patient has a diagnosis of hypertensiono Patient has a diagnosis of congestive heart failure   + Patient has a diagnosis of Duchenne muscular dystrophy (DMD); **AND** * Trial and failure, contraindication, or intolerance of spironolactone |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Inspra® | NP | See eplerenone prior authorization criteria |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Kerendia® | NP | * Patient is > 18 years of age; **AND** * Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D); **AND** * Currently taking the maximum tolerated dose of an ACE inhibitor or ARB, unless contraindicated or intolerant; **AND** * Currently taking an antidiabetic agent (e.g., insulin, metformin, GLP-1 receptor agonist, SGLT2 inhibitor) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| spironolactone susp | NP | * One of the following:   o Diagnosis of hypertension o Diagnosis of heart failure o Diagnosis of edema associated with hepatic cirrhosis; **AND**   * Patient is unable to swallow solid dosage forms; **AND** • Trial and failure of Carospir® |  |  |
|  |  | **Diuretics: Thiazide and Related** |  |  |
| Diuril® | NP | • Patient is unable to swallow solid dosage forms |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **Hemostatics, Oral** |  |  |
| tranexamic acid | P | * Diagnosis of acute uterine or cyclic heavy menstrual bleeding; **AND** o Trial and failure, contraindication, or intolerance to ALL the following:   ­ Two other forms of hormone therapy (oral, vaginal, topical, or injectable estrogen and/or progesterone) ­ Levonorgestrel-releasing IUD; **OR**   * All other diagnoses require trial and failure, intolerance, or contraindication to aminocaproic acid. |  |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Lipotropics: Antihyperlipidemic Agents** | |  |  |
| Praluent® | P | **Cardiovascular disease (CVD) Prevention Initial Criteria (6-month duration):**   * Treatment is for the prevention of cardiovascular disease; **AND** * Patient age ≥ 18 years; **AND** * Patient has history of ONE of the following:   + MI, unstable angina, or symptomatic peripheral artery disease o Stroke   + Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia (HeFH)) o Baseline LDL-C ≥ 190; **AND** * Documentedcurrent LDL-C value (within 3 months); **AND** • Patient specific target LDL-C value is provided; **AND** * One of the following:   + Failure to reach patient specific LDL target despite a > 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance: ­ High-intensity statin (atorvastatin/rosuvastatin)   ­ Ezetimibe; **OR** o Patient requires > 25% additional LDL-C lowering to meet LDL target after a > 3-month trial (supported by claims history or clinical documentation) of therapy with a high-intensity statin, unless contraindicated or intolerance; **AND**   * Agent will be used in combination with other lipid lowering therapies, unless documented intolerance **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target) **Heterozygous familial hypercholesterolemia (HeFH) or homozygous familial hypercholesterolemia (HoFH) Initial Criteria (6-month duration):** * Diagnosis of HeFH or HoFH confirmed by one of the following:   + Presence of a mutation in LDL receptor, ApoB, PCSK9 gene   + Clinical criteria using either the Simon Broome or WHO/Dutch Lipid Network criteria; **AND** * Patient age is appropriate according to package labeling (i.e., Praluent is indicated for age >8 years, Repatha is indicated for age >10 years); **AND** * One of the following:   + Failure to reach patient specific LDL target despite a > 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance: ­ High-intensity statin (atorvastatin/rosuvastatin)   ­ Ezetimibe; **OR** o Patient requires > 25% additional LDL-C lowering to meet LDL target after a > 3-month trial (supported by claims history or clinical documentation) of therapy with a high-intensity statin, unless contraindicated or intolerance; **AND**   * Agent will be used in combination with other lipid lowering therapies, unless documented intolerance **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target) | 2 pens /28 days | [PCSK9](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/PCSK9%20PA%20Form.pdf)  [Inhibitors](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/PCSK9%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/PCSK9%20PA%20Form.pdf) |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Repatha® | P | • See Praluent® prior authorization criteria | Repatha: 2/28 days  Repatha Pushtronex: 1/28 days | [PCSK9](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/PCSK9%20PA%20Form.pdf)  [Inhibitors](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/PCSK9%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/PCSK9%20PA%20Form.pdf) |
| Juxtapid® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by one of the following: o Presence of a mutation in LDL receptor, ApoB, PCSK9 gene   + Clinical criteria using either the Simon Broome or WHO/Dutch Lipid Network criteria; **AND** * Patient age is appropriate according to package labeling (i.e., Praluent is indicated for age >18 years, Repatha is indicated for age >10 years; **AND** * Documentedcurrent LDL-C value (within 3 months); **AND** * Patient specific target LDL-C value is provided; **AND** * Failure to reach patient specific LDL target despite a > 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:   + High-intensity statin (atorvastatin/rosuvastatin) o Ezetimibe; **AND** * Trial and failure, contraindication, or intolerance to Repatha; **AND** * Agent will be used in combination with other lipid lowering therapies, unless documented intolerance; **AND** * If female, documentation patient is not currently pregnant; **AND** * Patient is not concomitantly taking strong or moderate inhibitors of cytochrome P450 (CYP) 3A4 **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target) | 5 mg, 10mg: 1/day 20mg: 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nexletol® | NP | **Primary Prevention of Cardiovascular Disease Initial Criteria (6-month duration):**   * Age ≥ 18 years; **AND** * Agent is being use for primary prevention of cardiovascular disease; **AND** * Documented current LDL-C value (within 3 months); **AND** * Patient specific target LDL-C value is provided; **AND** * Failure to reach patient specific LDL target despite a > 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:   o High-intensity statin (atorvastatin/rosuvastatin) o Ezetimibe  **Renewal criteria:**   * Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target)   **All Other Indications**  **Initial Criteria (6-month duration):**   * Age ≥ 18 years; **AND** * Diagnosis of ONE of the following:   + Primary hyperlipidemia o Atherosclerotic cardiovascular disease (ASCVD) o Heterozygous familial hypercholesterolemia (HeFH)) confirmed by one of the following:   ­ Presence of a mutation in LDLR, ApoB, PCSK9 or ARH adaptor protein (LDLRAP1) gene  ­ Clinical criteria is met using either the Simon Broome or WHO/Dutch Lipid Network criteria; **AND**   * Documented current LDL-C value (within 3 months); **AND** * Patient specific target LDL-C value is provided; **AND** * Failure to reach patient specific LDL target despite a > 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:   + High-intensity statin (atorvastatin/rosuvastatin) o Ezetimibe; **AND** * Trial and failure, contraindication, or intolerance to Repatha; **AND** * Agent will be used in combination with other lipid lowering therapies, unless documented intolerance  **Renewal criteria:** * Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Nexlizet® | NP | • See Nexeltol® prior authorization criteria | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Lipotropics: Bile Acid Sequestrant** | |  |  |
| colesevelam packets | NP | • Patient is unable to swallow solid dosage forms |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Welchol® packets | NP | • Patient is unable to swallow solid dosage forms |  |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Lipotropics: Cholesterol Absorption Inhibitors** | |  |  |
| Zetia® | NP | * One of the following: * Patient is currently taking a high-intensity statin and has experienced less than anticipated therapeutic response * Patient is unable to tolerate lower doses of high-intensity therapy * Use in combination with a bile acid sequestrant, fibrate, or niacin will be approved. * For requests as monotherapy, recipients must have been intolerant to, or have a contraindication to, a statin | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Lipotropics: Combination Agents** | |  |  |
| ezetimibe/ simvastatin | NP | * For patients that require ≤45% LDL reduction: 4-week trial and failure of both atorvastatin and simvastatin; **OR** * For patients that require >45% LDL reduction: 4-week trial and failure of atorvastatin | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Roszet® | NP | * One of the following:   o For patients that require ≤45% LDL reduction: 4-week trial and failure of both atorvastatin and rosuvastatin o For patients that require >45% LDL reduction: 4-week trial and failure of atorvastatin; **AND**   * Clinically valid reason as to why the patient is unable to take components individually | 1/day |
| Vytorin® | NP | See ezetimibe/simvastatin prior authorization criteria | 1/day |
|  | **Lipotropics: Fibric Acid Derivatives** | |  |  |
| fenofibrate caps | NP | * Patient will take fenofibrate concomitantly with a sulfonylurea, thiazolidinedione, repaglinide, or a statin; **OR** * Clinically valid reason why a preferred agent cannot be used (e.g., gemfibrozil, fenofibrate tabs 48, 145, & 160 mg) |  |  |
| fenofibrate tabs 40, 54, & 120 mg | NP | See fenofibrate caps prior authorization criteria |  |
| fenofibric acid | NP | See fenofibrate caps prior authorization criteria |  |
| Fenoglide® | NP | See fenofibrate caps prior authorization criteria |  |
| Fibricor® | NP | See fenofibrate caps prior authorization criteria |  |
| Lipofen® | NP | See fenofibrate caps prior authorization criteria |  |
| Lofibra® | NP | See fenofibrate caps prior authorization criteria |  |
| TriCor® | NP | See fenofibrate caps prior authorization criteria |  |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Lipotropics: Niacin Derivatives** | |  |  |
| niacin ER | P | One of the following:   * Triglycerides > 500 mg/dL; **AND** o Trial and failure. contraindication, or intolerance to BOTH gemfibrozil and fenofibrate; **OR** * Diagnosis of hyperlipidemia; **AND** o Use in combination with a statin will be approved if the dose of the statin tried is considered sufficient to achieve   ≥35% LDL reduction; **OR** o For requests as monotherapy, recipients must have been intolerant to, or have a contraindication to a statin |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Niacor® | NP | See niacin ER prior authorization criteria |  |
|  | **Lipotropics: Omega-3 Fatty Acids** | |  |  |
| omega-3 acid ethyl esters | P | **Initial Criteria:**   * Diagnosis of Severe Hypertriglyceridemia (TG level is above 500 mg/dl) **Renewal Criteria:** * Documentation of positive clinical response (e.g., reduction in TG from baseline) | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| icosapent ethyl | NP | **Initial Criteria:**   * Diagnosis of Severe Hypertriglyceridemia (TG level is above 500 mg/dl); **OR** * Patient is on maximally tolerated statin AND has triglyceride levels > 135 **Renewal Criteria:** * Documentation of positive clinical response (e.g., reduction in TG from baseline) | 0.5 g: 2/day 1 g: 4/day |
| Lovaza® | NP | **Initial Criteria:**   * Diagnosis of Severe Hypertriglyceridemia (TG level is above 500 mg/dl); **AND** * Trial and failure, contraindication, or intolerance to preferred omega-3 acid ethyl esters **Renewal Criteria:** * Documentation of positive clinical response (e.g., reduction in TG from baseline) | 4/day |  |
|  | **Lipotropics: Low and Moderate Intensity Statins** | |  |  |
| atorvastatin | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| lovastatin | P |  | 1/day |
| pravastatin | P |  | 1/day |
| simvastatin 5, 10, 20, & 40 mg | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Altoprev® | NP |  | 1/day |
| Atorvaliq® | NP | • Patient is unable to swallow solid dosage forms | 80 mg/day |
| Ezallor Sprinkles® | NP | • Patient is unable to swallow solid dosage forms | 1/day |
| Flolipid® | NP | * Patient is 10 to 17 years of age; **AND** * Patient is unable to swallow solid dosage forms | 40 mg/day |
| fluvastatin | NP |  | 1/day |
| fluvastatin ER | NP |  | 1/day |

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|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Lescol XL® | NP |  | 1/day |  |
| Livalo® | NP |  | 1/day |
| pitavastatin | NP |  | 1/day |
| Zocor® | NP |  | 1/day |
| Zypitamag® | NP |  | 1/day |
|  | **Lipotropics: High Intensity Statins** | |  |  |
| atorvastatin | P |  | 1/day | [High](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/High%20Potency%20Statin%20PA%20Form.pdf)  [Potency](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/High%20Potency%20Statin%20PA%20Form.pdf)  [Statin PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/High%20Potency%20Statin%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/High%20Potency%20Statin%20PA%20Form.pdf) |
| rosuvastatin | P |  | 1/day |
| simvastatin 80 mg | P | • Patient has previously received simvastatin 80 mg for 12 months or longer with no evidence of myopathy | 1/day |
| Crestor® | NP |  | 1/day |
| Ezallor Sprinkles® | NP | • Patient is unable to swallow solid dosage forms | 1/day |
| Lipitor® | NP |  | 1/day |
|  | **Lipotropics: Statin + Calcium Channel Blocker** | |  |  |
| amlodipine/ atorvastatin | NP | • Patient is unable to take the 2 components separately | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Caduet® | NP | • Patient is unable to take the 2 components separately | 1/day |
|  | **Pheochromocytoma Agents** | |  |  |
| Demser® | NP | * Documentation of pheochromocytoma diagnosis; **AND** * Trial and failure of an alpha and beta blocker |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| dibenzyline | NP | • Diagnosis of pheochromocytoma diagnosis | 4/day |
| metyrosine | NP | See Demser prior authorization criteria |  |
| phenoxybenzamine | NP | See dibenzyline prior authorization criteria | 4/day |
|  | **Platelet Inhibitors** | |  |  |
| Brilinta® | P | * History of Myocardial Infarction (MI); **OR** * ACS initial event (USA, NSTEMI or STEMI) or recurrence within previous 12 months; **OR** * Patient has diagnosis of coronary artery disease (CAD) and is at high risk for myocardial infarction (MI) or stroke, **OR** * Acute ischemic stroke or transient ischemic attack (TIA) risk reduction   **Note**: Will NOT be approved if patient is receiving aspirin doses > 100mg/day (includes Rx [& OTC a](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/Covered%20OTC%20List.pdf)spirin containing products) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| prasugrel | P | * Patients has unstable angina, NSTEMI, or STEMI; **AND** * PCI will be performed, or PCI is planned; **AND** * Age < 75 years; **AND** * Weight ≥ 60 kg; **AND** * No history of stroke or TIA |  |

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| **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Cablivi® | NP | **Criteria: (2-month duration)**   * Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP); **AND** * Used in combination with both of the following:   o Plasma exchange until at least 2 days after normalization of the platelet count o Immunosuppressive therapy (e.g., corticosteroids); **AND**   * Date Cablivi IV was initiated/administered by a healthcare provider; **AND** * Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange; **AND** * The patient has not experienced more than two recurrences of aTTP while on Cablivi   **Note**: If started as an inpatient hospital regimen and this is continuation of therapy, Cablivi® will be approved |  |  |
| Durlaza® | NP | * Trial and failure, contraindication, or intolerance to 2 preferred platelet inhibitors with the same indication; **AND** * Clinically valid reason why OTC aspirin cannot be used | 1/day |
| Effient® | NP | * Patients has unstable angina, NSTEMI, or STEMI; **AND** * PCI has been performed, or PCI is planned; **AND** * Age < 75 years; **AND** * Weight ≥ 60 kg; **AND** * No history of stroke or TIA; **AND** * Trial and failure of prasugrel |  |
| Yosprala® | NP | * Diagnosis of one of the following: o Ischemic stroke,   + Transient ischemia of the brain, o Previous myocardial infarction, o Unstable angina pectoris, o Chronic stable angina pectoris; **OR** * Patient has had **ONE** of the following:   + Coronary Artery Bypass Graft (CABG) o Percutaneous Transluminal Coronary Angioplasty (PTCA); **AND** * Patient meets **ALL** the following:   + Patient is considered a high-risk candidate for aspirin-associated gastric ulcers due to **ONE** of the following:   ­ Age ≥ 55, OR  ­ Documented history of gastric ulcers; **AND** o Patient had an inadequate treatment response, or intolerance to use of aspirin and omeprazole separately | 1/day |
| **Pulmonary Arterial Hypertension (PAH) Agents** | | | | |
| Alyq® | P | * Diagnosis of Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension (PPH); **OR** * Diagnosis of Congenital heart disease with elevated pulmonary vascular resistance | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| ambrisentan | P | See Alyq® prior authorization criteria | 1/day |
| bosentan | P | See Alyq® prior authorization criteria | 2/day |
| sildenafil | P | See Alyq® prior authorization criteria | 3/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| tadalafil | P | See Alyq® prior authorization criteria | 2/day |  |
| Tyvaso® | P | * Diagnosis of pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension (PPH); **OR** * Diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) to improve exercise ability; **OR** * Diagnosis of congenital heart disease with elevated pulmonary vascular resistance | 2.9 mL/day |
| Ventavis® | P | See Alyq® prior authorization criteria | 3 mL/day |
| Adcirca® | NP | * Diagnosis of one of the following:   o Pulmonary arterial hypertension (PAH)/elevated pulmonary vascular resistance or primary pulmonary hypertension o Congenital heart disease with elevated pulmonary vascular resistance; **AND**   * Clinically valid reason why the preferred generic cannot be used | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Adempas® | NP | • One of the following:  o Diagnosis of pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension (PPH); **AND**  ­ Trial of ONE preferred agent with persistent signs or symptoms o Diagnosis of congenital heart disease with elevated pulmonary vascular resistance; **AND**  ­ Trial of ONE preferred agent with persistent signs or symptoms o Diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) with one of the following: ­ Patient has disease that is inoperable; **OR**  ­ Patient has residual post-pulmonary endarterectomy hypertension  **Note**: Use of Adempas® is contraindicated in patients also taking PDE-5 inhibitors | 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Letairis® | NP | See Adcirca® prior authorization criteria | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Liqrev® | NP | * Diagnosis of one of the following:   + Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension o Congenital heart disease with elevated pulmonary vascular resistance; **AND** * One of the following:   + Patient is unable to swallow tablets o Patient is < 6 years of age   + Clinically valid reason why a preferred tablet formulation cannot be used | 240mg/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Opsumit® | NP | * Diagnosis of one of the following:   o Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension o Congenital heart disease with elevated pulmonary vascular resistance; **AND**   * Trial of one preferred agent with persistent signs or symptoms | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Opsynvi® | NP | * Diagnosis of Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension; **AND** * Clinically valid reason as to why the patient is unable to take components of Opsynvi individually | 1/day |
| Orenitram® | NP | See Opsumit® prior authorization criteria | 3/day |
| Revatio® tab | NP | See Adcirca® prior authorization criteria | 3/day |

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| **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Revatio® suspension | NP | See Liqrev® prior authorization criteria | 6 ml/day;  Max day supply=60 |  |
| sildenafil suspension | NP | See Liqrev® prior authorization criteria | 6 ml/day;  Max day supply=60 |
| Tadliq® | NP | See Liqrev® prior authorization criteria | 10mL/day |
| Tracleer® soluble tabs | NP | * Diagnosis of one of the following:   o Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension  (PPH) o Diagnosis of congenital heart disease with elevated pulmonary vascular resistance; **AND**   * Patient is unable to swallow solid dosage forms | 2.9 mL/day |
| Tracleer® tabs | NP | See Adcirca® prior authorization criteria | 2/day |
| Tyvaso DPI® | NP | * Diagnosis of one of the following:   o Pulmonary arterial hypertension (PAH)/elevated pulmonary vascular resistance or primary pulmonary hypertension o Pulmonary hypertension associated with interstitial lung disease; **AND**   * Clinically valid reason why the preferred Tyvaso inhalation solution cannot be used | Single cartridges:  4/day; Combo cartridges: 8/day;  Kits: 2/year |
| Uptravi® | NP | See Opsumit® prior authorization criteria | Tabs: 2 /day; Pack: 1 /Rx |
| Winrevair® | NP | * Patient is 18 years of age or older; **AND** * Diagnosis of Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension; **AND** * Patient is Functional Class II or III; **AND** * Trial and failure of 1 agent with persistent signs and symptoms from TWO different classes for PAH such as:   o Endothelin receptor antagonist (e.g. ambrisentan, bosentan) o Phosphodiesterade-5 inhibitors (e.g. sildenafil, tadalafil) o Prostacyclin analogue or receptor agonist (e.g., treprostinil, epoprostenol, Uptravi, Ventavis); **AND** • Winrevair will be used in combination with other PAH therapies | 1 kit/21 days |
| **Pulmonary Fibrosis Agents** | | | | |
| Ofev® | P | * Diagnosis of one of the following:   o Idiopathic pulmonary fibrosis o Interstitial Lung Disease Associated with Systemic Sclerosis- associated interstitial lung disease (SSc-ILD) o Chronic Fibrosing Interstitial Lunch Diseases (ILDs) with a progressive phenotype (at least 10% of the lungs show presence of fibrotic ILD); **AND**   * Prescribed by, or in consultation with, a pulmonologist (initial approval only) | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| pirfenidone tablets | P | * Patient has a diagnosis of idiopathic pulmonary fibrosis; **AND** * Prescribed by, or in consultation with, a pulmonologist (initial approval only) | 534, 801 mg: 3/day; 267 mg: 9/day |
| Esbriet® | NP | * Patient has a diagnosis of idiopathic pulmonary fibrosis; **AND** * Prescribed by, or in consultation with, a pulmonologist (initial approval only); **AND** * Clinically valid reason as to why the preferred pirfenidone cannot be used | 3/day: 801 mg: 3/day 9/day: 267 mg |

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| **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| pirfenidone capsules | NP | See Esbriet prior authorization criteria | 9/day: 267 mg |  |
| **Thrombopoietin Agonists, Orals** | | | | |
| Promacta® tabs | NP | * Diagnosis of persistent or chronic thrombocytopenia purpura (ITP) in patients ≥1 year of age; **AND** o Documentation of failure or insufficient response to adequate treatment with corticosteroids AND immunoglobulins,   OR ITP related splenectomy; **AND** o Documentation that patient's thrombocytopenia and clinical condition puts the patient at increased risk of bleeding; **OR**   * Diagnosis of thrombocytopenia in patient with chronic hepatitis C; **AND** o Patient receiving (or planning to initiate) interferon-based anti-viral therapy; **OR** * Diagnosis of severe aplastic anemia in patients 2 years of age or older; **AND** o Patient will use in combination with standard immunosuppressive therapy for first-line treatment; **OR** * Diagnosis of severe aplastic anemia; **AND** * Patient has tried and failed or has intolerance to immunosuppressive therapy | 1/day |  |
| Doptelet® | NP | * Patient is ≥ 18 years old; **AND** * Patient must have a diagnosis of thrombocytopenia and meet one of the following:   o Chronic liver disease AND scheduled to undergo a medical procedure; **AND**  ­ Patient is scheduled to take the requested agent 10 to 13 days prior to the procedure, with the procedure occurring 5 to 8 days following the last dose of Doptelet®; **OR**  ­ Prescribed dose is according to baseline platelet count (10 tabs per 5 days ≥ 40 x 109/L or 15 tabs per 5 days for platelets < 40 x 109/L)  ­ **PA Duration: single course of treatment per scheduled procedure, QL=15 per treatment** o Chronic Immune Thrombocytopenia (ITP); **AND**  ­ Patient has had an insufficient response to a previous treatment; **AND**  ­ Patient has a platelet count of < 50 x 109/L  ­ **PA Duration: 1 year, QL= 2/day** | See criteria | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Mulpleta® | NP | **Criteria**: (PA duration – single course of treatment per scheduled procedure):   * Patient is ≥ 18 years old; **AND** * Patient has a diagnosis of Chronic Liver Disease (CLD); **AND** * Patient does NOT have Child-Pugh class C liver disease, absence of hepatopetal blood flow, a prothrombotic condition other than CLD nor a history of splenectomy, partial splenic embolization, or thrombosis; **AND** * Patient has a platelet count of < 50 x 109/L; **AND** * Patient has an upcoming invasive procedure scheduled; **AND** * Patient is scheduled to take the requested agent 8 to 14 days prior to the procedure, with the procedure occurring 2 to 8 days following the last dose of Mulpleta®; **AND** * Patient is NOT scheduled for a thoracotomy, laparotomy, open-heart surgery, craniotomy, or organ resection. | 7 tabs/Rx |
| Promacta® suspension | NP | See Promacta® prior authorization criteria  • Patient is unable to swallow solid dosage forms | 4 packets/day |
|  | **CARDIOVASCULAR**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tavalisse® | NP | **Initial Criteria:**   * Patient has a diagnosis of chronic immune thrombocytopenia; **AND** * Trial and failure (platelet count ≥ 50 x 109/L not achieved) of ONE of the following:   + Corticosteroids   + Thrombopoietin receptor antagonists (e.g., Promacta) o Splenectomy   + Azathioprine (Azasan, Imuran), cyclosporine (Neoral, Sandimmune), cyclophosphamide (Cytoxan), mycophenolate mofetil (CellCept), danazol, or rituximab (Rituxan); **AND** * Patient is not on concomitant therapy with a strong CYP3A4 inducer; **AND** * Patient has received a baseline and will receive ongoing routine monitoring that includes:   + Neutropenia (measure ANC monthly) o Hepatotoxicity (measure LFTs monthly) o Hypertension (measure blood pressure every 2 weeks until stable dose established, then monthly) **Renewal Criteria:** * Patient has laboratory values documenting platelet response to therapy (platelet count ≥ 50 x 109/L; **AND** * Patient has not experienced severe adverse effect as a result of fostamatinib therapy | 2/day | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Vasopressors** | |  |  |
| droxidopa | NP | * Diagnosis of symptomatic neurogenic orthostatic hypotension secondary to primary autonomic failure, dopamine betahydroxylase deficiency, or non-diabetic autonomic neuropathy; **AND** * Trial and failure, contraindication, or intolerance to midodrine OR fludrocortisone | 100 & 200 mg: 3/day 300 mg: 6/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Northera® | NP | See droxidopa prior authorization criteria | 100 & 200 mg: 3/day 300 mg: 6/day |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Agents for Neuropathic Pain and Fibromyalgia**  **Note: The maximum daily dose limit for gabapentin, including all formulations and Brand products, is 3,600 mg.** | | |  |
| duloxetine 20,30, & 60 mg | P |  | 2/day | [SNRI PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Antidepressant%20SNRI%20PA%20Form.pdf) |
| gabapentin capsules | P |  | 100 mg: 6/day;  300 mg: 12/day;  400 mg: 9/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Horizant® | P | * Diagnosis of post-herpetic neuralgia; **OR** * Diagnosis of Restless Leg Syndrome | 1/day  Max daily gabapentin dose: 3600 mg |
| lidocaine 5% patch | P | • Diagnosis of post-herpetic neuralgia | 2/day |
| pregabalin capsules | P | * Diagnosis of neuropathic pain; **OR** * Diagnosis of postherpetic neuralgia; **OR** * Diagnosis of fibromyalgia; **OR** * Diagnosis of seizure disorder |  |
| pregabalin solution | P | See pregabalin capsules prior authorization criteria: **AND**   * Patient is less than 12 years of age; **OR** * Patient is unable to swallow solid oral dosage forms |  |  |
| Cymbalta® | NP |  | 2/day | [SNRI PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Antidepressant%20SNRI%20PA%20Form.pdf) |
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| duloxetine 40 mg | NP | • Clinically valid reason as to why the preferred duloxetine strengths (20 mg, 30 mg, 60 mg) cannot be used | 2/day |  |
| gabapentin solution | NP | • One of the following:  o Patient is less than 12 years of age; **OR** o Inability to swallow solid oral dosage forms | 72 mL/day | General PA Form |
| gabapentin tablets | NP | • Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT present in the tablets | 600 mg: 6/day;  800 mg: 4.5/day |
| Gralise® | NP | • Clinically valid reason why the preferred gabapentin agents cannot be used | 3/day |
| Lyrica® capsules |  | See pregabalin capsules prior authorization criteria; **AND** • Trial and failure of preferred pregabalin capsules |  |
| Lyrica® solution |  | See pregabalin solution prior authorization criteria; **AND** • Trial and failure of preferred pregabalin solution |  |
| Lyrica® CR | NP | * Diagnosis of postherpetic neuralgia OR neuropathic pain associated with‐diabetic peripheral neuropathy; **AND** * Trial and failure, contraindication, or intolerance to a tricyclic antidepressant OR gabapentin; **AND** * Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus immediate-release pregabalin | 82.5 mg & 165 mg:  1/day  330 mg: 2/day |
| Neurontin® capsules | NP |  | 100 mg: 6/day;  300 mg: 12/day;  400 mg: 9/day |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Neurontin® solution | NP | See gabapentin solution prior authorization criteria | 72 mL/day |  |
| Neurontin® tablets | NP |  | 600 mg: 6/day;  800 mg: 4.5/day |
| pregabalin CR | NP | See Lyrica® CR prior authorization criteria | 82.5 mg & 165 mg:  1/day  330 mg: 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Savella® | NP | * Patient has a diagnosis of fibromyalgia accompanied by fatigue; **AND** * Patient is 18 years of age or older; **AND** * Patient MUST have tried and failed, or have contraindication, or intolerance to duloxetine | 2/day |
|  | **Agents for Restless Leg Syndrome (RLS)** | | |  |
| pramipexole | P |  | 3/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Horizant® | P | * Diagnosis of Restless Leg Syndrome; **OR** * Diagnosis of post-herpetic neuralgia | 1/day  Max daily gabapentin dose: 3600 mg |
| Neupro® | NP | * Diagnosis of Parkinson’s Disease or Restless Leg Syndrome, **AND** * Trial and failure, contraindication, or intolerance to Horizant, pramipexole, and ropinirole, **OR** • Inability to swallow |  |
|  | **Alzheimer’s: Cholinesterase Inhibitors** | | |  |
| donepezil (excluding 23 mg) | P |  | 1/day | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| donepezil ODT | P | * Patient is unable to swallow; **OR** * Unable to absorb medications through the GI tract | 1/day |
| Exelon® | P |  | 1/day |
| Adlarity® | NP |  | 4 patch/month |
| Aricept® | NP |  | 1/day |
| Aricept® 23 mg | NP | • Patient has been established (at least 3 months) on therapy with Aricept 10mg daily | 1/day |
| Aricept® ODT | NP | * Patient is unable to swallow; **OR** * Unable to absorb medications through the GI tract | 1/day |
| donepezil 23 mg | NP | • Patient has been established (at least 3 months) on therapy with donepezil 10mg daily | 1/day |
| galantamine ER | NP |  | 1/day |
| rivastigmine patch | NP |  | 1/day |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Alzheimer’s: NMDA Receptor Agent** | | |  |
| memantine tablets | P |  | 5, 10 mg: 2/day;  Titration Pack: 1/Rx | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| memantine ER | NP | • Diagnosis of moderate to severe Alzheimer's disease | 1/day |
| memantine solution | NP | • Diagnosis of moderate to severe Alzheimer's disease | 10mL/day |
| Namzaric® | NP | * Diagnosis of moderate to severe dementia associated with Alzheimer’s disease; **AND** * Concomitantly taking donepezil and memantine (immediate release or extended release) [≥10mg/day on both agents]; **AND** * Clinical reason why recipient is unable to take the components individually | 1/day |
| Zunvey® | NP |  | 2/day |  |
|  | **Analeptics** | | |  |
| caffeine citrate soln | NP | **Criteria (2-month duration)**   * Diagnosis of apnea in premature infants (born between 28 and <33 weeks gestational age); **AND** * Patient is continuing therapy from an inpatient hospital stay (to facilitate transition to outpatient for completion of therapy); **AND** * Infant does not have renal impairment, hepatic impairment, or cardiovascular disease; **AND** * Prescriber must attest that they are aware of the risks of fatal necrotizing enterocolitis in premature infants and will monitor patient for efficacy and to avoid serious toxicity; **AND** * Prescribed by, or in consultation with a board-certified neonatologist |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Antiparkinson Agents: Adenosine Antagonists** | | |  |
| Nourianz® | NP | **Initial Criteria: (6-month duration)**   * Diagnosis of Parkinson's disease; **AND** o Patient is experiencing “off” episode; **AND** * Patient is 18 years of age or older; **AND** * Patient is currently being treated with a stable dosage of levodopa/carbidopa; **AND** * Prescriber advises women of childbearing potential to use contraception during treatment; **AND** * Prescriber agrees to monitor the following: o Patients with moderate hepatic impairment (Child-Pugh B) for adverse reactions o Exacerbation of pre-existing dyskinesia o Presence of hallucinations/psychotic behavior   o Presence of impulse control/compulsive behaviors; **AND**   * Trial and failure, intolerance, or contraindication to ONE agent in TWO different antiparkinson classes (e.g., Dopamine Agents, Decarboxylase Inhibitors, COMT Inhibitors, MAO-B inhibitors, NMDA Antagonists) **Renewal Criteria:** * Patient is currently being treated with levodopa/carbidopa; **AND** * Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of “off” episodes, increase   “on” time without troublesome dyskinesia) | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antiparkinson Agents: COMT Inhibitors** | |  |  |
| Ongentys® | NP | **Initial Criteria: (6-month duration)**   * Diagnosis of Parkinson’s disease; **AND** * Patient is experiencing “off” episodes; **AND** * Patient is currently being treated with a stable dose of carbidopa/levodopa; **AND** * Trial and failure, intolerance, or contraindication to ONE agent in TWO different antiparkinson classes (e.g., dopamine agents, decarboxylase inhibitors, COMT inhibitors, MAO-B inhibitors, NMDA antagonists); **AND** * Will not be taken concomitantly with a non-selective monoamine oxidase inhibitor (MAOI); **AND** * Patient does not have a history of pheochromocytoma, paraganglioma, or other catecholamine secreting neoplasms **Renewal Criteria:** * Patient is currently being treated with levodopa/carbidopa; **AND** * Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of “off” episodes, increase   “on” time without troublesome dyskinesia) | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Antiparkinson Agents: Dopamine Agents** | |  |  |
| pramipexole | P |  | 3/day |  |
| Apokyn® | NP | * Patient has a diagnosis of Parkinson's disease; **AND** * Patient is experiencing acute, intermittent treatment of “off” episodes; **AND** * Must be 18 years of age or older; **AND** * Patient is currently being treated with a carbidopa/levodopa agent; **AND** * Patient has had a trial and failure, contraindication, or intolerance of TWO of the following preferred adjunct drugs prescribed in combination with levodopa/carbidopa, each from different classes:   + MAO-B inhibitor: selegiline   + COMT inhibitor: entacapone, carbidopa/levodopa/entacapone, Stalevo o Dopamine agonist: pramipexole, ropinirole; **AND** * Patient must not meet any of the following:   + Patient is on concomitant 5HT3 antagonist o Patient is pregnant   + Patient has a sensitivity to sulfites |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| apomorphine  injection | NP | See prior authorization criteria for Apokyn® |  |
| Neupro® | NP | • Diagnosis of Parkinson’s Disease OR Restless Leg Syndrome, **AND**  o Trial and failure, contraindication, or intolerance to BOTH pramipexole AND ropinirole, **OR** • Inability to swallow |  |
| pramipexole ER | NP |  | 1/day |  |
|  | **Antiparkinson Agents: Levodopa Combinations** | |  |  |
| Dhivy® | NP | Clinically valid reason as to why all the preferred carbidopa/levodopa agents cannot be used |  |  |
| Inbrija® |  | **Initial Criteria: (6-month duration)** | 60 blisters/month | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | NP | * Diagnosis of Parkinson’s disease; **AND** * Experiencing “off” episodes; **AND** * Patient is currently being treated with a stable dose of carbidopa/levodopa; **AND** * Trial and failure, intolerance, or contraindication to ONE agent in TWO different antiparkinson classes (e.g., dopamine agents, decarboxylase inhibitors, COMT inhibitors, MAO-B inhibitors, NMDA antagonists); **AND** * Will not be taken concomitantly with a non-selective monoamine oxidase inhibitor (MAOI); **AND** • Patient does not have asthma, COPD, or other chronic lung disease **Renewal Criteria:** * Patient is currently being treated with levodopa/carbidopa; **AND** * Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of “off” episodes, increase   “on” time without troublesome dyskinesia) |  | [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Antiparkinson Agents: MAOI-Bs** | |  |  |
| Xadago® | NP |  | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Zelapar® | NP | * Inability to swallow solid dosage forms; **OR** * Clinically valid reason why the preferred selegiline formulation cannot be used |  |
|  | **Antiparkinson Agents: NMDA Antagonists** | |  |  |
| Gocovri® | NP | **Initial Criteria:**   * One of the following:   o Patient has a diagnosis of dyskinesia associated with Parkinson’s disease o Patient is experiencing “off” episodes; **AND**   * Patient must be on concomitant levodopa-based therapy; **AND** * Patient has tried/failed an adequate trial of or is intolerant to amantadine immediate release; **AND** * Patient does not have end-stage renal disease (creatinine clearance < 15 mL/min/1.73 m2) **Renewal Criteria:** * Patient is currently being treated with levodopa/carbidopa; **AND**   Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of “off” episodes, increase “on” time without troublesome dyskinesia) | 68.5 mg: 1/day; 137 mg: 2/day |  |
| Osmolex® ER tabs | NP | **Initial Criteria:**   * One of the following:   o Diagnosis of Parkinson’s disease o Treatment of drug-induced extrapyramidal reactions; **AND**   * Patient does not have end-stage renal disease (creatinine clearance below 15 mL/min/1.73 m2); **AND**  • Patient has had an adequate trial of or is intolerant to amantadine IR (capsules) **Renewal Criteria:** * Documentation of decreased Parkinson’s disease symptoms OR decreased extrapyramidal effects | 193 mg & 258 mg:  1/day;  129 mg: 2/day |  |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Anti-anxiety agents prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed bay a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers* * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| **Anti-Anxiety and Anti-Panic Agents** | | | | |
| alprazolam tabs | P | * Diagnosis of one of the following:   + Anxiety disorder o Panic disorder with or without agoraphobia; **AND** * Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, short-term psychodynamic psychotherapy, mindfulness-based therapy); **AND** * Trial and failure, contraindication, or intolerance to therapy with TWO of the following:   + SSRI (minimum trial duration of 4 weeks) o SNRI (minimum trial duration of 4 weeks) o Buspirone; **AND** * Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND** * Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use | 3/day | [Anti-anxiety PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| alprazolam ER tabs | P | See alprazolam tablets prior authorization criteria | 2/day |
| buspirone | P |  | 30 mg: 2/day;  All other strengths: 3/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| chlordiazepoxide | P | * Diagnosis of acute alcohol withdrawal syndrome; **OR** * Diagnosis of anxiety disorder; **AND** o Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**   o Trial and failure, contraindication, or intolerance to therapy with TWO of the following:  ­ SSRI (minimum trial duration of 4 weeks)  ­ SNRI (minimum trial duration of 4 weeks) ­ Buspirone; **AND**   * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND** * Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND** * Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use | 4/day | [Anti-anxiety PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| clonazepam | P | * Diagnosis of seizure disorder; **OR** * Diagnosis of panic disorder; **AND** o Trial and failure, contraindication, or intolerance to therapy with TWO of the following:   ­ SSRI (minimum trial duration of 4 weeks)  ­ SNRI (minimum trial duration of 4 weeks)  ­ Buspirone; **AND**   * Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse * Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use | 3/day |
| clorazepate | P | * Diagnosis of acute alcohol withdrawal syndrome; **OR** * Diagnosis of seizure disorder; **AND** o Must be used in conjunction with another anticonvulsant; **OR** * Diagnosis of anxiety disorder; **AND** o Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**   o Trial and failure, contraindication, or intolerance to therapy with TWO of the following:  ­ SSRI (minimum trial duration of 4 weeks)  ­ SNRI (minimum trial duration of 4 weeks)  ­ Buspirone; **AND**   * Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol/meprobamate, or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse (does not apply to diagnosis of acute alcohol withdrawal syndrome); **AND** * Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use | 3/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Anti-anxiety Agents *(continued)*** | | | | |
| diazepam tablets, solution, concentrate | P | * Diagnosis of acute alcohol withdrawal syndrome; **OR** * Diagnosis of seizure disorder; **AND**  o Must be used in conjunction with another anticonvulsant; **OR** * Diagnosis of muscle spasms; **AND** o Patient has tried and failed at least TWO preferred skeletal muscle relaxants; **OR** * Diagnosis of anxiety disorder; **AND** o Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**   o Trial and failure, contraindication, or intolerance to therapy with TWO of the following:  ­ SSRI (minimum trial duration of 4 weeks)  ­ SNRI (minimum trial duration of 4 weeks)  ­ Buspirone; **AND**   * Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse (does not apply to diagnosis of acute alcohol withdrawal syndrome); **AND** * Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use | tabs: 4/day  soln: 10 mL/day concentrate: 2 mL/day | [Anti-anxiety PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| lorazepam tablets and concentrate | P | * Patient is < 1 year of age and completing taper following inpatient hospital use for Neonatal Withdrawal symptoms; **OR** * Diagnosis of anxiety disorder; **AND** o Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**   o Trial and failure, contraindication, or intolerance to therapy with TWO of the following:  ­ SSRI (minimum trial duration of 4 weeks)  ­ SNRI (minimum trial duration of 4 weeks)  ­ Buspirone; **AND**   * Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND** * Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use | tabs: 3/day concentrate: 3 mL/day |
| Xanax® | P | See alprazolam tablets prior authorization criteria | 3/day |
| Xanax® XR | P | See alprazolam tablets prior authorization criteria | 2/day |
| alprazolam ODT | NP | See alprazolam prior authorization criteria; **AND**   * Patient is unable to swallow solid dosage forms or unable to absorb medications through the GI tract; **AND** * Trial and failure, contraindication, or intolerance to the BOTH preferred concentrate solutions | 3/day |
| alprazolam concentrate | NP | See alprazolam prior authorization criteria; **AND**   * Patient is unable to swallow solid dosage forms or unable to absorb medications through the GI tract; **AND** * Patient must have a trial and failure, contraindication, or intolerance to the BOTH preferred concentrate solutions | 6 mL/day | [Anti-anxiety PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Ativan® | NP | See lorazepam prior authorization criteria; **AND**  • Clinically valid reason as to why the preferred lorazepam tablets or concentrate cannot be used | 3/day |  |
| Loreev XR® | NP | See lorazepam prior authorization criteria; **AND**  • Clinically valid reason as to why the preferred lorazepam tablets or concentrate cannot be used | 1/day |
| meprobamate | NP | See alprazolam prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance of TWO preferred agents |  |
| oxazepam | NP | See chlordiazepoxide prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance of TWO preferred agents | 4/day |
| Valium® | NP | * Diagnosis of acute alcohol withdrawal syndrome; **OR** * Diagnosis of seizure disorder; **AND**  o Must be used in conjunction with another anticonvulsant; **AND** o Trial and failure of the following preferred agents:   ­ Clorazepate  ­ Diazepam   * Diagnosis of muscle spasms; **AND**  o Trial and failed TWO preferred skeletal muscle relaxants; **OR** * Diagnosis of acute alcohol withdrawal syndrome; **OR** * Diagnosis of anxiety disorder; **AND** o Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**   o Trial and failure, contraindication, or intolerance to therapy with TWO of the following:  ­ SSRI (minimum trial duration of 4 weeks)  ­ SNRI (minimum trial duration of 4 weeks)  ­ Buspirone; **AND**   * Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol/meprobamate, or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse (does not apply to diagnosis of acute alcohol withdrawal syndrome); **AND** * Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for the concomitant controlled substance use; **AND** * Trial and failure of 2 preferred agents | 3/day |
|  | **Anticonvulsants** | |  |  |
| Aptiom® | P | * Use as monotherapy for partial onset seizures and trial and failure with ONE preferred anticonvulsant with the same indication; **OR** * Use as adjunctive therapy for partial onset seizures when used in combination with at least ONE other anticonvulsant. |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| clobazam tablets | P | * Diagnosis of Lennox-Gastaut Syndrome; **AND** * Used as adjunct therapy with at least one other anticonvulsant |  |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| clonazepam | P | * Diagnosis of seizure disorder; **OR** * Diagnosis of panic disorder; **AND** o Trial and failure, contraindication, or intolerance to therapy with TWO of the following:   ­ SSRI (minimum trial duration of 4 weeks)  ­ SNRI (minimum trial duration of 4 weeks)  ­ Buspirone; **AND**   * Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND** * Prescriber has checked the Tennessee Controlled Substance Database on the date of the request for concomitant controlled substance use | 3/day | [Anti-anxiety PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| diazepam rectal gel | P | * Prior Authorization will not be required for patients less than 21 years of age. * Will be approved for patients 21 years of age and older with a Diagnosis of Seizure Disorder or Epilepsy. | 2 packs/30 days |  |
| Epidiolex® | P | **Initial Criteria:**   * Diagnosis of one of the following: o Dravet Syndrome (DS) o Lennox-Gastaut Syndrome (LGS) o Tuberous sclerosis complex (TSC) o Treatment-Refractory Epilepsy; **AND** * Trial of 2 anticonvulsants within the past 12 months (documented by claims); **AND** * Epidiolex will be used as adjunct therapy with > 1 anticonvulsant (documented by claims) **Renewal Criteria** * Epidiolex will be used as adjunct therapy with > 1 anticonvulsant (documented by claims) |  |
| gabapentin capsules | P |  | 100 mg: 6/day  300 mg: 12/day  400 mg: 9/day  Max daily gabapentin dose: 3600 mg |
| gabapentin solution | P | • Inability to swallow solid oral dosage forms, **AND** o Patient and caregiver are unable to open capsule and empty contents in food or drink; **OR** • Patient is < 12 years of age | 72 mL/day  Max daily gabapentin dose: 3600 mg |  |
| lacosamide tablets | P | * Use as monotherapy for partial onset seizures requires trial and failure with at least ONE other preferred anticonvulsant for the same indication; **OR** * Use as adjunctive therapy for partial onset seizures when used in combination with at least ONE other anticonvulsant; **OR** * Used as adjunctive therapy in the treatment of primary generalized tonic-clonic (PGTC) seizures in patients 4 years of age and older |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Libervant® | P | **Initial Criteria (6-month duration):**   * Diagnosis of intermittent, stereotypic episodes of frequent seizure activity (e.g., seizure clusters, acute repetitive seizures) that are distinct from a patient’s usual seizure pattern; **AND** * Patient is 2 to 5 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient is on a stable antiepileptic regimen; **AND** * Prescriber has counseled patient on the following:   + Risks if combined with opioids or benzodiazepines   + Identification of a seizure cluster o Proper administration o When to seek emergency medical treatment; **AND** * Patient is not using moderate or strong CYP2C19 and CYP 3A4 inhibitors or, if unavoidable, prescriber will monitor toxicity risk during concomitant use; **AND** * Patient does not have acute narrow-angle glaucoma **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not have treatment-limiting adverse effects (e.g., treatment-limiting central nervous system depression or cognitive impairment, worsened glaucoma, respiratory depression, suicidal ideation, clinically significant changes in blood pressure or heart rate); **AND** * Prescriber to provide verbal attestation of diazepam effectiveness (e.g., decreased typical length of repetitive seizures) | 10 doses/ 30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Nayzilam® | P | **Initial Criteria (6-month duration):**   * Patient has diagnosis of intermittent, stereotypic episodes of frequent seizure activity (e.g., seizure clusters, acute repetitive seizures) that are distinct from a patient’s usual seizure pattern; **AND** * Patient is 12 years of age or older; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient is on a stable antiepileptic regimen; **AND** * Prescriber has counseled patient on the following:   o Risks if combined with opioids o Identification of a seizure cluster o Proper administration o When to seek emergency medical treatment; **AND**   * Patient is not using moderate or strong CYP 3A4 inhibitors or, if unavoidable, prescriber will monitor toxicity risk during concomitant use; **AND** * Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, CNS depressants, carisoprodol, meprobamate, or barbiturates; **AND** * Patient does not have acute narrow-angle glaucoma **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not have treatment-limiting adverse effects (e.g., treatment-limiting central nervous system depression or cognitive impairment, worsened glaucoma, respiratory depression, suicidal ideation, clinically significant changes in blood pressure or heart rate); **AND** * Prescriber to provide verbal attestation of midazolam effectiveness (e.g., decreased typical length of repetitive seizures) | 10 doses/ 30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| pregabalin capsules | P | * Diagnosis of neuropathic pain; **OR** * Diagnosis of postherpetic neuralgia; **OR** * Diagnosis of fibromyalgia; **OR** * Diagnosis of seizure disorder |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| pregabalin solution | P | * One of the following:   o Diagnosis of neuropathic pain o Diagnosis of postherpetic neuralgia o Diagnosis of fibromyalgia o Diagnosis of seizure disorder; **AND**   * Patient is less than 12 years of age; **OR** o Patient is unable to swallow solid oral dosage forms |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| phenobarbital | P | • Will be approved for use ONLY in patients with diagnosis of seizure disorders. |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| phenobarbital elixir | P | • Will be approved for use ONLY in patients with diagnosis of seizure disorders. **Note**: PA is not required for patients less than 2 years of age |  |
| rufinamide tablets | P | * Diagnosis of Lennox‐Gastaut Syndrome; **AND** * Used as adjunct therapy with at least one other anticonvulsant |  |
| rufinamide susp | P | * Diagnosis of Lennox‐Gastaut Syndrome; **AND** * Used as adjunct therapy with at least one other anticonvulsant; **AND** • Unable to swallow solid dosage forms |  |
| Trokendi XR | P | * Adjunctive therapy for patients with partial-onset seizures or primary generalized tonic-clonic seizures; OR seizures associated with Lennox-Gastaut syndrome; **AND** o Will be used approved in combination with at least one other anticonvulsant; **AND**   o Trial and failure of preferred immediate release product and one additional preferred agent; **OR**   * Initial monotherapy in patients with partial-onset or primary generalized tonic-clonic seizures; **AND** o Trial and failure of preferred immediate release product and one additional preferred agent; **OR** • Migraine Prophylaxis in patients ≥ 12 years of age | 25, 50, & 100 mg:  1/day;  200 mg: 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Valtoco® | P | **Initial Criteria (6-month duration):**   * Patient has diagnosis of intermittent, stereotypic episodes of frequent seizure activity (e.g., seizure clusters, acute repetitive seizures) that are distinct from a patient’s usual seizure pattern; **AND** * Patient is 2 years of age or older; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient is on a stable antiepileptic regimen; **AND** * Prescriber has counseled patient on the following:   o Risks if combined with opioids o Identification of a seizure cluster o Proper administration o When to seek emergency medical treatment; **AND**   * Patient is not using CYP 2C19 and CYP 3A4 inhibitors or, if unavoidable, prescriber will monitor toxicity risk during concomitant use; **AND** * Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, CNS depressants, carisoprodol, meprobamate, or barbiturates; **AND** * Patient does not have acute narrow-angle glaucoma **Renewal Criteria (1 year duration):** • Patient continues to meet initial criteria; **AND** * Patient does not have treatment-limiting adverse effects (e.g., treatment-limiting CNS depression or cognitive impairment, worsened glaucoma, respiratory depression, suicidal ideation, clinically significant changes in blood pressure); **AND** * Prescriber to provide verbal attestation of diazepam effectiveness (e.g., decreased typical length of repetitive seizures) | 5 boxes/30 days |  |
| zonisamide | P |  | 25 mg (4/day);  50 mg (2/day);  100 mg (6/day) |
| Ztalmy® | P | **Initial Criteria:**   * Patient is 2 years of age and older; **AND** * Diagnosis of seizure disorder associated with cyclin-dependent kinase-like 5 deficiency disorder; **AND** * Prescriber has confirmed that patient is not pregnant (if applicable) and counseled patient on risks of pregnancy while taking Ztalmy; **AND** * Prescriber has confirmed member does not have hepatic disease and will monitor hepatic function (dose reductions may be required in impaired hepatic function) **Renewal Criteria:** * Prescriber has confirmed that patient is not pregnant (if applicable); **AND** * Prescriber has confirmed member does not have hepatic disease and will monitor hepatic function (dose reductions may be required in impaired hepatic function) | 36 mL/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Banzel® tablets | NP | * Diagnosis of Lennox‐Gastaut Syndrome; AND * Used as adjunct therapy with at least one other anticonvulsant |  |
| Banzel® suspension | NP | * Diagnosis of Lennox‐Gastaut Syndrome; **AND** * Used as adjunct therapy with at least one other anticonvulsant; **AND** • Unable to swallow solid dosage forms |  |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Briviact® solution | NP | See Briviact® tablets prior authorization criteria  • Additionally, patient must be unable to swallow tablets | 20 mL/day |  |
| Briviact® tablets | NP | * Patient is ≥ 1 month of age; **AND** * Have diagnosis of partial-onset seizures; **AND** * Have tried and failed at least 1 other medication indicated for partial-onset seizures   **NOTE**: A dose reduction is required for all stages of hepatic impairment (Child-Pugh A, B, and C) and use is not recommended in end- stage renal disease patients. | 2/day |
| clobazam suspension | NP | • Must meet clobazam tablets prior authorization criteria; **AND** • Patient must be unable to swallow tablets |  |
| clonazepam ODT | NP | * Must meet clonazepam prior authorization criteria; **AND** * Patient must be unable to swallow, OR unable to absorb medications through the GI tract. | 3/day |
| Diacomit® | NP | **Initial Criteria:**   * Patient is ≥ 6 months of age; **AND** * Patient must also be taking clobazam concomitantly; **AND** * Diagnosis of Dravet syndrome (DS); **AND** * Prescribed by neurologist or epileptologist; **AND** * Prescriber attests that baseline serum hematologic testing has been completed; **AND** * Prescriber attests the patient has refractory epilepsy (failed to become seizure free after trials of 2 antiepileptic drugs);   **AND**   * If the oral powder for suspension is prescribed, the patient does not have phenylketonuria (PKU). **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has no treatment-limiting adverse effects (e.g., thrombocytopenia, neutropenia, new onset or worsened depression; suicidal thoughts, worsened seizure control); **AND** * Prescriber to provide verbal attestation of Diacomit effectiveness (e.g., reduced seizure frequency and/or duration) | 250 mg (1/day); 500 mg (6/day) | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Elepsia® XR | NP | * Patient has a diagnosis or history of partial-onset seizures, juvenile myoclonic epilepsy, or primary generalized tonic-clonic seizure; **AND** * Will be used as adjunctive therapy with another anticonvulsant; **AND** * Patient must be 12 years of age or older; **AND** * Clinically valid reason why the preferred levetiracetam ER cannot be used | 1000 mg: 3/day;  1500 mg: 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Eprontia® solution | NP | • One of the following:   * Will be used as initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures in patients 2 years of age and older * Will be used as adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, and seizures associated with Lennox-Gastaut syndrome in patients 2 years of age and older * Will be used as preventive treatment of migraine in patients 12 years and older; **AND** • Patient is unable to swallow tablets | 16 ml/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Felbatol® and felbamate | NP | **Initial Criteria:**   * Used as adjunctive therapy for the treatment of partial and generalized seizures associated with Lennox-Gastaut Syndrome in children 2-14 years of age with a contraindication to, or trial and failure of, **TWO** of the following:   + Valproic acid/divalproex sodium   + Lamotrigine o Topiramate * Used as monotherapy and adjunctive therapy for the treatment of partial seizures with or without generalization in adults > 14 years of age with a contraindication to, or trial and failure of, **THREE** of the following:   + Carbamazepine o Oxcarbazepine o Phenytoin o Gabapentin o Lamotrigine o Topiramate   + Valproic acid/divalproex sodium   **Note:** Will not be approved if there is a history of blood dyscrasia or liver disease unless the prescriber can make a compelling clinical case demonstrating that the benefits of the drug outweigh the risks. |  |  |
| Fintepla® | NP | **Initial Criteria:**   * Patient must be ≥ 2 years of age; **AND** * Diagnosis of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS); **AND** * Prescribed by a neurologist or epileptologist; **AND** * Patient has not received MAOI therapy within 14 days and will not receive during Fintepla therapy; **AND** * Prescriber attestation that baseline echocardiogram has been completed and will be monitored throughout treatment and   3 – 6 months after the final dose; **AND**   * Inadequate response to trials of 2 preferred anticonvulsant agents **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has no treatment-limiting adverse effects (e.g., serotonin syndrome, abnormal AST/ALT, CrCl, abnormal echocardiogram); **AND** * Patient is responding to therapy (e.g., reduced seizure frequency and/or duration) | 1 bottle/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Fycompa® | NP | * Diagnosis of partial onset seizures with or without secondarily generalized seizures; **AND** o Patient is ≥ 4 years of age; **AND**   + Trial and failure, contraindication, or intolerance to 2 preferred agents, one of which must be lacosamide **OR** * Will be used as adjunctive therapy for the treatment of primary generalized tonic-clonic (PGTC) seizures; **AND** o Patient is ≥ 12 years of age; **AND**   + Trial and failure, contraindication, or intolerance to TWO preferred agents | 2, 4, 8, 10, & 12 mg:  1/day;  6 mg: 2/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| gabapentin tablets | NP | • Clinically valid reason why the preferred gabapentin capsules cannot be used | 100 & 600 mg: 6/day;  800 mg: 4.5/day;  All other strengths:  3/day  Max daily gabapentin dose: 3600 mg |  |
| Klonopin® | NP | See clonazepam prior authorization criteria; **AND**  • Trial and failure of clonazepam | 3/day | [Anti-anxiety PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| Lamictal® ODT | NP | • Unable to swallow solid dosage forms |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Lamictal® XR | NP | • Trial and failure of a regular-release lamotrigine product and 1 other preferred agent |  |
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| lamotrigine ER | NP | • Trial and failure of a regular-release lamotrigine product and 1 other preferred agent |  |  |
| lamotrigine ODT | NP | • Unable to swallow solid dosage forms |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Lyrica® capsules | NP | See pregabalin capsules prior authorization criteria; **AND**  • Trial and failure of preferred pregabalin capsules |  |
| Lyrica® solution | NP | See pregabalin solution prior authorization criteria; **AND** • Trial and failure of preferred pregabalin solution |  |
| Lyrica® CR | NP | * Diagnosis of postherpetic neuralgia OR neuropathic pain associated with‐diabetic peripheral neuropathy; **AND** * Trial and failure, contraindication, or intolerance to a tricyclic antidepressant OR gabapentin; **AND** * Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus immediate-release pregabalin | 82.5 mg & 165 mg:  1/day  330 mg: 2/day |
| Motpoly ®XR | NP | * One of the following:   + Initial monotherapy for partial onset seizures   + Adjunctive therapy for partial onset seizures and will be used in combination with at least one other anticonvulsant; **AND** * Trial and failure of preferred immediate release product and one additional preferred agent |  |
| Neurontin® solution | NP | See gabapentin solution prior authorization criteria.  **Note:** Prior authorization criteria is waived for recipients 12 years of age and under | 72 mL/day  Max total daily gabapentin dose:  3600mg |
| Onfi® | NP | See clobazam tablets prior authorization criteria |  | [Anti-anxiety PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Qudexy® XR | NP | * Will be used as monotherapy or adjunctive therapy in patients with focal (partial) onset or primary generalized tonic-clonic seizures; **OR** * Will be used as adjunctive therapy in patients with seizures associated with Lennox-Gastaut syndrome; **OR** * Migraine Prophylaxis in patients ≥ 12 years of age; **AND** o Trial and failure of an Trokendi XR and 1 other preferred agent | 200 mg: 2/day  All other strengths: 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| rufinamide tablet | NP | * Diagnosis of Lennox‐Gastaut Syndrome; **AND** * Used as adjunct therapy with at least one other anticonvulsant |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Sabril® | NP | * Adjunctive therapy for patients with refractory complex partial seizures who have responded inadequately to several alternative treatments; **AND** o Patient has tried and failed 2 preferred anticonvulsants; **OR** * Monotherapy for patients with infantile spasms   **Note:**  This drug is subject to REMS requirements to ensure the benefits of treatment outweigh the risks of vision loss |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Spritam® | NP | * Patient is unable to swallow solid oral dosage form; **AND** * Provider must have a clinically valid reason as to why the generic levetiracetam solution cannot be used | 250, 500, & 1000 mg:  2/day;  750 mg: 4/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Sympazan® | NP | * Patient has a diagnosis of Lennox-Gastaut syndrome (LGS); **AND** * Requested drug will be used as adjunctive therapy in combination with at least one other anticonvulsant; **AND** * Provider must have a clinically valid reason as to why both clobazam tablets and suspension cannot be used. (NOTE: Patient convenience is NOT an approvable reason) | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| topiramate ER | NP | * Will be used as monotherapy or adjunctive therapy in patients with focal (partial) onset or primary generalized tonic-clonic seizures; **OR** * Will be used as adjunctive therapy in patients with seizures associated with Lennox-Gastaut syndrome; **OR** * Migraine Prophylaxis in patients ≥ 12 years of age; **AND** o Trial and failure of an Trokendi XR and 1 other preferred agent | 200 mg: 2/day  All other strengths: 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| vigabatrin | NP | See Sabril® prior authorization criteria |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Vigafyde® |  | * Treatment is for monotherapy for patients with infantile spasms; **AND** * Clinically valid reason why vigabatrin 50 mg/mL powder oral solution cannot be used   **Note**: This drug is subject to REMS requirements to ensure the benefits of treatment outweigh the risks of vision loss |  |
| Vigadrone® | NP | See Sabril® prior authorization criteria |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Vimpat® | NP | See lacosamide prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to lacosamide |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Xcopri® | NP | **Initial criteria:**   * Diagnosis of partial-onset seizures; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Must be 18 years of age and older; **AND** * Trial and failure, contraindication, or intolerance to 2 preferred anticonvulsants indicated for partial-onset seizures; **AND** • Patient does not have Familial Short QT syndrome **Renewal criteria:** * Patient must demonstrate disease improvement and stabilization as a result of the medication; **AND** * Patient is absent of unacceptable toxicity from the drug; **AND** * Patient’s QT interval is being monitored | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Zonisade® | NP | * Diagnosis of partial-onset seizures; **AND** * Zonisade will be used as adjunctive therapy; **AND** * Patient must be unable to swallow solid dosage forms | 30 mL/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Movement Disorders** | | | | |
| Austedo® | P | **Diagnosis of tardive dyskinesia:**   * Patient age ≥ 18 years; **AND** * Documentation that AIMS test has been completed (e.g., score or copy of AIMS assessment); **AND** * Prescribed by, or in consultation with, a neurologist or psychiatrist (or other mental health provider), provided patient has reasonable access; **AND** * Documentation or claims history of current or former chronic patient use of a dopamine antagonist (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine) **Diagnosis of chorea related to Huntington’s Disease:** * Physician is experienced in the treatment of Huntington’s Disease or is in a Center of Excellence for Huntington’s Disease; **AND** * Patient does not have a history of untreated or inadequately treated depression or suicidal ideation due to a boxed warning that it increases the risk of depression and suicidal thoughts and behavior **Patients meeting any of the following criteria will NOT be approved:** * Concurrent therapy with tetrabenazine, reserpine, or MAOIs * Hepatic impairment * Hypersensitivity to the active ingredient • Pregnancy | 4/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Austedo XR® | P | See Austedo prior authorization criteria | 1/day |
| Ingrezza® | P | **Diagnosis of tardive dyskinesia:**   * Patient age ≥ 18 years; **AND** * Documentation that AIMS test has been completed (e.g., score or copy of AIMS assessment); **AND** * Prescribed by, or in consultation with, a neurologist or psychiatrist (or other mental health provider), provided patient has reasonable access; **AND** * Documentation or claims history of current or former chronic patient use of a dopamine antagonist (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine) **Diagnosis of chorea related to Huntington’s Disease:** * Physician is experienced in the treatment of Huntington’s Disease or is in a Center of Excellence for Huntington’s Disease; **AND** * Patient does not have a history of untreated or inadequately treated depression or suicidal ideation due to a boxed warning that it increases the risk of depression and suicidal thoughts and behavior **Patients meeting any of the following criteria will NOT be approved:**   o Concurrent use of MAOIs or strong CYP3A4 inducers o Hypersensitivity to the active ingredient o Pregnancy | 40 mg: 2/day  60, 80 mg: 1/day |
| tetrabenazine | P | Will only be approved for the treatment of chorea associated with Huntington’s disease. |  |
| Xenazine® | P | * Diagnosis of chorea associated with Huntington’s disease; **AND** * Clinically valid reason why preferred generic tetrabenazine cannot be used |  |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Antidepressants: MAOIs** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers;* ***OR*** * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| phenelzine | P | * Diagnosis of major depression; **AND** * Trial and failure of THREE antidepressant agents from TWO different following drug classes:   + SSRIs o SNRIs   + New generation antidepressants | 6 tabs/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Emsam® | NP | See Marplan® prior authorization criteria; **AND**  • Patient must be 13 years of age or older | 1/day |
| Marplan® | NP | * Diagnosis of major depression; **AND** * Trial and failure of THREE antidepressant agents from TWO different following drug classes:   o SSRIs o SNRIs o New generation antidepressants; **AND**   * Trial and failure, contraindication, or intolerance to preferred phenelzine | 6 tabs/day |
| Nardil® | NP | See Marplan® prior authorization criteria | 6 tabs/day |
| Parnate® | NP | See Marplan® prior authorization criteria | 6 tabs/day |
| tranylcypromine | NP | See Marplan® prior authorization criteria | 6 tabs/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Antidepressants: New Generation** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers* * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| Aplenzin® | P |  |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| bupropion IR/SR | P |  |  |
| bupropion XL | P |  | 1/day |
| mirtazapine | P |  |  |
| mirtazapine ODT | P | • Patient is unable to swallow solid dosage forms |  |
| trazodone (excluding 300mg) | P |  |  |
| Auvelity® | NP | * Diagnosis of Major Depressive Disorder (MDD); **AND** * Patient is 18 years of age or older; **AND** * Trial and failure, or contraindication, intolerance to 2 preferred antidepressants; **AND** * Patient does not have ANY of the following:   + Seizure disorder   + Current or prior diagnosis of bulimia or anorexia nervosa o Undergoing abrupt discontinuation of alcohol, benzodiazepines, barbiturates, or antiepileptic drugs; **AND** * Prescriber attests patient has not received MAOI therapy within 14 days and will not receive during therapy |  |
| Forfivo XL® | NP | * Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** * Patient must currently be on a bupropion product titrated to a dose of 300 mg per day |  |
| nefazodone | NP | * Diagnosis of major depression; **AND** * Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Patient does not have hepatic impairment |  |
| Remeron® | NP |  |  | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Remeron SolTab® | NP | • Patient is unable to swallow solid dosage forms |  |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| trazodone 300mg | NP | * Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** * Clinically valid reason why the preferred lower strength tablets cannot be used (i.e., trazodone 50mg, 100mg, 150mg) |  | [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Wellbutrin® IR & SR | NP |  |  |
| Wellbutrin XL® | NP |  | 1/day |
| Zurzuvae® | NP | **Criteria: (3 month-duration)**   * Patient is 18 years of age or older; **AND** * Diagnosis of postpartum depression (PPD); **AND** * Patient’s symptoms began in the third trimester or within 4 weeks of delivery; **AND** * Prescriber attests that the PPD requires rapid improvement and resolution of symptoms; **AND** * Prescribed by, or in consultation with, a psychiatrist, psychologist, or an obstetrician-gynecologist; **AND** * Prescriber attests to ALL of the following:   + Patient has been advised not to drive or operate machinery until at least 12 hours after administration due central nervous system (CNS) depressant effects such as somnolence and confusion   + Females of reproductive potential have been advised to use effective contraception during treatment and for 1 week after the final dose due to potential risk to fetus and to notify healthcare provider if they become pregnant during treatment o Lactating women have been counseled on risk versus benefits of breastfeeding while on treatment | 1 treatment course/year | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| **Antidepressants: SNRIs** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers;* ***OR*** * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| desvenlafaxine ER | P |  | 1/day |  |
| duloxetine 20, 30, & 60 mg | P |  | 2/day | [SNRI PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Antidepressant%20SNRI%20PA%20Form.pdf) |
| Effexor XR® | P |  | 1/day |
| venlafaxine IR tabs | P |  | 2/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| venlafaxine ER caps | P |  | 37.5, 75 mg: 1/day  150 mg: 2/day  **Note**: for 225 & 375 mg doses:use 150 mg  & 75 mg caps |  |
| Cymbalta® | NP |  | 2/day |
| duloxetine 40 mg | NP | • Clinically valid reason why the preferred duloxetine capsules (20, 30, or 60 mg) cannot be used | 2/day |
| Fetzima® | NP |  | Titration Pack: 1/day (56 tabs/ lifetime) | [SNRI PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Antidepressant%20SNRI%20PA%20Form.pdf) |
| Pristiq® | NP |  | 1/day |
| venlafaxine besylate ER tabs | NP | • Clinically valid reason why preferred venlafaxine agents cannot be used (Effexor XR, venlafaxine ER caps, venlafaxine IR tabs) | 1/day |
| venlafaxine ER tabs | NP |  | 1/day |
| **Antidepressants: SSRI** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers;* ***OR*** * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| citalopram | P |  | 10, 20 mg: 1.5/day 40 mg: 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| escitalopram | P |  | 1.5/day |
| escitalopram solution | P |  |  |
| fluoxetine capsules | P |  | 3/day |
| fluoxetine solution | P |  |  |
| fluvoxamine | P |  | 3/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| paroxetine tablets | P |  | 10, 20 mg: 1/day; 30, 40 mg: 2/day |  |
| sertraline | P |  | 25, 50 mg: 1.5/day; 100 mg: 2/day |
| vilazodone | P |  | 1/day |
| Celexa® | NP |  | 10, 20 mg: 1.5/day 40 mg: 1/day |
| fluoxetine DR caps | NP | * Stabilized at a dose of 20 mg/day of fluoxetine for > one month; **AND** * Documented reason why the patient is unable to continue fluoxetine 20 mg daily | 4/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| fluoxetine tablets | NP |  | 20 mg: 3/day; 60 mg: 1/day |
| fluvoxamine ER | NP |  | 100 mg: 3/day; 150 mg: 2/day |
| Lexapro® | NP |  | 1.5/day |
| paroxetine 7.5 mg | NP | * Diagnosis of hot flashes associated with menopause; **AND** * Trial and failure, contraindication, or intolerance to estrogen therapy; **AND** * An allergy or intolerance to an inactive ingredient in paroxetine |  |
| paroxetine CR | NP |  | 12.5, 25 mg: 1/day;  37.5 mg: 2/day |
| Paxil® tablets | NP |  | 10, 20 mg: 1/day; 30, 40 mg: 2/day |
| Paxil® CR | NP |  | See paroxetine CR |
| Paxil® solution | NP |  |  |
| Prozac® | NP |  | 3/day |
| sertraline capsules | NP |  | 1/day |
| Trintellix® | NP | * Diagnosis of Major Depression Disorder; **AND** * Adequate trial and failure of TWO agents at an appropriate dose (3 weeks at the maximum tolerated dose within the recommended therapeutic range) within the following drug classes: SSRI, SNRI, or New Generation Antidepressants | 1/day |
| Viibryd | NP |  | 1/day |
| Zoloft® | NP |  | 25, 50 mg: 1.5/day; 100 mg: 2/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Antidepressants: Tricyclics** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers;* ***OR*** * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Duration of short-term therapy is 90 days for antidepressants* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| amitriptyline | P |  |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| doxepin caps | P |  |  |
| imipramine tabs | P |  |  |
| nortriptyline | P |  |  |
| amoxapine | NP |  |  |
| Anafranil® | NP | See prior authorization criteria for clomipramine |  |
| clomipramine | NP | * Diagnosis of obsessive-compulsive disorder; **AND** * Trial and failure of at least 2 unique SSRIs |  |
| desipramine | NP |  |  |
| imipramine caps | NP |  |  |
| Norpramin® | NP |  |  |
| nortriptyline solution | NP | • Patient is unable to swallow nortriptyline capsules |  |
| Pamelor® | NP |  |  |
| protriptyline | NP |  |  |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Antihyperkinesis: Stimulants** | | | | |
| Adderall® XR | P | See amphetamine salt ER combination prior authorization criteria | 5, 10, 15 mg: 1/day  25 & 30mg: 2/day  20mg: 3/day  Max total amphetamine dose  (Age ≥ 21): 60mg/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| amphetamine salt ER combination | P | * Agent must not be prescribed by a pain clinic * Patient will not concurrently take a benzodiazepine, barbiturate, sedative hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol; **AND** * Patient has NOT had active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age; **AND** * One of the following:   o Diagnosis of Attention Deficit Disorder and/or Hyperactivity Disorder (ADD/ADHD); **AND**  ­ Documentation that the symptoms affect the patient’s ability to function in daily life tasks or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home) o Diagnosis of Narcolepsy supported with documentation of polysomnography or multiple sleep latency test (MSLT) o Diagnosis of neurocognitive disorder (also known as organic brain disorder) o Diagnosis of treatment resistant Major Depressive Disorder; **AND**  ­ Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes: • SSRI   * SNRI * New Generation Antidepressants * TCAs   **Note**: Patients < 20 years of age will be subject to the initial criteria if they exceed 80 mg/day of total amphetamine. | 5, 10, 15 mg: 1/day  25 & 30 mg: 2/day  20 mg: 3/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| amphetamine salt IR combo | P | See amphetamine salt ER combination prior authorization criteria | 5, 7.5, 10, & 12.5 mg:  4/day  15 & 30 mg: 2/day  20 mg: 3/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| amphetamine sulfate | P | See amphetamine salt ER combination prior authorization criteria | See Evekeo® | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
|  |  |  |  |
| Aptensio XR® | P | See amphetamine salt ER combination prior authorization criteria | 1/day | [Stimulants PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Concerta® | P | See amphetamine salt ER combination prior authorization criteria | 18, 27, 54 mg: 1/day; 36 mg: 2/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Daytrana® | P | See amphetamine salt ER combination prior authorization criteria | 1/day |
| dexmethylphenidate | P | See amphetamine salt ER combination prior authorization criteria | 1/day |
| dexmethylphenidate XR | P | See amphetamine salt ER combination prior authorization criteria | 1/day |
| dextroamphetamine  tablets | P | See amphetamine salt ER combination prior authorization criteria | 20 mg: 3/day  30 mg: 2/day  All others: 4/day  Max total amphetamine dose  (Age ≥ 21): 60mg/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Focalin XR® | P | See amphetamine salt ER combination prior authorization criteria | 1/day |
| methylphenidate  (generic for Ritalin®) | P | See amphetamine salt ER combination prior authorization criteria | 1/day |
| methylphenidate solution | P | See amphetamine salt ER combination prior authorization criteria |  | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| methylphenidate ER tablets | P | See amphetamine salt ER combination prior authorization criteria | See Metadate ER® |
| ProCentra® | P | See amphetamine salt ER combination prior authorization criteria | 20 mL/day Max (Age ≥ 21):  60mg/day |
| Vyvanse® capsules and chewables | P | See amphetamine salt ER combination prior authorization criteria | 1/day;  Max total amphetamine dose  (Age ≥ 21): 60mg/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Adderall® | NP | * Agent must not be prescribed by a pain clinic * Patient will not concurrently take a benzodiazepine, barbiturate, sedative hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol; **AND** * Patient has NOT had active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age; **AND** * One of the following:   o Diagnosis of Attention Deficit Disorder and/or Hyperactivity Disorder (ADD/ADHD); **AND**  ­ Documentation that the symptoms affect the patient’s ability to function in daily life tasks or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home) o Diagnosis of Narcolepsy supported with documentation of polysomnography or multiple sleep latency test (MSLT) o Diagnosis of neurocognitive disorder (also known as organic brain disorder) o Diagnosis of treatment resistant Major Depressive Disorder; **AND**  ­ Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes: • SSRI   * SNRI * New Generation Antidepressants * TCAs; **AND** * Trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated | See amphetamine salt IR combo | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Adderall® XR | NP | See Adderall® prior authorization criteria | 5, 10, 15 mg: 1/day  25 & 30mg: 2/day  20mg: 3/day  Max total amphetamine dose  (Age ≥ 21): 60mg/day |
| Adhansia XR® | NP | See Adderall® prior authorization criteria | 1/day |
| Adzenys ER® solution | NP | See Adderall® prior authorization criteria  • Patient must have clinical reason as to why the preferred generic methylphenidate solution cannot be used. | 10mL/day |
| Adzenys XR® ODT | NP | See Adderall® prior authorization criteria | 1/day |
| amphetamine ER suspension | NP | See Adderall® prior authorization criteria  • Patient must have clinical reason as to why the preferred generic methylphenidate solution cannot be used. | 10mL/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
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| Azstarys® | NP | See Adderall® prior authorization criteria | 1/day | [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Cotempla XR® ODT | NP | See Adderall® prior authorization criteria | 1/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Desoxyn® | NP | See Adderall® prior authorization criteria | 4/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| dextroamphetamine solution | NP | See Adderall® prior authorization criteria | 20 mL/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Dexedrine® | NP | See Adderall® prior authorization criteria | 4/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day |
| Dyanavel XR® | NP | See Adderall® prior authorization criteria | 8 mL/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day | [Anti-](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [hyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Evekeo® tab & ODT | NP | See Adderall® prior authorization criteria | 5 mg tab & ODT: 3/day 10 mg tab & ODT:  6/day  15 mg ODT: 4/day  20 mg ODT: 6/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day |
| Focalin® | NP | See Adderall® prior authorization criteria |  | [Anti-](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Jornay PM® | NP | See Adderall® prior authorization criteria | 1/day |
| lisdexamfetamine caps and chewables | NP | See Adderall® prior authorization criteria | 1/day;  Max total amphetamine dose  (Age ≥ 21): 60mg/day |
| [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| methamphetamine | NP | See Adderall® prior authorization criteria | 4/day  Max total amphetamine dose  (Age ≥ 21): 60 mg/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Methylin® solution | NP | See Adderall® prior authorization criteria |  |
| methylphenidate chewables | NP | See Adderall® prior authorization criteria |  |
| methylphenidate patch | NP | See Adderall® prior authorization criteria | 1/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| methylphenidate ER 24hr capsules  (generic for Aptensio XR, Ritalin LA) | NP | See Adderall® prior authorization criteria | 1/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| methylphenidate ER OSM tablets (generic for Concerta® & Relexxii®) | NP | See Adderall® prior authorization criteria | See Concerta® | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| methylphenidate XR ODT (generic for  Cotempla® XR ODT) | NP | See Adderall® prior authorization criteria | 1/day |
| Mydayis ER® | NP | See Adderall® prior authorization criteria | 1/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
| Quillichew ER® | NP | See Adderall® prior authorization criteria | 1/day |
| Quillivant XR® | NP | See Adderall® prior authorization criteria | 12 mL/day |
| Relexxii® ER | NP | See Adderall® prior authorization criteria | 1/day |
| Ritalin® | NP | See Adderall® prior authorization criteria | 1/day |
| Ritalin® LA | NP | See Adderall® prior authorization criteria | 1/day |
| Zenzedi® | NP | See Adderall® prior authorization criteria | 20 mg: 3/day  30 mg: 2/day  All others: 4/day  Max total amphetamine dose  (Age ≥ 21): 60mg/day | [Antihyperkinesis:](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Stimulants PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/home-page/pa-forms/Schedule%20II%20Stimulant%20PA%20Form.pdf) |
|  | **Antihyperkinesis: Non-Stimulants** | | |  |
| atomoxetine | P |  | 60 mg, 80 mg, 100 mg:  1/day  All other strengths: 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
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| clonidine 12hr ER | P |  | 4/day |  |
| guanfacine ER | P |  | 1/day |
| Qelbree® | P | * Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD); **AND** * Patient is 6 years of age or older; **AND** * Patient’s blood pressure and heart rate will be assessed prior to therapy and monitored throughout therapy; **AND** * Patient will not concomitantly use monoamine oxidase inhibitors (MAOIs); **AND** * Patient will not concomitantly use CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range; **AND** • Patient is not pregnant; **AND** * Trial and failure, contraindication, or intolerance to 2 preferred antihyperkinesis stimulant and/or non-stimulant agents | 100 mg: 2/day  150 mg: 2/day  200 mg: 3/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Intuniv® | NP | • Clinically valid reason why preferred guanfacine ER cannot be used | 1/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Onyda XR® | NP | * Diagnosis of attention deficit hyperactivity disorder (ADHD); **AND** • Patient is 6 years of age or older; **AND** * One of the following:   o Trial &failure, contraindication, or intolerance of 2 preferred non-stimulant antihyperkinesis agents; **OR** o Patient is unable to swallow solid dosage forms | 4mL/day |  |
| Strattera® | NP |  | 60, 80, 100 mg: 1/day  All others: 2/day |
| **Agents for Narcolepsy** | | | | |
| modafinil | P | * Diagnosis of ADD/ADHD; **AND**  o Contraindication, adverse reaction, or drug-drug interaction to **ALL** preferred antihyperkinesis agents; **OR** * Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND** o Diagnosis is associated with ONE of the following:   ­ Idiopathic hypersomnia  ­ Diagnosis of Narcolepsy  ­ Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND**   * Trial and failure (minimum duration 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device, unless contraindications ­ Diagnosis of Shift Work Sleep Disorder; **AND** * Statement of patient’s work schedule showing a minimum of 6 hours work between 10 pm and 8 am; **AND**   o Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out | 2/day | [Narcolepsy](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf)  [Agents PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf) |
| Provigil® | P | See modafinil prior authorization criteria | 2/day |
| Xyrem® | P | * Enrolled in the Xyrem Program (1-866-997-3688); **AND** * One of the following:   o Diagnosis of cataplexy associated with narcolepsy o Diagnosis of excessive daytime sleepiness/hypersomnolence associated with narcolepsy occurring > 3 months; **AND** ­ Trial and failure, intolerance, or contraindication to modafinil; **AND**   * Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out | 9 grams/day | [Narcolepsy](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf)  [Agents PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf) |
| armodafinil | NP | * Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND** * Diagnosis is associated with ONE of the following:   o Diagnosis of Narcolepsy o Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND**  ­ Trial and failure (minimum duration 3 months with documented compliance) of Continuous Positive Airway  Pressure (CPAP) or BiPAP device, unless contraindications o Diagnosis of Shift Work Sleep Disorder; **AND**  ­ Statement of patient’s work schedule showing a minimum of 6 hours work between 10 pm and 8 am; **AND**   * Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out; **AND** * Trial and failure, contraindication, or intolerance to modafinil | 50mg: 2/day  150mg, 200mg,  250mg: 1/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nuvigil® | NP | See armodafinil prior authorization criteria | 50mg: 2/day  150mg, 200mg,  250mg: 1/day |  |
| sodium oxybate | NP | See Xyrem® prior authorization criteria; **AND** • Trial and failure of Xyrem® | 9 grams/day |
| Sunosi® | NP | * Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND** * Diagnosis is associated with ONE of the following:   o Diagnosis of Narcolepsy o Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND**  ­ Trial and failure (minimum duration 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device, unless contraindications; **AND**   * Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out; **AND** * Trial and failure, contraindication, or intolerance to modafinil | 1/day |
| Wakix® | NP | * Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND** * ONE of the following:   o Diagnosis of cataplexy associated with narcolepsy; **AND**  ­ Trial and failure, contraindication, or intolerance to Xyrem o Diagnosis of excessive daytime sleepiness (EDS) associated with Narcolepsy; **AND**  ­ Trial and failure, contraindication, or intolerance to modafinil; **AND**   * Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out | 2/day |
| Xywav® | NP | * Enrolled in the Xywav Program (1-866-997-3688); **AND** * One of the following:   o Diagnosis of cataplexy associated with narcolepsy; **AND**  ­ Clinically valid reason is given why the patient requires Xywav over Xyrem o Diagnosis of excessive daytime sleepiness/hypersomnolence associated with narcolepsy occurring > 3 months; **AND** ­ Trial and failure, intolerance, or contraindication to modafinil; AND  ­ Clinically valid reason is given why the patient requires Xywav over Xyrem o Diagnosis of idiopathic hypersomnia (IH) in patients ≥ 18 years of age; **AN**D  ­ Trial and failure, intolerance, or contraindication to modafinil; **AND**   * Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out | 18 mL per day | [Narcolepsy](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf)  [Agents PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Narcolepsy%20Agents%20PA%20Form.pdf) |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antimigraine Preparations: CGRP Antagonists** | | | |
| Aimovig® | P | **Initial Criteria:**   * Patient has a diagnosis of migraine with or without aura; **AND** * Patient has ≥ 4 migraine days per month; **AND** * Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, life-style modifications); **AND**  • Trial (duration > 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:   + Antidepressants (i.e., amitriptyline, venlafaxine) o Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol)   + Antiepileptics (i.e., valproate, topiramate) **Renewal Criteria:** * Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches); **AND** * Patient has absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation) | 1 syringe/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Emgality®syringe & pen | P | **Initial Criteria:**   * Diagnosis of episodic cluster headache; **OR** * Diagnosis of migraine with or without aura; **AND**  o Patient has ≥ 4 migraine days per month; **AND**  o Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, life-style modifications); **AND**  o Trial (duration > 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:   ­ Antidepressants (i.e., amitriptyline, venlafaxine)  ­ Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol) ­ Antiepileptics (i.e., valproate, topiramate); OR **Renewal Criteria:**   * Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches); **AND** * Patient has absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation) | 1 syringe/month  (120 mg for migraine and 300 mg for cluster headache) | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nurtec ODT® | P | **Initial Criteria:**   * Diagnosis of migraine with or without aura; **AND** * One of one of the following:   o Acute treatment of migraine, **AND**  ­ Medication will not be used in combination with another acute CGRP inhibitor; **AND**  ­ Trial and failure or intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan) OR contraindication to all triptans o Preventative treatment of migraine; **AND**  ­ Patient has ≥ 4 migraine days per month; **AND**  ­ Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, life-style modifications);  **AND**  ­ Trial (duration > 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:   * Antidepressants (i.e., amitriptyline, venlafaxine) * Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol) * Antiepileptics (i.e., valproate, topiramate); **AND**  **Renewal Criteria:** * Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches) | Acute treatment:   1. dose pack (8 tablets)/30 days     Prophylaxis:   1. dose packs (16 tablets)/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Qulipta® | P | **Initial Criteria:**   * Patient has a diagnosis of migraine with or without aura; **AND** * Patient has ≥ 4 migraine days per month; **AND** * Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, lifestyle modifications); **AND**  • Trial (duration > 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:   o Antidepressants (i.e., amitriptyline, venlafaxine) o Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol) o Antiepileptics (i.e., valproate, topiramate); **AND** **Renewal Criteria:**   * Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches) | 1/day |
| Ubrelvy® | P | **Initial Criteria:**   * Diagnosis of migraine with or without aura and will be used for the acute treatment of migraine, **AND** * Trial and failure or intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan) OR contraindication to all triptan; **AND** * Medication will not be used in combination with another acute CGRP inhibitor **Renewal Criteria:** * Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea) | 1 box (10 tablets) / 30 days |
| Ajovy®autoinjector and prefilled syringe | NP | See Aimovig prior authorization criteria; **AND**  • Trial and failure of Aimovig and Emgality | 3 injections/90 days |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Zavzpret® |  | **Initial Criteria:**   * Diagnosis of migraine with or without aura and will be used for the acute treatment of migraine, **AND** * Trial and failure or intolerance to Nurtec ODT and Ubrelvy; **AND** * Medication will not be used in combination with another acuteCGRP inhibitor **Renewal Criteria:** * Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea) | 60 mg/30 days  (6 devices) | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| **Antimigraine: Ergotamine Derivatives** | | | |  |
| Migranal® | P |  | 8 mL/30 days | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| dihydroergotamine nasal spray | P |  | 8 mL/30 days |
| dihydroergotamine injection | NP |  | 8 mL/30 days |
| Migergot® | NP |  | 15/30 days |
| Trudhesa® | NP | See dihydroergotamine injection prior authorization criteria | 1 package/30 days |
| **Antimigraine: Barbiturate Combination Agents** | | | |  |
| \*\***Quantity Limit Override Criteria for Butalbital-Containing Products**:  Butalbital-containing products have a quantity limit of 20 caps per 30 days. Requests for quantities greater than 20/30 will be approved if the following criteria is met:   * Trial and failure of a tricyclic antidepressant (unless contraindicated); **AND** * Trial and failure of divalproex sodium, sodium valproate, topiramate, frovatriptan, or a beta-blocker | | | |  |
| butalbital/APAP | P |  | 20/30 days\*\*  APAP: 4 g/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| butalbital/APAP/ caffeine | P |  | 20/30 days\*\*  APAP: 4 g/day |
| Allzital® | NP |  | 20/30 days\*\*  APAP: 4 g/day |
| butalbital/ASA/ caffeine | NP | • Allergy or intolerance to APAP | 20/30 days\*\* |
| Fioricet® | NP |  | 20/30 days\*\*  APAP: 4 g/day |
| Esgic® | NP |  | 20/30 days\*\*  APAP: 4 g/day |
| **Antimigraine: Selective 5-HT1 Agonists** | | | |  |
| eletriptan | P |  | 6/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| rizatriptan | P |  | 12/30 days |
| rizatriptan ODT | P |  | 12/30 days |
| sumatriptan tabs | P |  | 9/30 days |
| sumatriptan vials | P |  | 8 vials/30 days |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| zolmitriptan nasal spray | P |  | 6/30 days |  |
| Frova® | NP |  | 9/30 days |
| frovatriptan | NP |  | 9/30 days |
| Imitrex Injectable® | NP |  | 8 vials/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Imitrex Kit® | NP | • Clinically valid reason why the injectable vials cannot be used (**NOTE:** Patient convenience is NOT an approvable reason) | 4/30 days |
| Imitrex Nasal® | NP |  | 6/30 days |
| Imitrex® tablets | NP |  | 9/30 days |
| Maxalt® | NP |  | 12/30 days |
| Maxalt MLT® | NP |  | 12/30 days |
| naratriptan | NP |  | 9/30 days |
| Onzetra Xsail® | NP | * Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; **AND** * Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; **AND** * Clinically valid reason why the patient requires a nasal powder (**NOTE:** Patient convenience is NOT an approval reason) | 16/30 days |
| Relpax® | NP |  | 6/30 days |
| Reyvow® | NP | **Initial Criteria (3-month duration):**   * Agent is being used for acute treatment of migraine with or without aura; **AND** * Patient is 18 years of age or older; **AND** * Trial and failure, contraindication, or intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan); **AND Renewal Criteria:** * Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea) | 4/30 days |
| sumatriptan autoinjector | NP | • Clinically valid reason as to why the patient cannot use the injectable vials. (**Note:** Patient convenience is NOT an approvable reason) | 4/30 days |
| sumatriptan cartridge |  | • Clinically valid reason as to why the patient cannot use the injectable vials. (**Note:** Patient convenience is NOT an approvable reason) |  |
| sumatriptan nasal | NP |  | 6/30 days |
| sumatriptan/ naproxen | NP |  | 9/30 days |
| Tosymra® | NP |  | 12/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Treximet® | NP |  | 9/30 days |
| zolmitriptan nasal spray and tablets | NP |  | 6/30 days |
| Zembrace Symtouch® | NP | * Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; **AND** * Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; **AND** * Clinically valid reason why the patient requires an autoinjector device (**NOTE:** Patient convenience is NOT an approval reason) | 2 mL/30 days |
| Zomig® nasal spray | NP | • | 6/30 days |
| Zomig® tablets | NP |  | 6/30 days |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Atypical Antipsychotic/SSRI Combos** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers;* ***OR*** * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Duration of short-term therapy is 90 days for antipsychotics* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at****:***[*I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| fluoxetine/ olanzapine | NP | * For diagnosis of depressive episodes associated with bipolar disorder; **AND** o Refractory to treatment with components taken separately * For diagnosis of major depressive disorder:   o Must have undergone an adequate trial of at least **ONE** agent in THREE of the following classes of antidepressants (unless contraindicated or intolerant to):  ­ Selective serotonin reuptake inhibitors (SSRIs)  ­ Serotonin-norepinephrine reuptake inhibitors (SNRIs)  ­ New generation antidepressants (including bupropion, mirtazapine, etc.); **AND** o Refractory to treatment with components taken separately | 1/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Symbyax® | NP | See fluoxetine/olanzapine prior authorization criteria | 1/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Atypical Antipsychotics** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers* * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Duration of short-term therapy is 90 days for antipsychotics* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| ***Note****: A list of ICD-10 to allow PA bypass for preferred atypical antipsychotics that require PA can be found a*[*t Appropriate Diagnosis for PA Bypass List*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/pharmacist/program-information/Appropriate%20Diagnosis%20for%20PA%20Bypass%20List.pdf) | | | | |
| Abilify Asimtufii® | P | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to the oral active ingredient | 1 injection/60 days | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Abilify Maintena® | P | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to the oral active ingredient | 1/30 days |
| aripiprazole ODT | P |  | 1/day |
| aripiprazole solution | P |  | 10 mL/day |
| aripiprazole tablets | P |  | 1/day |
| Aristada® | P | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to the oral active ingredient | 1064 mg: 1/60 days; All other strengths: 1/30 days |
| Aristada® Initio | P | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to the oral active ingredient | 2.4 mL/60 days |
| asenapine | NP | See lurasidone prior authorization criteria | 2/day |
| clozapine | P |  | 1/day |
| Erzofri® | P | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to the oral active ingredient | 1 injection/28 days |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Invega Hafyera® | P | * Patient is > 18 years of age; **AND** * TennCare prescription claims history must indicate patient has been on Invega Sustenna® for 4 months OR Invega Trinza for at least one three-month cycle | 1 syringe/168 days | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Invega Sustenna® | P | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to the oral active ingredient | 1 syringe/28 days |
| Invega Trinza® | P | * Patient is > 18 years of age; **AND** * TennCare prescription claims history must indicate patient has been on Invega Sustenna® for 4 months | 1 syringe/76 days |
| lurasidone | P | * Diagnosis of ONE of the following: o Agitation in dementia o Bipolar and manic disorders   + Bipolar depression, bipolar maintenance, bipolar mania-acute, bipolar mixed states o Brief psychotic disorder o Delusional disorder   + Depression with psychotic symptoms   + Drug-induced psychotic disorder with hallucinations   + Impulse control disorders, including Oppositional Defiant Disorder and Intermittent Explosive Disorder o Organic psychotic condition   + Psychosis secondary to a medical condition, psychotic depression, psychotic disorders   + Schizoaffective disorder, schizoid/schizotypal personality disorder, schizophrenia, schizophrenic disorders o Substance-induced psychotic disorder, substance-induced withdrawal psychotic disorder o Severe refractory OCD or PTSD o Tourette’s/Severe tic disorder; **OR** * Diagnosis of major depressive disorder (MDD)**; AND** o Atypical agents will be approved only as adjunctive treatment for MDD; **AND** o Adequate trial(4 - 6 weeks) of ONE agent from any of the following classes (unless contraindication or intolerance): ­ SSRIs   ­ SNRIs  ­ TCAs  ­ New generation antidepressants (including bupropion, mirtazapine, etc.); **OR**   * For patients without one of the above diagnoses:   + May be approved if the physician can provide documented clinical evidence supporting the use of the requested medication for the requested indication | 1/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| olanzapine tablets | P |  | 1/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| olanzapine IM injection | P | See lurasidone prior authorization criteria | 1/day |
| olanzapine ODT | P | See lurasidoneprior authorization criteria; **AND**  • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance | 1/day |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| paliperidone ER | P |  | 6 mg: 2/day; All other strengths: 1/day |  |
| Perseris® | P | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to oral risperidone | 1 injection/month | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| quetiapine | P |  | 4/day |
| quetiapine ER | P | See lurasidone prior authorization criteria | 2/day |
| risperidone ODT | P | See olanzapine ODTprior authorization criteria | 2/day |
| risperidone solution | P | See lurasidone prior authorization criteria |  | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| risperidone tabs | P |  | 2/day |
| Uzedy | P | * Patient is > 18 years of age; **AND** * Documented tolerance to the oral active ingredient | 50, 75, 100, & 125 mg:  1 injection/30 days 150, 200, & 250 mg:  1 injection/60 days |
| Vraylar® | P | See lurasidone prior authorization criteria | 1/day |
| ziprasidone injection | P | See lurasidone prior authorization criteria | 2/day |
| ziprasidone caps | P |  | 2/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Abilify® tablets | NP | * Approval of non-preferred atypical antipsychotics requires trial and failure of ONE preferred agent; **AND** * Diagnosis of ONE of the following: o Agitation in dementia o Bipolar and manic disorders   + Bipolar depression, bipolar maintenance, bipolar mania-acute, bipolar mixed states o Brief psychotic disorder o Delusional disorder   + Depression with psychotic symptoms   + Drug-induced psychotic disorder with hallucinations   + Impulse control disorders, including Oppositional Defiant Disorder and Intermittent Explosive Disorder o Organic psychotic condition   + Psychosis secondary to a medical condition, psychotic depression, psychotic disorders   + Schizoaffective disorder, schizoid/schizotypal personality disorder, schizophrenia, schizophrenic disorders o Substance-induced psychotic disorder, substance-induced withdrawal psychotic disorder o Severe refractory OCD or PTSD o Tourette’s/Severe tic disorder; **OR** * Diagnosis of major depressive disorder (MDD)**; AND** o Atypical agents will be approved only as adjunctive treatment for MDD; **AND** o Adequate trial(4 - 6 weeks) of ONE agent from any of the following classes (unless contraindication or intolerance): ­ SSRIs   ­ SNRIs  ­ TCAs  ­ New generation antidepressants (including bupropion, mirtazapine, etc.); **OR**   * For patients without one of the above diagnoses:   + May be approved if the physician can provide documented clinical evidence supporting the use of the requested medication for the requested indication | 1/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Abilify MyCite® | NP | See lurasidone prior authorization criteria; **AND**  • Clinically valid reason why none of the other forms of aripiprazole cannot be used | 1/day |
| Caplyta® | NP | See Abilify® tablets prior authorization criteria | 1/day |
| clozapine ODT | NP | See Abilify® tablets prior authorization criteria; **AND**  • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance | 12.5 & 25 mg: 2/day; 100mg: 9/day; 150mg:  6/day; 200mg: 4/day |
| Clozaril® | NP | See Abilify® tablets prior authorization criteria | 1/day |
| Cobenfy® |  | * Patient is 18 years of age or older; **AND** * Diagnosis of schizophrenia; **AND** * Approval of non-preferred atypical antipsychotics requires trial and failure of ONE preferred agent; **AND** * Prescriber attests patient does NOT have any of the following:   + Urinary retention   + Moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment o Gastric retention   + Untreated narrow-angle glaucoma | 2/day |  |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Fanapt® | NP | See Abilify® tablets prior authorization criteria | 2/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Geodon® | NP | See Abilify® tablets prior authorization criteria | 2/day |
| Invega® | NP | See Abilify® tablets prior authorization criteria | 6 mg: 2/day; All others: 1/day |
| Latuda® | NP | See Abilify® tablets prior authorization criteria |  |
| Lybalvi® | NP | * Patient is ≥18 years of age; **AND** * One of the following:   + Diagnosis of schizophrenia   + Diagnosis of Bipolar I disorder and will be used for the acute treatment of manic or mixed episodes o Diagnosis of Bipolar I disorder and will be used as maintenance monotherapy treatment * Prescriber must attest that patient does not meet any of the following:   + Patient is using opioids or has used a short-acting opioid in the last 7 days or a long-acting opioid in the last 14 days o Patient is undergoing acute opioid withdrawal; **AND** * Approval of non-preferred atypical antipsychotics requires trial and failure of ONE preferred agent; **AND** * Submission of medical records (e.g. chart notes) documenting ONE of the following:   + Patient has a BMI of 30 kg/m2 or greater; **OR**   + Patient has a BMI of 27 kg/m2 or greater with a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) ; **OR**   + Patient has a documented history of weight gain of greater than or equal to 10% of their baseline weight after trial and failure of a preferred atypical antipsychotic; **OR** o Patient is stable on Lybalvi (minimum trial duration 4 weeks) and the request is for continuation of therapy | 1/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Nuplazid® | NP | * Hallucinations and/or delusions associated with Parkinson’s disease psychosis; **AND** * Must be ≥18 years of age; **AND** * Trial of dose adjustment or withdrawal of anti-Parkinson medications (anticholinergics, amantadine, dopamine agonists, COMT inhibitors, selegiline) prior to treatment with Nuplazid® * Trial and failure of ONE preferred agent   **Note:** Coverage will not be approved for psychosis not related to Parkinson’s disease | 2/day |
| Opipza® | NP | See lurasidone prior authorization criteria; AND  • Clinically valid reason why none of the other forms of aripiprazole (e.g. aripiprazole ODT) cannot be used | 2mg, 5mg: 1/day; 10mg: 3/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Rexulti® | NP | See Abilify® tablets prior authorization criteria  **Note**: Rexulti used for the diagnosis of agitation in dementia does NOT require trial and failure of ONE preferred agent | 1/day |
| Risperdal® | NP | See Abilify® tablets prior authorization criteria | 2/day |
| Risperdal Consta® | NP | * Patient is > 18 years of age; **ANDa** * Documented tolerance to the oral active ingredient; **AND** * One of the following:   + Diagnosis of Bipolar Disorder   + Clinically valid reason why the patient cannot use the preferred long-acting injectables | 2 vials/28 days | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| risperidone ER injection | NP | See Risperdal Consta® prior authorization criteria | 2 vials/28 days |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Rykindo® | NP | See Risperdal Consta® prior authorization criteria | 2 injections/28 days |  |
| Saphris® | NP | See Abilify® tablets prior authorization criteria | 2/day |  |
| Secuado® | NP | See Abilify® tablets prior authorization criteria; **AND**  • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance | 1/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Seroquel® | NP | See Abilify® tablets prior authorization criteria | 4/day |
| Seroquel® XR | NP | See Abilify® tablets prior authorization criteria | 2/day |
| Versacloz® | NP | See Abilify® tablets prior authorization criteria; **AND**  • Allergy or intolerance to inactive ingredient in clozapine ODT tab (i.e., dye, filler, excipient, etc); **OR** • Dose not achievable with ODT tab |  |
| Zyprexa® IM injection | NP | * Patient is > 18 years of age; **AND** * Patient has documented tolerance to the oral active ingredient; **AND** * Trial and failure of ONE preferred atypical antipsychotic | 1/day | [Atypical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [Antipsychotic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf)  [PA form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Atypical%20Antipsychotic%20PA%20Form.pdf) |
| Zyprexa® tablets | NP | See Abilify® tablets prior authorization criteria | 1/day |
| Zyprexa Relprevv® | NP | * Patient is > 18 years of age; **AND** * Documented tolerance to the oral active ingredient; **AND** * Clinically valid reason why the patient cannot use the preferred long-acting injectables | 210mg, 300mg:  1 injection/2 weeks; 450mg:  1 injection/month |
| Zyprexa Zydis® | NP | See Abilify® tablets prior authorization criteria; **AND**  • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance | 1/day |
|  | **Miscellaneous CNS Agents** | | |  |
| Nuedexta® | NP | * Diagnosis of Pseudobulbar Affect (PBA); **AND** * The following patient circumstances have been excluded:   o Heart failure or high grade (second/third degree) atrioventricular block (AV) without an implanted pacemaker o Patient receiving drugs that prolong QT interval and are metabolized by CYP2D6 system o Prolonged QT interval (including congenital long QT syndrome) or a history of torsades de pointes o Concomitantly taking monoamine oxidase inhibitors (MAOIs) or have used a MAOI in the past 14 days | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Mood Stabilizers** | | |  |
| Lamictal® ODT | NP | * Unable to swallow; **OR** * Unable to absorb medications through the GI tract |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Sedative Hypnotics** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Sedative hypnotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers* * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| doxepin concentrate 10mg/mL | P |  |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| eszopiclone | P |  | 14/30 days\* |
| ramelteon | P |  | 14/30 days\* |
| zaleplon | P |  | 14/30 days\* |
| zolpidem | P |  | 14/30 days\* |
| Ambien® | NP |  | 14/30 days\* |
| Ambien CR® | NP |  | 14/30 days\* |
| Belsomra® | NP |  | 14/30 days\* |
| Dayvigo® | NP | * Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance; **AND** • Patient is 18 years of age or older; **AND** * Narcolepsy and other insomnia related disorders have been ruled out (e.g., movement, breathing, psychiatric disorders, medications); **AND** * Trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND** * Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** * Patients who are pregnant should be registered in the Dayvigo® pregnancy registry | 14/30 days\* |
| Doral® | NP | See Halcion® prior authorization criteria | 14/30 days\* |
| doxepin soln | NP | • Documented trial/failure (defined as ≥ 1 week) at an appropriate dose of the doxepin 10mg/mL concentrated solution | 14/30 days\* |
| Edluar® | NP | • Patient is unable to swallow solid dosage forms | 14/30 days\* |  |
| estazolam | NP | See flurazepam prior authorization criteria | 14/30 days\* | [Anti-anxiety](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| flurazepam | NP | * Diagnosis of Insomnia; **AND** * Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders and medication); **AND** * Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND** * Use of 2 preferred agents, unless patient has a contraindication or allergy; **AND** * Due to increased risk of toxicity, patient should not be pregnant; **AND** * Will not be taken concurrently with CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse | 14/30 days\* | [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| Halcion® | NP | * Diagnosis of Insomnia; **AND** * Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders & medication/substance use); **AND** * Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures & relaxation therapy); **AND** * Use of 2 preferred agents, unless patient has a contraindication or allergy; **AND** * Clinical reason as to why patient cannot use generic equivalent; **AND** * Due to increased risk of toxicity, patient should not be pregnant; **AND** * Will not be taken concurrently with CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol **OR** drug dependence/abuse | 14/30 days\* |
| Hetlioz® capsules | NP | * Treatment of non-24-hour sleep wake disorder (non-24 or N24) in members who are unable to distinguish between light and darkness in both eyes; **OR** * Treatment of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older; **AND** * Trial and failure or contraindication to melatonin; **AND** * Patient will not take any of the following:   o Strong CYP1A2 inhibitors (e.g., fluvoxamine) o Strong CYP3A4 inducers (e.g., rifampin) | 30/60 days\* | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Hetlioz® suspension | NP | * Treatment of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS); **AND** * Patient is at least 3 years of age but not greater than 15 years of age; **AND** * Trial and failure or contraindication to melatonin; **AND** * Patient is unable to swallow/absorb medications through the GI tract; **AND** * Patient will not take any of the following:   o Strong CYP1A2 inhibitors (e.g., fluvoxamine) o Strong CYP3A4 inducers (e.g., rifampin) | 5 mL per day  158 mL/60 days\* |
| Intermezzo® | NP |  | 14/30 days\* |
| Lunesta® | NP |  | 14/30 days\* |
| Rozerem® | NP |  | 14/30 days\* |
| quazepam | NP | See flurazepam prior authorization criteria | 14/30 days\* |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Quviviq® | NP | * Patient must 18 years of age or older; **AND** * Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance; **AND** * Narcolepsy and other insomnia related disorders have been ruled out (e.g., movement, breathing, psychiatric disorders, medications); **AND** * Trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND** * Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** * Patient should not have any of the following diagnoses: Narcolepsy, COPD, or moderate to severe OSA; **AND** * Concurrently not taking CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND** * Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND** • Patients who are pregnant should be registered in the Quviviq® pregnancy registry | 14/30 days\* |  |
| Restoril® | NP | See Halcion® prior authorization criteria | 14/30 days\* | [Anti-anxiety Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| Rozerem® | NP |  | 14/30 days\* |  |
| tasimelteon capsules |  | See Hetlioz capsules prior authorization criteria; **AND** Clinically valid reason why Hetlioz® cannot be used | 30/60 days\* |  |
| tasimelteon suspension | NP | See Hetlioz suspension prior authorization criteria; **AND**  • Clinically valid reason why Hetlioz® cannot be used | 5 mL per day  158 mL/60 days\* |  |
| temazepam | NP | See flurazepam prior authorization criteria | 14/30 days\* | [Anti-anxiety Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Anti-anxiety%20PA%20Form.pdf) |
| triazolam | NP | See flurazepam prior authorization criteria | 14/30 days\* |
| zolpidem ER | NP |  | 14/30 days\* | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| zolpidem tartrate SL | NP |  | 14/30 days\* |
| ***\* For children, larger quantities may be approved as medically necessary.*** | | |  |  |
| **Skeletal Muscle Relaxants** | | |  |  |
| Amrix ® | NP | * Diagnosis of an FDA-approved indication; **AND** * Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred cyclobenzaprine | 1/day | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| baclofen solution | NP | * Diagnosis of spasticity with flexor spasms and concomitant pain, clonus, and/or muscular rigidity (e.g., multiple sclerosis, spinal cord injury, other spinal cord disease); **AND** * Documented inability to swallow baclofen tablets | 16 mL/day |
| baclofen suspension | NP | * Diagnosis of spasticity with flexor spasms and concomitant pain, clonus, and/or muscular rigidity (e.g., multiple sclerosis, spinal cord injury, other spinal cord disease); **AND** * Documented inability to swallow baclofen tablets; **AND** * Trial and failure of baclofen solution | 16 mL/day |
| carisoprodol | NP | * Patient is 16 years of age or older; **AND** * Contraindication, drug to drug interaction, or history of toxic side effects that will cause immediate or long-term damage with ALL preferred skeletal muscle relaxants; **AND** | 4/day |

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|  | **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | * Patient does not have a history of, or received treatment for, drug dependency or drug abuse; **AND** * Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 30 days; **AND** • Patient is not concurrently utilizing any other opioid therapy |  |  |
| cyclobenzaprine ER | NP | See Amrix® prior authorization criteria | 1/day |
| Fleqsuvy® | NP | See baclofen suspension prior authorization criteria | 16 mL/day |
| Lyvispah® | NP | See baclofen suspension prior authorization criteria | 4 packets/day |
| Norgesic Forte® | NP | * Diagnosis of an FDA-approved indication**; AND** * Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents |  |
| Soma® | NP | See carisoprodol prior authorization criteria | 4/day |

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| **CENTRAL NERVOUS SYSTEM**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Typical Antipsychotics** | | | | |
| **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**  *Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if* ***ONE*** *of the following is met:*   * *Prescribed by a Gold Card prescriber;* ***OR*** * *There has been a mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;* ***AND***o *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist;* ***AND***   + *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers;* ***OR*** * *Short-term therapy (less than 90 days) has been prescribed;* ***AND***o *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement;* ***OR***   ­ *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met;* ***AND***o *Efficacy and potential side effects to be monitored;* ***AND***   * + *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following****:* * *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* * *The I/DD Worksheet can be found at*[***:*** *I/DD Prior Authorization Form*](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/IDD%20Worksheet%20PA%20Form.pdf) | | | | |
| chlorpromazine | P |  |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| fluphenazine | P |  |  |
| haloperidol | P |  |  |
| loxapine | P |  |  |
| perphenazine | P |  |  |
| pimozide | P |  |  |
| thioridazine | P |  |  |
| thiothixene | P |  |  |
| trifluoperazine | P |  |  |
| molindone | NP |  |  |
| Orap® | NP |  |  |

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|  |  | **DERMATOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Acne Agents, Topical**  (Covered for recipients < 21 years old only) |  |  |
| benzoyl peroxide 2.5%, 5%, 10% (excluding cleanser, gel, microspheres, and towelettes) | P |  | 1 package/Rx | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| clindamycin phosphate (excluding foam, lotion, & 75 mL bottle of gel) | P |  | 1 package/Rx |
| clindamycin/benzoyl peroxide gel | P |  | 1 package/Rx |
| erythromycin (excluding swab &  gels) | P |  | 1 package/Rx |
| sodium  sulfacetamide/ sulfur | P |  | 1 package/Rx |
| Aczone® | NP | * Patient is at least 12 years of age and less than 21 years of age; **AND** * Patient has a diagnosis of acne vulgaris; **AND** * Clinically valid reason why generic dapsone gel cannot be used | 1 package/Rx |
| Amzeeq® | NP | * Diagnosis of non-nodular moderate to severe acne vulgaris; **AND** * Patient is at least 9 years of age and less than 21 years of age; **AND** * Trial and failure, contraindication, or intolerance to ALL the following:   o 2 preferred agents o minocycline capsules; **AND**   * Prescriber must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents | 1 package/28 days | [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| benzoyl peroxide (excluding preferred products) | NP |  | 1 package/Rx |
| Cabtreo® | NP | * Patient is at least 12 years of age and less than 21 years of age; **AND** * Patient has a diagnosis of acne vulgaris; **AND** * Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents | 1 package/Rx |
| clindamycin  (excluding preferred products) | NP |  | 1 package/Rx |
| dapsone gel | NP | * Patient is at least 12 years of age and less than 21 years of age; **AND** * Patient has a diagnosis of acne vulgaris; **AND** * Clinically valid reason why the preferred agents cannot be used | 1 package/Rx |

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|  |  | **DERMATOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| dermatological kits | NP | * Trial and failure of 3 preferred agents; **AND** * Trial and failure of the individual components of the kit | 1 package/Rx | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| erythromycin/benzol peroxide | NP |  | 1 package/Rx |
| erythromycin swab & gel | NP |  | 1 package/Rx |
| sulfacetamide suspension | NP |  | 1 package/Rx |
| Winlevi® | NP | * Diagnosis of acne vulgaris; **AND** * Patient is at least 12 years of age and less than 21 years of age; **AND** * Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** * Prescriber provides peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents | 1 tube/30 days |
| All branded single agent and combination products of benzoyl peroxide, clindamycin, erythromycin, and sodium sulfacetamide | NP |  | 1 package/Rx |
|  |  | **Agents for Burns, Topical** |  |  |
| silver sulfadiazine | P |  | 1 package/Rx | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| SSD® | P |  | 1 package/Rx |
| mafenide | NP |  | 1 package/Rx |
| Silvadene® | NP |  | 1 package/Rx |
| Sulfamylon® | NP |  | 1 package/Rx |
|  |  | **Agents for Rosacea, Topical**  (Covered for recipients < 21 years old only) |  |  |
| Finacea® foam | P |  | 50 g/Rx | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| metronidazole cream, lotion, and gel | P |  | 60 g/Rx |
| brimonidine gel | NP |  | 30 g/Rx |
| ivermectin cream | NP |  | 45 g/Rx |
| Mirvaso® | NP |  | 30 g/Rx |

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|  |  | **DERMATOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Noritate® cream | NP |  | 60 g/Rx |  |
| Rhofade® | NP | * Patient age < 21 years of age; **AND** * Patient has a diagnosis of persistent facial erythema associated with rosacea; **AND** * Trial and failure, or contraindication, of 2 of the following: brimonidine, ivermectin, tetracycline, minocycline, doxycycline, erythromycin, clindamycin, benzoyl peroxide; **AND** * Trial and failure of 2 preferred topical agents for rosacea | 30 g/30 days |  |
|  |  | **Anesthetics, Topical** |  |  |
| lidocaine (excluding lotion, solution, kits) | P |  | 1 tube/Rx | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| lidocaine patch 5% | P | • Diagnosis of post-herpetic neuralgia | 3/day |
| lidocaine/prilocaine | P |  | 30 g/Rx |
| ZTLido® | P | • Diagnosis of Postherpetic neuralgia | 3/day |
| lidocaine kits | NP | * Diagnosis of FDA-approved indication; **AND** * Clinically valid reason why the preferred topical anesthetics cannot be used; **AND** • For combination kits, trial and failure of individual agents |  |
| lidocaine/ hydrocortisone | NP | * Diagnosis of FDA-approved indication; **AND** * Clinically valid reason why the preferred topical anesthetics cannot be used | 1 package/Rx |
| Pliaglis® | NP |  | 1 package/Rx |
| Pramosone® 2.5-1% lotion | NP |  | 1 package/Rx |
|  |  | **Antibiotics, Topical** |  |  |
| mupirocin ointment | P |  | 44 g/Rx | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| mupirocin cream | NP |  | 30 g/Rx |
|  |  | **Antifungal Agents, Topical** |  |  |
| ciclopirox cream | P |  | 1 package/Rx | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| ciclopirox solution 8% | P |  |  |
| clotrimazole 1% cream & soln [(OTC)](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/Covered%20OTC%20List.pdf) | P |  | 1 package/Rx |
| clotrimazole 1% cream (Rx) | P |  | 1 package/Rx |
| clotrimazole/ betamethasone | P |  | 1 package/Rx |
| ketoconazole (cream and shampoo) | P |  | 1 package/Rx |
| nystatin/ triamcinolone | P |  | 1 package/Rx |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| nystatin powder | P |  | 120 g/Rx |  |
| Vusion® | P |  | 1 package/Rx |
| ciclopirox gel and suspension | NP |  | 1 package/Rx |
| ciclopirox nail kit | NP | • Clinically valid reason for why the preferred topical ciclopirox 8% solution cannot be used |  |
| clotrimazole 1% solution (Rx) | NP |  | 1 package/Rx | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| econazole | NP |  | 1 package/Rx |
| Ertaczo® | NP |  | 1 package/Rx |
| Jublia® | NP | * Diagnosis of mild to moderate onychomycosis of the toenails; **AND** * Trial and failure, contraindication, or intolerance to the preferred topical ciclopirox 8% solution | 1 package/Rx |
| Klayesta® | NP |  | 1 package/Rx |
| luliconazole | NP |  | 1 package/Rx |
| Luzu® | NP |  | 1 package/Rx |
| miconazole/zinc/ petrolatum | NP | • Clinically valid reason for why the preferred Vusion cannot be used | 1 package/Rx |
| naftifine gel | NP |  | 1 package/Rx |
| Nyamyc® | NP |  | 1 package/Rx |
| oxiconazole | NP |  | 1 package/Rx |
| Oxistat® | NP |  | 1 package/Rx |
| tavaborole soln | NP | See Jublia® prior authorization criteria | 1 package/Rx |
|  | **Antineoplastics, Topical** | |  |  |
| diclofenac 3% gel | P | • Diagnosis of actinic keratosis | 1 package/Rx |  |
| fluorouracil 5% cream | P |  | 1 package/Rx |
| imiquimod | P |  | 1 package/Rx |
| Targretin® | P |  | 1 package/Rx |
| bexarotene | NP |  | 1 package/Rx |
| Efudex® | NP |  | 1 package/Rx |
| fluorouracil 0.5% cream | NP |  | 1 package/Rx |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Hyftor® | NP | **Initial Criteria (4-month duration):**   * Diagnosis of facial angiofibroma associated with tuberous sclerosis complex; **AND** * Patient is 6 years of age or older; **AND** * Prescribed by or in consultation with a dermatologist or neurologist; **AND** • Patient is not a candidate for laser therapy or surgical treatments **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement in size or redness of facial angiofibroma) | 30 g/month | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Valchlor® | NP | * Diagnosis of stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma; **AND** * Patient has received skin directed therapy | 1 package/Rx |
| Zyclara® | NP | * Diagnosis of actinic keratosis; **OR** * Diagnosis of basal cell carcinoma | 1 package/Rx |
|  | **Antipruritics/Antihistamines, Topical** | |  |  |
| doxepin cream | NP | * Patient has moderate pruritus due to various forms of eczematous dermatitis, including atopic dermatitis and lichen simplex chronicus; **AND** * Inadequate response, intolerance, or contraindication to BOTH of the following:   o A topical corticosteroid o An oral antihistamine (first or second generation) or a topical antihistaminic agent | 45g/90 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Prudoxin® | NP | See doxepin cream prior authorization criteria | 45g/90 days |
| Zonalon® | NP | See doxepin cream prior authorization criteria | 45g/90 days |
|  | **Antipsoriatics, Oral** | |  |  |
| acitretin | NP | * Patient has a diagnosis of severe psoriasis; **AND** * Minimum duration of a 4-week trial and failure, contraindication, or intolerance to at least two of the following:   + Corticosteroids (e.g., betamethasone, clobetasol) o Vitamin D analogs (e.g., calcitriol, calcipotriene) o Tazarotene   + Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) * Prescriber attests to each of the following:   + Patient doesNOT have impaired liver or kidney function, or abnormally elevated lipid levels   + Patient will NOT be receiving concomitant methotrexate (due to risk of hepatitis) or tetracyclines (due to risk of increased intracranial pressure)   + If applicable, appropriate laboratory assessments and counseling have been conducted regarding risks associated with pregnancy   **Note:** Will not be covered for the diagnosis of acne or rosacea for recipients > 21 years of age. | 10 mg (3/day);  17.5, 22.5, & 25 mg (2/day) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| methoxsalen | NP | * Diagnosis of severe, recalcitrant, disabling psoriasis supported by biopsy; **AND** * Minimum duration of a 4-week trial and failure, contraindication, or intolerance to at least two of the following:   + Corticosteroids (e.g., betamethasone, clobetasol) o Vitamin D analogs (e.g., calcitriol, calcipotriene) o Tazarotene   + Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) |  |

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| **DERMATOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Antipsoriatics, Topical** | | | | |
| calcipotriene cream | P | • Trial and failure, contraindication, or intolerance to > 1 topical steroid | 1 package/Rx | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| calcipotriene foam |  | • Trial and failure, contraindication, or intolerance to > 1 topical steroid | 1 package/Rx |
| calcipotriene scalp soln | P | • Trial and failure, contraindication, or intolerance to > 1 topical steroid |  |
| Sorilux® | P | • Trial and failure, contraindication, or intolerance to > 1 topical steroid | 1 package/Rx |
| Taclonex® | P | • Trial and failure, contraindication, or intolerance to > 1 topical steroid |  |
| tazarotene 0.1% cream | P | * Diagnosis of psoriasis; **OR** * Diagnosis of acne in patients less than 21 years of age | 1 package/Rx |
| calcipotriene ointment | NP | * Trial and failure, contraindication, or intolerance to > 1 topical steroid; **AND** * Trial and failure, contraindication, or intolerance to a preferred topical antipsoriatic agent | 1 package/Rx |
| calcitriol ointment | NP | See calcipotriene foam prior authorization criteria | 1 package/Rx |
| calcipotriene/ betamethasone | NP | See calcipotriene ointment prior authorization criteria | 1 package/Rx |
| Саlϲitreոe® ointment |  | See calcipotriene ointment prior authorization criteria | 1 package/Rx |
| Duobrii® | NP | * Patient has a diagnosis of plaque psoriasis; **AND** * Trial and failure, contraindication, or intolerance to at least one topical steroid; **AND** * Clinically valid reason why the preferred individual components cannot be taken separately | 200 mg/30 days |
| Enstilar® | NP | See calcipotriene ointment prior authorization criteria | 1 package/Rx |
| Sorilux® | NP | See calcipotriene ointment prior authorization criteria | 1 package/Rx |
| tazarotene 1% gel | NP | * Diagnosis of psoriasis AND Both of the following:   + Trial and failure, contraindication, or intolerance to at least one topical steroid;   + Trial and failure, contraindication, or intolerance to a preferred topical antipsoriatic agent**; OR** * Diagnosis of acne in patients less than 21 years of age; **AND** o Trial and failure, contraindication, or intolerance to TWO preferred topical retinoids | 1 package/Rx |
| Vtama® | NP | **Initial Criteria:**   * Diagnosis of plaque psoriasis; **AND** o Minimum duration of a 4-week trial and failure, contraindication, or intolerance to at least two of the following: ­ Corticosteroids (e.g., betamethasone, clobetasol)   ­ Vitamin D analogs (e.g., calcitriol, calcipotriene) ­ Tazarotene  ­ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus; **OR**   * Diagnosis of atopic dermatitis and Both of the following:   + Trial and failure, contraindication, or intolerance to a topical corticosteroid AND a topical calcineurin inhibitor; **AND** • Prescribed by, or in consultation with, a dermatologist **Renewal Criteria:** * Documentation of positive clinical response to therapy as evidenced by one of the following:   + Reduction in the body surface area (BSA) involvement from baseline o Improvement in symptoms (e.g., pruritus, inflammation) from baseline | 60 grams/28 days |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Zoryve® 0.3% cream | NP | **Initial Criteria:**   * Diagnosis of mild to plaque psoriasis; **AND** * Patient is 6 years of age or older; AND * Patient does not have moderate to severe liver impairment (Child-Pugh B or C); **AND** * Request is for Zoryve 0.3% cream; **AND** * Trial and failure, contraindication, or intolerance to TWO preferred topical antipsoriatic agents **Renewal Criteria:** * Patient continues to be monitored for liver impairment; **AND** * Documented clinical improvement in response to treatment (e.g. reduction in itch, rash, inflammation) | 60 grams/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Antiseborrheic Agents** | |  |  |
| selenium sulfide 2.5% lotion | P |  | 1 package/Rx | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Zoryve® 0.3% topical foam | NP | **Initial Criteria: (3-month duration)**   * Diagnosis of seborrheic dermatitis; **AND** * Patient is 9 years of age or older; **AND** * Patient does not have moderate to severe liver impairment (Child-Pugh B or C); **AND** * Trial and failure, contraindication, or intolerance to BOTH of the following agents:   o Topical antifungals (ketoconazole, ciclopirox, miconazole, clotrimazole) o Topical corticosteroids **Renewal Criteria:**   * Patient continues to be monitored for liver impairment; **AND** * Documented clinical improvement in response to treatment (e.g., decreased erythema, scaling, inflammation); **AND** • Patient does not have any treatment limiting adverse effects | 1 can (60 gr)/30 days |
|  | **Antivirals, Topical** | |  |  |
| acyclovir 5% ointment | P |  | 1 tube/Rx | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| penciclovir cream | P |  | 1 tube/Rx |
| acyclovir cream | NP |  | 1 tube/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Denavir® cream | NP |  | 1 tube/Rx |
| Xerese® | NP | * Patient must be 6 years of age and older; **AND** * Diagnosis of recurrent herpes labialis; **AND** * Trial and failure of the individual components of the kit | 1 tube/Rx |
| Zovirax® cream | NP |  | 1 tube/Rx |
| Zovirax® ointment | NP |  | 1 tube/Rx |
|  | **Atopic Dermatitis, Topical** | |  |  |
| Elidel® | P |  | 1 package/Rx |  |
| tacrolimus ointment | P |  | 1 package/Rx |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Eucrisa® | NP | * Diagnosis of atopic dermatitis; **AND** * One of the following:   o Patient is ≥ 2 years and meets BOTH of the following; **AND**  ­ Trial and failure, contraindication, or intolerance to BOTH of the following:   * A topical corticosteroid; **AND** * A topical calcineurin Inhibitor (e.g., Elidel or tacrolimus ointment)**; OR**   o Patient is <2 years and greater than 3 months of age; **AND**  ­ Trial and failure, contraindication, or intolerance to ONE topical corticosteroid | 1 tube/month | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Opzelura® | NP | **Initial Criteria:**   * One of the following:   + Diagnosis of mild to moderate atopic dermatitis (3-month approval duration)and BOTH of the following: ­ Patient is not immunocompromised; **AND**   ­ Opzelura will only be used for short-term and/or non-continuous chronic treatment; **O*R***o Diagnosis of Nonsegmental Vitiligo (12-month approval duration); **AND**   * Patient is 12 years of age or older; **AND** * Patient is not breastfeeding; **AND** * Trial and failure, contraindication, or intolerance to a topical corticosteroid; **AND** • Trial and failure, contraindication, or intolerance to a topical calcineurin inhibitor; **AND** * Prescriber attests to each of the following:   + Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**   + Benefits of using this agent outweigh the heart-related or cardiovascular risk factors; **AND**   + Risk of malignancy has been considered and it has been determined that Jak Kinase inhibitor therapy is appropriate**Renewal Criteria:** * Positive response to therapy [e.g., reduction in symptoms (itch, rash, etc.), re-pigmentation, etc.] | 240 g/month | [Topical](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Topical%20Immunomodulator%20PA%20Form.pdf)  [Immunomodulators](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Topical%20Immunomodulator%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Topical%20Immunomodulator%20PA%20Form.pdf) |
| pimecrolimus | NP | * Patient must have a diagnosis of atopic dermatitis; **AND** * Trial and failure of 1 preferred agent (e.g., Elidel® or tacrolimus ointment) | 1 package/Rx |
| Zoryve® 0.15%cream | NP | **Initial Criteria:**   * Diagnosis of mild to moderate atopic dermatitis; **AND** * Patient is 6 years of age or older; **AND** * Patient does not have moderate to severe liver impairment (Child-Pugh B or C); **AND** * Request is for Zoryve 0.15% cream; **AND** * Trial and failure, contraindication, or intolerance to ONE topical corticosteroid; **AND** * Trial and failure, contraindication, or intolerance to ONE topical calcineurin inhibitor   **Renewal Criteria:**   * Patient continues to be monitored for liver impairment; **AND** * Documented clinical improvement in response to treatment (e.g. reduction in itch, rash, inflammation) | 60 gram/28 days |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Emollients** | |  |  |
| ammonium lactate (Rx & OTC) | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Genital Warts** | |  |  |
| imiquimod | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Condylox® | P |  | 1 package/Rx |
| Imiquimod pump | NP |  | 1 package/Rx |
| Veregen® | NP |  | 1 package/Rx |
| Zyclara® | NP |  | 1 package/Rx |  |
|  | **Keratolytic Agents** | |  |  |
| generic urea products | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| generic salicylic acid products | P |  | 1 package/Rx |
| brand urea products | NP |  | 1 package/Rx |
| brand salicylic acid products | NP |  | 1 package/Rx |
|  | **Pediculocides/Scabicides** | |  |  |
| Natroba® | P |  | 2 bottles/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| permethrin | P |  | 2 tubes/Rx |
| VanaLice® | P |  | 1 bottle/Rx |
| Crotan® | NP | * Patient is being treated for scabies or pruritis; **AND** * Patient has tried/failed permethrin (unless patient has a contraindication) | 1 bottle/Rx |
| ivermectin lotion | NP |  | 1 tube/Rx |
| malathion | NP |  | 2 bottles/Rx |
| Ovide® | NP |  | 2 bottles/Rx |
| Sklice® | NP |  | 1 tube/Rx |
| spinosad | NP |  | 2 bottles/Rx |
|  | **Retinoids, Oral** | |  |  |
| Absorica® &  Absorica LD® | NP | * Diagnosis of chronic myelogenous leukemia, head or neck cancer, ichthyosis, keratosis follicularis, neuroblastoma, or pityriasis rubra pilaris will be reviewed on a case-by-case basis; **OR** * Diagnosis of severe recalcitrant nodular acne **AND**  o Patient is < 21 years of age (will not be covered for acne or rosacea for recipients ≥ 21 years of age)   **Note:** Active registration and compliance with the iPLEDGE program is required by prescriber, patient, and pharmacy. |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Accutane® | NP | See Absorica® prior authorization criteria |  |
| Amnesteem® | NP | See Absorica® prior authorization criteria |  |
| Claravis® | NP | See Absorica® prior authorization criteria |  |
| isotretinoin | NP | See Absorica® prior authorization criteria |  |
| Zenatane® | NP | See Absorica® prior authorization criteria |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Retinoids, Topical** | |  |  |
| adapalene | P | See tretinoin prior authorization criteria | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| tazarotene 0.1% cream | P | See Tazorac® prior authorization criteria (Topical Antipsoriatics section) | 1 package/Rx |
| tretinoin cream | P | * Patient is < 21 years old; **AND** o Diagnosis of acne, keratosis follicularis, verruca plana, or actinic keratosis; **OR** * Patient is > 21 years old: **AND** o Diagnosis of keratosis follicularis (1 year approval duration); **OR** o Diagnosis of verruca plana (2-month approval duration); **OR**   o Diagnosis of actinic keratosis for the prevention of future lesions (1 year approval duration)  **Note**: Will not be covered for patients > 21 years old with a diagnosis of acne | 1 package/Rx |
| adapalene/benzoyl peroxide | NP | See tretinoin prior authorization criteria  In addition, non-preferred criteria and trial and failure of individual components is required. | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Altreno® | NP | See Aklief® prior authorization criteria | 1 package/Rx |
| Atralin® | NP | See tretinoin prior authorization criteria | 1 package/Rx |
| Arazlo® | NP | * Patient is 9 years of age or older and less than 21 years of age; **AND** * Diagnosis of acne; **AND** * Patient is not pregnant; **AND** * Trial and failure, contraindication, or intolerance to 2 preferred agents; **AND** * Clinically valid reason why the requested drug is the only appropriate choice versus the preferred agents | 1 package/28 days |
| clindamycin/tretinoin | NP | See tretinoin prior authorization criteria | 1 package/Rx |
| Fabior® | NP | See Tazorac® prior authorization criteria (Topical Antipsoriatics section) | 1 package/Rx |
| Retin A® | NP | See tretinoin prior authorization criteria | 1 package/Rx |
| Retin A Micro® | NP | See tretinoin prior authorization criteria | 1 package/Rx |
| tretinoin gel | NP | See tretinoin prior authorization criteria | 1 package/Rx |
| Ziana® | NP | See tretinoin prior authorization criteria |  |
|  | **Topical Steroids: Least Potent** | |  |  |
| hydrocortisone 0.5% cream and ointment (Rx [& OTC)](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| hydrocortisone 1% cream, lotion, gel, and ointment (Rx & [OTC)](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | P |  | 1 package/Rx |
| hydrocortisone 2.5% cream, lotion, and ointment | P |  | 1 package/Rx |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Topical Steroids: Mild** |  |  |
| desonide 0.05% cream& ointment | P |  | 1 package/Rx |  |
| fluocinolone 0.01% cream, oil, solution | P |  | 1 package/Rx |
| Synalar® 0.01% solution | NP |  | 1 package/Rx |
|  |  | **Topical Steroids: Lower Mid-Strength** |  |  |
| betamethasone dipropionate 0.05% lotion | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| betamethasone valerate 0.1% cream | P |  | 1 package/Rx |
| Locoid Lipocream | P |  | 1 package/Rx |
| clocortolone 0.1% cream and pump | NP |  | 1 package/Rx |
| desonide 0.05% lotion | NP |  | 1 package/Rx |
| hydrocortisone butyrate 0.1% cream, lotion, ointment, solution | NP |  | 1 package/Rx |
| hydrocortisone valerate 0.2% cream | NP |  | 1 package/Rx |
| Locoid® lotion | NP |  | 1 package/Rx |
| Pandel® 0.1% cream | NP |  | 1 package/Rx |
|  |  | **Topical Steroids: Mid-Strength** |  |  |
| triamcinolone acetonide 0.1%  cream | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| hydrocortisone |  |  |  |
| valerate 0.2% ointment | NP |  | 1 package/Rx |  |
|  |  | **Topical Steroids: Upper Mid-Strength** |  |  |
| betamethasone valerate 0.1% ointment | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| fluticasone |  |  |  |
| propionate 0.005% ointment | P |  | 1 package/Rx |  |

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| **DERMATOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| triamcinolone acetonide 0.025% cream, lotion and ointment | P |  | 1 package/Rx |  |
| triamcinolone acetonide 0.05% ointment | P |  | 1 package/Rx |
| triamcinolone acetonide 0.1% lotion and ointment | P |  | 1 package/Rx |
| triamcinolone acetonide 0.5% cream and ointment | P |  | 1 package/Rx |
| amcinonide 0.1% cream and lotion | NP |  | 1 package/Rx |
| betamethasone dipropionate 0.05%  cream | NP |  | 1 package/Rx |
| betamethasone valerate 0.12% foam | NP |  | 1 package/Rx |
| desoximetasone 0.05% cream | NP |  | 1 package/Rx |
| fluocinonide 0.05% emulsified base cream | NP |  | 1 package/Rx |
| **Topical Steroids: Potent** | | | | |
| betamethasone dipropionate, augmented 0.05% cream | P |  | 1 package/Rx | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| ApexiCon E® 0.05% cream | NP |  | 1 package/Rx |
| betamethasone dipropionate,  augmented 0.05%  lotion | NP |  | 1 package/Rx |
| betamethasone dipropionate 0.05% ointment | NP |  | 1 package/Rx |
| desoximetasone  0.05% gel and | NP |  | 1 package/Rx |

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|  | | | **DERMATOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |
| **Medication** | **PDL** |  | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| ointment |  |  |  |  | [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| desoximetasone 0.25% cream, ointment, spray | NP |  |  | 1 package/Rx |
| diflorasone diacetate 0.05% cream and ointment | NP |  |  | 1 package/Rx |
| fluocinonide 0.05% cream, gel, and ointment | NP |  |  | 1 package/Rx |
| Halog® 0.1% ointment and cream | NP |  |  | 1 package/Rx |
| Halog® solution | NP |  |  | 120 mL per 30 days |
|  | | | **Topical Steroids: Super Potent** | | |
| clobetasol propionate 0.05% cream, gel, ointment, lotion, and solution | P |  |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| clobetasol propionate emollient base 0.05% cream | P |  |  | 1 package/Rx |
| fluocinonide 0.1% cream | P |  |  | 1 package/Rx |
| Bryhali® lotion | NP | •  • | Diagnosis of an FDA‐approved indication; **AND**  Clinically valid reason why the preferred individual components cannot be taken concomitantly | 200 g/28 days |
| betamethasone dipropionate, augmented 0.05% gel and ointment | NP |  |  | 1 package/Rx |
| clobetasol 0.025% cream | NP |  |  | 1 package/Rx |
| clobetasol propionate 0.05% foam, shampoo, and spray | NP |  |  | 1 package/Rx |
| clobetasol propionate emollient base 0.05% foam | NP |  |  | 1 package/Rx |
| halobetasol propionate 0.05% | NP |  |  | 1 package/Rx |
|  |  | **DERMATOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | | **Qty. Limits** | **PA Form** |
| cream, foam, and ointment |  |  | |  |  |
| Lexette® | NP | See Bryhali® prior authorization criteria | | 100 g/Rx |
| Ultravate® 0.05% lotion | NP |  | | 1 package/Rx |
|  |  | **Wound Care, Topical** | | |  |
| Filsuvez® | NP | **Initial Criteria: (6-month duration)**   * One of the following:   + Diagnosis of Dystrophic Epidermolysis bullosa (EB); o Diagnosis of Junctional Epidermolysis bullosa (EB); **AND** * Prescriber attests the target wound(s) meet ALL of the following:   + Wound is clean in appearance and does not appear to be infected o Wound is 10 cm2 to 50 cm2; **AND** * Patient will continue standard treatments for EB such asappropriate wound management and avoiding skin trauma; **AND** • Prescribed by or in consultation with a dermatologist or wound management **Renewal Criteria:** * Patient has a clinical response to therapy (e.g., decreased wound size, decreased frequency of wound dressing changes, reduction in pain)   **Note:** New wounds untreated with Filsuvez or recurrent reopened wounds are subject to initial criteria. Unhealed wounds > 6 months should rule out squamous cell and basal cell carcinoma. | | 15 tubes/per 30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  |  | **DIABETIC SUPPLIES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Blood Glucose Meters and Test Strips**  [(OTC)](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/program-information/Covered%20OTC%20List.pdf) |  |  |
|  |  | **Abbott Products** |  |  |
| FreeStyle Meters:  Lite, Freedom Lite, InsuLinx | P |  | **Meters:**  1/730 days  **Test Strips:**  Age ≤ 5: 306/30 days  Age > 6: 204/30 days | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
| Freestyle Test Strips: Lite, InsuLinx | P |  |
| All other Abbott diabetic supplies | P |  |
|  |  | **AgaMatrix Products** |  |  |

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|  | **DIABETIC SUPPLIES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Various | NP | See prior authorization criteria for Breeze-2 Meter (Bayer Products) | **Meters:**  1/365 days  **Test Strips:**  Age ≤ 5: 306/30 days  Age > 6: 204/30 day | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
|  | **Bayer Products** | | |  |
| Bayer Meters:  Breeze-2 & Contour | NP | • Non-preferred meters will be approved for patients meeting **ONE** of the following criteria:   * Patient is using an insulin pump that does not adequately communicate with a preferred meter. * Patient requires a special meter due to visual impairment | **Meters:** 1/365 days;  **Test Strips:**  Age ≤ 5: 306/30 days  Age > 6: 204/30 days | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
| Bayer Test Strips | NP | • Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for a Bayer diabetes meter. |
|  | NP |
|  | **Home Diagnostics Products** | | |  |
| Various | NP | See prior authorization criteria for Breeze-2 Meter (Bayer Products) | See Bayer Products | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
|  | **Johnson and Johnson Products** | | |  |
| OneTouch Meters:  UltraMini, Ping,  Ultra-2, UltraLink,  UltraSmart | NP | See prior authorization criteria for Breeze-2 Meter (Bayer Products) | **Meters:** 1/365 days; **Test Strips:**  Age ≤ 5: 306/30 days  Age > 6; 204/30 days | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
| Johnson & Johnson  Test Strips | NP | Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for a OneTouch diabetes meter. |
| All other OneTouch diabetic supplies | NP |
|  | **LifeScan Products** | | |  |
| Various | NP | See prior authorization criteria for Breeze-2 Meter (Bayer Products) | **Meters:** 1/365 days;  **Test Strips:**  Age ≤ 5: 306/36 days Age > 6: 204/30 days | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
|  | **Roche Products** | | |  |
| Accu-Chek Meters:  Aviva & Compact  Plus | NP | See prior authorization criteria for Breeze-2 Meter (Bayer Products) | **Meters:** 1/365 days;  **Test Strips:**  Age ≤ 5: 306/36 days  Age > 6: 204/30 days | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
| Roche Test Strips | NP | Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for an Accu-Chek diabetes meter. |
|  | NP |

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|  | **DIABETIC SUPPLIES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **All Manufacturers** | | |  |
| Ketone Testing  Strips |  |  | 50 /30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Continuous Glucose Monitors and Supplies** | | |  |
|  | **Dexcom** | | |  |
| Dexcom G6;  Dexcom G7 | P | **Initial Criteria:**   * One of the following:   + Diagnosis of Gestational Diabetes Mellitus with suboptimal glycemic control that is likely to cause risk or harm to the mother/fetus; **OR**   + Patient has Diagnosis of Type 1 Diabetes Mellitus OR Diagnosis of Type 2 Diabetes Mellitus and meets ONE of the following:   ­ Documented HbA1C ≥7% measured within 6-months of PA request (e.g., submission of chart notes or lab data) ­ Documented frequent hypoglycemia or nocturnal hypoglycemia episodes with blood glucose < 50 mg/dL ­ Documented history of hypoglycemic unawareness  ­ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL  ­ History of emergency room visit(s) or hospitalization related to ketoacidosis or hypoglycemia; **AND**   * Prescribed by or in consultation with an endocrinologist or healthcare practitioner with experience in diabetes management; **AND** * Patient requires frequent use of insulin ( ≥ 3 times per day) oris currently on an insulin pump **Renewal Criteria:** * Patient has been seen and evaluated by an endocrinologist or healthcare practitioner with experience in diabetes management at least once on an annual basis; **AND** * Documented evidence of improvement or compliance with current CGM treatment plan based on submitted medical documentation or log data of device (e.g. decreased A1C, decreased hypoglycemia episodes, decreased percentage of time below therapeutic range (TBR), increased percentage of time in therapeutic range (TTR)) | **G6**  Sensor: 3/30 days  Transmitter: 1/90 days  Receiver: 1/year    **G7**  Sensor: 3/month  Receiver: 1/year | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
|  | **Senseonics and Ascensia Diabetes Care** | | |  |
| Eversense Mis | NP | * See Dexcom prior authorization criteria; **AND** * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | Sensor: 1/90 days Transmitter: 1/90 days | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
| Eversense E3 | NP | * See Dexcom prior authorization criteria; **AND** * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | Sensor: 2/year Transmitter: 1/year |
| Eversense E365 | NP | * See Dexcom prior authorization criteria; **AND** * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | Sensor: 1/year Transmitter: 1/year |
|  |  | **DIABETIC SUPPLIES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Abbot** | |  |
| Freestyle;  Freestyle Libre 2  Freestyle Libre 3 | NP | * See Dexcom prior authorization criteria; **AND** * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | Readers: 1/year Sensors:2/28 days | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |
| Freestyle Libre Plus (2 and 3) |  | * See Dexcom prior authorization criteria; **AND** * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | 2 kits/30 days |
|  |  | **Medtronic** | |  |
| Guardian 3; Guardian 4 | NP | * One of the following:   o Patient is a currently using MiniMed insulin pump; **OR** o See Dexcom prior authorization criteria; **AND**   * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | Transmitter: 1/year Sensors: 5/30 days |  |
| Guardian Connect | NP | * See Dexcom prior authorization criteria; **AND** * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | 1 transmitter/year |  |
| Guardian CGM supplies | NP | * See Dexcom prior authorization criteria; **AND** * Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom | Charger: 1/year Test plug: 1/year | [Diabetic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf)  [Supply PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Diabetic%20Supply%20PA%20Form.pdf) |

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|  | **DIABETIC SUPPLIES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Insulin Management Systems** | |  |  |
| Omnipod 5®  Omnipod 5 G7®  Omnipod Dash® | P | **Initial Criteria: (6-month duration)**   * One of the following:   + Diagnosis of Type 1 Diabetes Mellitus; **OR** o Diagnosis of Type 2 Diabetes Mellitus has had ONE of the following in the last 9-months:   ­ Patient has an HgA1c of greater than 7% with 2 consecutive HbA1c; **OR**  ­ Patient has not met individual goal for A1c or time in range (if on a CGMS) with 2 consecutive HbA1c*;* **AND** • Prescribed by, or in consultation with, an endocrinologist or diabetologist; **AND**   * Patient or caregiver has completed a physician-directed comprehensive diabetes management program which included a visit with a dietician; **AND** * Patient has met one of the following insulin administration methods within the last 6-months:   + If patient has used insulin pump within the last 6-months, clinically valid reason why current insulin pump is no longer appropriate; **OR**   + Administration of at least three daily insulin injections with frequent self- adjustments of insulin dose and exhibits one or more of the following criteria while on a regimen of multiple daily injections of insulin: ­ Glycosylated hemoglobin level (HbA1c) >7%   ­ History of reoccurring hypoglycemia  ­ Wide fluctuations in blood glucose before mealtime  ­ Dawn phenomenon with fasting blood glucose frequently exceeding 200 mg/dL ­ History of severe glycemic excursions; **AND**   * Documented monitored blood glucose self-testing ≥ 4 times a day or regular use of calibrated CGMS during 2 months prior to initiation of insulin pump; **AND** * Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting the member’s insulin administration methods and blood glucose monitoring methods.   **Renewal Criteria:**   * Documentation of a positive clinical response (e.g. decrease HbA1C from baseline, decrease hypoglycemia episodes, decrease fasting and mealtime blood glucose levels) | Pods: 10/30 days; Device: 1/year | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **DIABETIC SUPPLIES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Omnipod Go® | P | **Initial Criteria (6-month duration):**   * Patient is ≥ 18 years of age; **AND** * Diagnosis of Type 2 Diabetes Mellitus has had ONE of the following in the last 9-months:   + Patient has an HgA1c of greater than 7% with 2 consecutive HbA1c; OR   + Patient has not met individual goal for A1c or time in range (if on a CGMS) with 2 consecutive HbA1c; **AND** * Is not using more than 40 units of basal insulin per day; **AND** * Prescriber by or in consultation with an endocrinologist or diabetologist; **AND** * Prescriber must provide a clinically valid reason as to why the Omnipod GO insulin management system is needed for the patient versus standard insulin injections; **AND** * Patient or caregiver has completed a physician-directed comprehensive diabetes management program **Renewal Criteria:** * Patient is ≥ 18 years of age; **AND** * Patient has Diagnosis of Type 2 diabetes; **AND** * Is not using more than 40 units of basal insulin per day; **AND** * Documentation of a positive clinical response (e.g. decrease HbA1C from baseline) | Pods: 10/30 days; Device: 1/year | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cequr Simplicity® | P | **Initial Criteria: (6-month duration)**   * One of the following:   + Diagnosis of Type 1 Diabetes Mellitus; **OR** o Diagnosis of Type 2 Diabetes Mellitus has had ONE of the following in the last 9-months:   ­ Patient has an HgA1c of greater than 7% with 2 consecutive HbA1c; **OR**  ­ Patient has not met individual goal for A1c or time in range (if on a CGMS) with 2 consecutive HbA1c*;* **AND**   * Patient is > 21 years old; **AND** * Prescribed by, or in consultation with, an endocrinologist or diabetologist; **AND** * Patient or caregiver has completed a physician-directed comprehensive diabetes management program which included a visit with a dietician; **AND** * Patient has met ONE of the following insulin administration methods within the last 6-months:   + If patient has used an insulin pump within the last 6-months, clinically valid reason why current insulin pump is no longer appropriate; **OR**   + Administration of at least three daily insulin injections with frequent self- adjustments of insulin dose and exhibits one or more of the following criteria while on a regimen of multiple daily injections of insulin: ­ Glycosylated hemoglobin level (HbA1c) >7%   ­ History of reoccurring hypoglycemia  ­ Wide fluctuations in blood glucose before mealtime  ­ Dawn phenomenon with fasting blood glucose frequently exceeding 200 mg/dL ­ History of severe glycemic excursions; **AND**   * Documented monitored blood glucose self-testing ≥ 4 times a day or regular use of calibrated CGMS during 2 months prior to initiation of insulin pump; **AND** * Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting the member’s insulin administration methods and blood glucose monitoring methods.   **Renewal Criteria:**   * Documentation of a positive clinical response (e.g. decrease HbA1C from baseline, decrease hypoglycemia episodes, decrease fasting and mealtime blood glucose levels) | 3-day patch:  10 /30 days    4-day patch:  8 /32 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **DIABETIC SUPPLIES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| InPen® | NP | • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use the preferred products |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| V-Go® products | NP | • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use the preferred products | 30 patches/30 days |
|  |  | **Insulin Syringes and Pen Needles** [(OTC)](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | |  |
| BD/Embecta products | P | Refer t[o OTC List f](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf)or covered NDCs |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Adrenocorticotropins** | |  |  |
| Acthar® gel | NP | • Appropriate FDA-approved diagnosis (e.g., diuresis in nephrotic syndrome, treatment of SLE or polymyositis, or acute MS exacerbation) for use AND has a contraindication, or intolerance to oral and injectable glucocorticoids; **OR** • Diagnosis of infantile spasms | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cortrophin® gel | NP | See Acthar® gel prior authorization criteria; **AND**  • Clinically valid reason why Acthar® gel cannot be used | 1/day |
|  | **Agents for Dyspareunia** | |  |  |
| Intrarosa® | NP | * Female younger than 21 years of age; **AND** * Cessation of menses due to menopause; **AND** • Painful intercourse   **Note:** This product is excluded from coverage in patients 21 years of age and older. Not a Covered Benefit. |  |  |
| Osphena® | NP | See Intrarosa® prior authorization criteria  **Note:** This product is excluded from coverage in patients 21 years of age and older. Not a Covered Benefit. |  |  |
|  | **Agents for Gout** | |  |  |
| colchicine tablet | P | * Diagnosis of Familial Mediterranean Fever; **OR** * Diagnosis of acute pericarditis, **AND** must be taken concurrently with NSAID (unless contraindicated); **OR** * For initiation of colchicine for acute gout attack; **OR** * For continuation of colchicine prophylaxis for gout:   o Current history of urate lowering therapy with compliance in the past three months; **AND** o One of the following:  ­ Patient is currently experiencing gout symptoms; **OR** ­ Urate level ≥ 6 mg/dL in the past three months |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| colchicine capsules | NP | See colchicine tablet prior authorization criteria; **AND** • Trial and failure of the preferred colchicine product |  |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Gloperba® | NP | **Initial Criteria (3 months):**   * Diagnosis or history of gout flares; **AND** * Patient is 18 years of age or older; **AND** * Patient has had a trial and failure of colchicine tablets; **OR** o Patient is unable to swallow or has difficulty swallowing colchicine tablets/capsules; **AND** * Females of reproductive potential and males with female partners of reproductive potential should be advised to use effective contraception; **AND** * Patient does not meet the following:   + Presence of an active gout flare o Renal or hepatic impairment o In combination with CYP3A4 and P-gp inhibitors; **AND** * Prescriber attests that the following will be monitored:   + CBC, ALTs, ASTs, Scr o Serum uric acid levels   + Neuromuscular toxicity (creatine phosphokinase (CPK), SGOT, SGPT, and LDH) **Renewal Criteria (3 months):** * Patient continues to meet the initial criteria; **AND** * Patient has not experienced any treatment-restricting adverse effects (e.g., colchicine toxicity, neuromuscular toxicity, blood dyscrasias, liver and renal toxicity) | 300 ml/28 days |  |
| Mitigare® | NP | See colchicine tablet prior authorization criteria; **AND** • Trial and failure of the preferred colchicine product |  |
| Uloric® | NP | * Trial and failure, contraindication, or intolerance to allopurinol; **AND** * Clinically valid reason as to why the preferred febuxostat cannot be used |  |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Androgens** | |  |  |
| AndroGel® pump | P | **Initial Criteria:**   * Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome,   Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies:   * + Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism o CNS tumors and treatment including irradiation, surgery, and chemotherapy o Significantly delayed puberty o Approval requires:   ­ Baseline Luteinizing Hormone  ­ Baseline testosterone level [faxed labs required]   * Patient age 21 years of age or less: diagnosis not specified above:   + Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: ­ Baseline hematocrit ≤ 50% ­ Baseline Luteinizing Hormone * Patient age 22 years of age and older:   + Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: ­ Baseline hematocrit ≤ 50%   ­ Baseline Luteinizing Hormone  ­ PSA level < 3 ng/mL   * Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination **Renewal Requests:** * Documentation of low or normal fasting testosterone level from previous 12 months [faxed labs required] * Hematocrit ≤ 50% * PSA level <3 ng/mL [not required for <21] | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| testosterone gel (excluding 2%) | P | See AndroGel® pump prior authorization criteria | 1 package/Rx |
| testosterone cypionate | P | See AndroGel® pump prior authorization criteria | 4 mL/30 days |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| AndroGel® 1% and  1.62% packets | NP | **Initial Criteria:**   * Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome,   Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies:   * + Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism o CNS tumors and treatment including irradiation, surgery, and chemotherapy o Significantly delayed puberty o Approval requires:   ­ Baseline Luteinizing Hormone  ­ Baseline testosterone level [faxed labs required] o Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product   * Patient age 21 years of age or less: diagnosis not specified above:   + Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: ­ Baseline hematocrit ≤ 50%   ­ Baseline Luteinizing Hormone o Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product   * Patient age 22 years of age and older:   + Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: ­ Baseline hematocrit ≤ 50%   ­ Baseline Luteinizing Hormone  ­ PSA level < 3 ng/mL o Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product   * Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination **Renewal Requests:** * Documentation of low or normal fasting testosterone level from previous 12 months [faxed labs required] * Hematocrit ≤ 50% * PSA level < 3 ng/mL [not required for <21] | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Depo-Testosterone® | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria | 4 mL/30 days |  |
| Jatenzo® | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria | 2/day |  |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Methitest® | NP | **Initial Criteria:**   * Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome,   Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies:   * + Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism o CNS tumors and treatment including irradiation, surgery and chemotherapy o Significantly delayed puberty o Approval requires:   ­ Baseline Luteinizing Hormone  ­ Baseline testosterone level [faxed labs required]   * Intolerance or contraindication to at least ONE preferred testosterone product • Patient age 21 years of age or less: diagnosis not specified above:   + Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: ­ Baseline hematocrit ≤ 50%   ­ Baseline Luteinizing Hormone  ­ Intolerance or contraindication to at least ONE preferred testosterone product   * Patient age 22 years of age and older:   + Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required]and requires: ­ Baseline hematocrit ≤ 50%   ­ Baseline Luteinizing Hormone  ­ PSA level < 3 ng/mL o Intolerance or contraindication to at least ONE preferred testosterone product   * Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination **Renewal Requests:** * Documentation of low or normal fasting testosterone level from previous 12 months [faxed labs required] * Hematocrit ≤ 50% * PSA level < 3 ng/mL [not required for <21] |  |  |
| methyltestosterone | NP | See Methitest® prior authorization criteria |  |
| Natesto® nasal gel | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria |  |
| Testim® | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria | 1 package/Rx |
| testosterone enanthate injection | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria; **OR**  • Palliative treatment of androgen-responsive, advanced, inoperable, metastatic breast cancer in women who are 1-5 years postmenopausal and in premenopausal women who have benefited from oophorectomy | 4 mL/30 days |
| Testosterone 2% gel | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria | 1 package/Rx |
| Tlando® | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria | 2/day |
| Undecatrex® |  | See AndroGel® 1% and 1.62% packets prior authorization criteria | 4/day |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Vogelxo® | NP | See AndroGel® 1% and 1.62% packets prior authorization criteria |  |  |
| Xyosted® | NP | See testosterone enanthate injection prior authorization criteria | 2 mL/30 days |
|  | **Bone: Bisphosphonate** | |  |  |
| alendronate | P |  | 5, 10, 40 mg: 1/day  35, 70 mg: 4/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| alendronate solution | P |  | 10 mL/day |
| Atelvia® | P |  | 4/28 days |
| ibandronate | P |  | 1/28 days |
| Actonel® | NP |  | 5, 30 mg: 1/day  35 mg: 4/28 days  150 mg: 1/28 days |
| Binosto® | NP |  | 4/28 days |
| Fosamax® | NP |  | see alendronate |
| Fosamax Plus D® | NP |  | 4/28 days |
| risedronate | NP |  | 5, 30 mg: 1/day  35 mg: 4/28 days  150 mg: 1/28 days |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Bone: Calcitonin** | |  |  |
| calcitonin nasal spray | P | • Diagnosis of osteoporosis in postmenopausal women greater than five years post menopause, **AND**  • Trial and failure, contraindication, or intolerance to **BOTH** bisphosphonates **AND** raloxifene. | 3.7 mL/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| calcitonin injection | NP | * Diagnosis of Paget’s disease of the bone; **AND** o Trial and failure, contraindication, or intolerance to bisphosphonates; **OR** * Treatment of hypercalcemia; **OR** * Diagnosis of osteoporosis in postmenopausal women greater than five years post-menopause; **AND** o Trial and failure, contraindication, or intolerance to **BOTH** bisphosphonates **AND** raloxifene; **AND**  o Trial and failure, contraindication, or intolerance to the preferred agent | 1 mL/day |
| Miacalcin® injection | NP | See calcitonin injection prior authorization criteria | 1 mL/day |
|  | **Bone: Parathyroid Hormone** | |  |  |
| Forteo® | P | **Initial Criteria:**   * Diagnosis of ONE of the following:   + Postmenopausal osteoporosis and patient is female; **OR** o Osteoporosis and patient is male; **OR** o Glucocorticoid-induced osteoporosis; **AND**   ­ History of prednisone or its equivalent at a dose ≥ 5 mg/day; **AND**   * Patient meets ONE of the following:   + Has a high risk for fracture (e.g., T-score of ≤ -3.0 even in the absence of fractures, T-score of -2.5 or below plus a fragility fracture, severe or multiple fractures, very high fracture probability by FRAX [e.g., major osteoporosis fracture > 30%, hip fracture > 4.5%]); **OR**   + Unable to tolerate bisphosphonates or has a relative contraindications to oral bisphosphonates (achalasia, scleroderma esophagus, esophageal strictures); **OR**   + Had an adequate trial of other osteoporosis therapies and had an insufficient response (fracture and/or loss of bone mineral density in spite of adherence to therapy); **AND** * Total lifetime length of therapy with PTH analogs has not exceeded 2 years **Renewal Criteria:** * The prescriber attests that the patient remains at, or has returned to, having a high risk for fracture despite 24 months of cumulative use of parathyroid hormone analogs; **AND** * The prescriber attests that the risk versus benefit of use greater than 24 months of cumulative use of parathyroid hormone analogs has been reviewed with the patient | 1 pen/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| teriparatide | NP | See Forteo prior authorization criteria; **AND**  • Clinically valid reason why preferred Forteo® cannot be used | 1 pen/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tymlos® | NP | **Initial Criteria:**   * Diagnosis of ONE of the following:   + Postmenopausal osteoporosis and patient is female o Osteoporosis and patient is male; **AND** * Patient meets ONE of the following:   + Has a high risk for fracture (e.g., T-score of ≤ -3.0 even in the absence of fractures, T-score of -2.5 or below plus a fragility fracture, severe or multiple fractures, very high fracture probability by FRAX [e.g., major osteoporosis fracture > 30%, hip fracture > 4.5%]); **OR**   + Unable to tolerate bisphosphonates or has a relative contraindications to oral bisphosphonates (achalasia, scleroderma esophagus, esophageal strictures); **OR**   + Had an adequate trial of other osteoporosis therapies and had an insufficient response (fracture and/or loss of bone mineral density in spite of adherence to therapy); **AND** * Total lifetime length of therapy with PTH analogs has not exceeded 2 years **Renewal Criteria:** * The prescriber attests that the patient remains at, or has returned to, having a high risk for fracture despite 24 months of cumulative use of parathyroid hormone analogs; **AND** * The prescriber attests that the risk versus benefit of use greater than 24 months of cumulative use of parathyroid hormone analogs has been reviewed with the patient | 1/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Bone: SERMs** | |  |  |
| raloxifene | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Evista® | NP |  | 1/day |
|  | **Contraceptives, Non-Oral** | |  |  |
| Depo IM Provera ® | P |  | 1 vial/ 90 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Depo SubQ Provera® | P |  | 1 vial/ 90 days |
| medroxyprogesteron e acetate injection | P |  | 1 vial/ 90 days |
| Nuvaring® | P |  | 1/28 days |
| Xulane® | P |  | 3/28 days |
| Annovera® | NP | • Patient has tried and failed or had a contraindication to two preferred non-oral contraceptives; **AND** Clinically valid reason as to why preferred Nuvaring cannot be used | 1/year |
| Eluryng® | NP |  | 1/28 days |
| Etonogestrel-ethinyl estradiol vaginal ring | NP |  | 1/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
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| Haloette® | NP |  | 1/28 days |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Phexxi® | NP | • Patient has tried and failed or had a contraindication to two preferred non-oral contraceptives; **AND** Provider attests the patient will be monitored for cystitis and pyelonephritis | 12/month |  |
| Twirla ® | NP | • Trial and failure, or contraindication/intolerance of two preferred non-oral contraceptives **AND**  Avoid concomitant use of hepatitis C drug combinations containing ombitasvir/paritaprevir/ritonavir, with or without dasabuvir | 3/28 days |
| Zafemy® | NP |  | 3/28 days |
|  | **Contraceptives, Oral** | |  |  |
| Various | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Emergency contraceptives | P |  | 1/21 days |
| Various | NP |  | 1/day |
|  | **Corticosteroids, Oral** | |  |  |
| Alkindi Sprinkles® | NP | * Diagnosis of adrenocortical insufficiency; **AND** * Patient is 18 years of age or younger; **AND** * Patient does not have ANY of the following:   o Hypersensitivity to hydrocortisone o Untreated fungal and bacterial infections; **AND**   * Clinically valid reason as to why the preferred prednisolone solution cannot be used | 0.5 mg: 3/day   1. mg: 3/day 2. mg: 3/day   5 mg: 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Eohilia® | NP | **Criteria:** **(3-month duration)**   * Patient is 11 years of age or older; **AND** * Diagnosis of Eosinophilic esophagitis (EoE); **AND** * Prescribed by, or in consultation with, a gastroenterologist, allergist, or immunologist; **AND** * Prescriber attest patient meets both of the following:   + Esophageal biopsy consists of ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) following treatment course of a proton pump inhibitor; **AND**   + Patient has symptoms of esophageal dysfunction (e.g., feeding difficulties, vomiting, pain, dysphagia); **AND** * Trial and failure, or contraindication, to swallowed inhaled corticosteroids such as budesonide or fluticasone | 180 packs / 365 days | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  |  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Hemady® | NP | * Patient must be 18 years of age or older; **AND** * Patient must have a diagnosis of Multiple Myeloma; **AND** * Must be used in combination with other anti-myeloma agents; **AND** * Patient must NOT have any of the following:   o Systemic fungal or bacterial infection o Glaucoma o Herpes Simplex Keratitis o Ocular infection o Tympanic membrane perforation o Prior hypersensitivity with dexamethasone o Strong CYP3A4 inhibitors or inducers o Pregnant or breastfeeding; **AND**   * Female patients should use effective contraception during treatment and for at least 1 week after treatment; **AND** * Trial and failure, contraindication, or intolerance to two preferred dexamethasone products; **AND** • Clinically valid reason why the preferred agents cannot be used | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| prednisolone ODT | NP | * Unable to swallow, **OR** * Unable to absorb medications through the GI tract |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rayos® | NP | * Trial and failure, contraindication, or intolerance to TWO preferred products (trial must include prednisone); **AND** * Clinically valid reason why the preferred agents cannot be used | 1 mg: 3/day 2 mg: 2/day  5 mg: 12/day |
|  |  | **Diabetes: Alpha-Glucosidase Inhibitors** | | |
| acarbose | P | • Trial and failure, contraindication, or intolerance to metformin monotherapy |  | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| miglitol | NP | * Trial and failure, contraindication, or intolerance to metformin monotherapy; **AND** * Trial and failure, contraindication, or intolerance of TWO preferred agents |  |
|  |  | **Diabetes: Amylin Analogs** | | |
| Symlin Pen® | NP | * Diagnosis of Type 1 or 2 diabetes; **AND** * On insulin therapy; **AND** * Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%); **AND** * Patients meeting any of the following will NOT be approved:   + Recurrent, severe hypoglycemia requiring assistance during the past 6-months o Confirmed diagnosis of gastroparesis   + Requiring the use of drugs that stimulate gastrointestinal motility |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **Diabetes: Biguanides** | | |
| metformin | P |  | 500 mg: 4/day  850 & 1000 mg: 2/day |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| metformin ER | P |  | 500 mg: 1/day  1000 mg: 2/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Glumetza® | NP |  | 500 mg: 1/day  1000 mg: 2/day |
| metformin ER osmotic | NP |  | 500 mg: 3/day  1000 mg: 2/day |
| metformin solution | NP | See Riomet prior authorization criteria | 20 mL/day |
| **Diabetes: DPP-4 Inhibitors and Combinations** | | | | |
| Janumet® | P |  | 2/day | [DPP-4 PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/DPP4%20PA%20Form.pdf) |
| Janumet XR® | P |  | 50/500 mg, 100/1000 mg: 1/day;  50/1000 mg: 2/day |
| Januvia® | P |  | 1/day |
| Jentadueto® | P |  | 2/day |
| Jentadueto® XR | P |  | 2.5/1000 mg: 2/day; 5/1000 mg: 1/day | [DPP-4 PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/DPP4%20PA%20Form.pdf) |
| saxagliptin | P |  | 1/day |
| Tradjenta® | P |  | 1/day |
| alogliptin | NP | * Diagnosis of type 2 diabetes; **AND** * Patient’s HbA1c level is greater than 6.5 (for **initial** approval); **AND** * Trial and failure, contraindication, or intolerance to TWO preferred single entity DPP-4 inhibitors (Januvia, Tradjenta) | 1/day |
| alogliptin/metformin | NP | * Diagnosis of type 2 diabetes; **AND** * Patient’s HbA1c level is greater than 6.5 (for **initial** approval); **AND** * Trial and failure, contraindication, or intolerance to TWO preferred DPP-4/metformin combination products (Janumet, Janumet XR, Jentadueto, Jentadueto XR) | 2/day | [DPP-4 PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/DPP4%20PA%20Form.pdf) |
| alogliptin/ pioglitazone | NP | See alogliptin/metformin prior authorization criteria | 1/day |
| saxagliptin/ metformin | NP | See alogliptin/metformin prior authorization criteria | 2/day |
| Zituvimet® | NP | Clinically valid reason why Janumet or Janumet XR cannot be used | 50/500 mg, 100/1000 mg: 1/day;  50/1000 mg: 2/day | [DPP-4 PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/DPP4%20PA%20Form.pdf) |
| Zituvimet XR® | NP | Clinically valid reason why Janumet or Janumet XR cannot be used | 2/day |
| Zituvio® | NP | Clinically valid reason why Januvia® cannot be used | 1/day |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Diabetes: Rapid-Acting Insulins** | | | | |
| Apidra SoloStar® | P | * Prior authorization not required for patients < 21 years of age; **OR** * Patient is 21 years of age or older; **AND** o Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s   Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke); **OR** o Recipient or caregiver has poor eyesight such that dosing errors may occur |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Humalog KwikPen® | P | See Apidra® Solostar® prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Humalog Jr Kwik Pen® | P | * Prior authorization not required for patients < 21 years of age; **OR** * Patient is 21 years of age or older; AND o Patient requires half unit (0.5) dosing or adjustments that cannot be achieved with Humalog® Kwik Pen® |  |
| insulin lispro KwikPen | P | See Apidra® Solostar® prior authorization criteria |  | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| insulin lispro Jr  Kwikpen | P | See Humalog® Jr KwikPen prior authorization criteria |  |
| Admelog SoloStar® | NP | * Patient < 21 years of age; **AND** o Trial and failure or intolerance of TWO preferred rapid acting insulin agents; **OR** * Patients ≥ 21 years old; **AND** o Trial and failure or intolerance of 2 preferred rapid acting insulin agents; **AND** o Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke); **OR**   ­ Recipient or caregiver has poor eyesight such that dosing errors may occur |  | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Afrezza® | NP | * Patient is not a current smoker and does not have a history of smoking in the past 6-months; **AND** * Prescriber attests that baseline spirometry has been performed prior to therapy and will be performed after 6-months of therapy, and every year thereafter; **AND** * Patient does not have a history of chronic lung disease (e.g., asthma, COPD); **AND** • Patient has ONE of the following diagnoses:   + Type 2 Diabetes   + Type 1 Diabetes while concurrently taking a long-acting insulin; **AND** * Recipient or caregiver has problems with manual dexterity which may result in dosing errors (i.e., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke); **OR** o Recipient or caregiver has poor eyesight such that dosing errors may occur | Cartridges:  4-unit: 3/day 8-unit: 6/day  12-unit:6/day    Combo package:  1 box/month | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Fiasp FlexTouch® | NP | See Admelog® SoloStar® prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Fiasp PenFill® | NP | See Admelog® SoloStar® prior authorization criteria |  |
| Humalog U-200 KwikPen® | NP | See Admelog® SoloStar® prior authorization criteria; **AND**  • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents |  |
| Humalog TempoPen® |  | See Admelog® SoloStar® prior authorization criteria |  |  |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Lyumjev® vial | NP | * Trial and failure or intolerance of 2 preferred, rapid-acting insulin agents; **AND** * Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Lyumjev KwikPen® | NP | See Admelog® SoloStar® prior authorization criteria; **AND**  • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents |  |
| Lyumjev TempoPen® | NP | See Admelog® SoloStar® prior authorization criteria |  |
| Novolog FlexPen® | NP | See Admelog® SoloStar® prior authorization criteria |  |
|  | **Diabetes: Intermediate-Acting Insulins** | |  |  |
| Humulin N KwikPen® | P | • Prescriber must provide valid clinical rationale as to why patient is unable to utilize preferred Novolin® N FlexPen® |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Diabetes: Mixed Insulins** | |  |  |
| Humalog Mix 50/50 KwikPen® | P | * Prior authorization not required for patients < 21 years of age; **OR** * Patient is 21 years of age or older; **AND** o Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s   Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke); **OR** o Recipient or caregiver has poor eyesight such that dosing errors may occur |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Humalog Mix 75/25 KwikPen® | P | See Humalog® Mix 50/50® KwikPen prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Humulin 70/30 KwikPen® | P | See Humalog® Mix 50/50® KwikPen prior authorization criteria |  |
| insulin aspart mix 70/30 FlexPen | P | See Humalog® Mix 50/50® KwikPen prior authorization criteria |  |
| insulin lispro mix 75/25 KwikPen® | NP | * Patient < 21 years of age; **AND** o Trial and failure or intolerance of TWO preferred rapid acting insulin agents; **OR** * Patients ≥ 21 years old; **AND** o Trial and failure or intolerance of 2 preferred rapid acting insulin agents; **AND** o Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke); **OR**   ­ Recipient or caregiver has poor eyesight such that dosing errors may occur |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Novolog Mix 70/30 FlexPen® | NP | See insulin lispro mix 75/25 KwikPen® prior authorization criteria |  |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Diabetes: Long-Acting Insulins** | | |  |  |
| Basaglar KwikPen® | NP | * Patients < 21 years of age approval requires a contraindication to a preferred insulin glargine pen that is not observed with the requested agent; **OR** * For patients ≥ 21 years old approval requires a contraindication to a preferred insulin glargine pen that is not observed with the requested agent; **AND** o Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s   Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke); **OR** o Recipient or caregiver has poor eyesight such that dosing errors may occur |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Basaglar Tempo Pen® | NP | See prior authorization criteria for Basaglar KwikPen® |  |
| insulin degludec FlexTouch | NP | * For patients < 21 years of age, trial and failure, contraindication, or intolerance of 2 preferred agents; **OR** * For patients ≥ 21 years of age, trial and failure, contraindication, or intolerance of 2 agents; **AND** o Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke, etc.); **OR** o Recipient or caregiver has poor eyesight such that dosing errors may occur |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rezvoglar® | NP | See prior authorization criteria for Basaglar KwikPen® |  |
| Semglee® | NP | See prior authorization criteria for Basaglar KwikPen® |  |
| Tresiba FlexTouch® | NP | See prior authorization criteria for insulin degludec FlexTouch |  |
| **Diabetes: Meglitinides** | | |  |  |
| nateglinide | P | • Trial and failure, contraindication, or intolerance of metformin monotherapy | 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| repaglinide | P | • Trial and failure, contraindication, or intolerance of metformin monotherapy | 0.5mg, 1mg: 4/day 2 mg: 8 day |
| **Diabetes: SGLT2 Inhibitors and Combinations** | | |  |  |
| Farxiga® | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Glyxambi® | P |  | 1/day |
| Invokana® | P |  | 1/day |
| Invokamet® | P |  | 2/day |
| Jardiance® | P |  | 1/day |
| Synjardy® | P |  | 2/day |
| Xigduo® XR | P |  | 1/day |

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|  |  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| dapagliflozin | NP | • Clinically valid reason why the preferred Farxiga® cannot be used | 1/day |  |
| dapagliflozin/ metformin ER | NP | • Clinically valid reason why the preferred Xigduo XR ® cannot be used | 1/day |  |
| Inpefa® | NP | • Requested medication is being used to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heat failure visit in adults with one of the following: o Heart Failure o Type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors; **AND** • Trial and failure, or intolerance, to TWO preferred agents | 1/day |  |
| Invokamet XR® | NP | * Diagnosis of Type 2 Diabetes; **AND** * Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • Clinically valid reason as to why patient cannot use Invokamet® | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Qtern® | NP | • Trial and failure or intolerance to separate components (Farxiga and Onglyza) | 1/day |
| Steglatro® | NP | * Diagnosis of Type 2 Diabetes; **AND** * Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance) | 2/day (5 mg);  1/day (15 mg) |
| Segluromet® | NP | * Diagnosis of Type 2 Diabetes; **AND** * Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** * Clinically valid reason as to why the patient cannot use a preferred single-entity SGLT2 agent and metformin as separate agents; **AND** * Patient does not have metabolic acidosis | 2/day |
| Steglujan® | NP | * Diagnosis of Type 2 Diabetes; **AND** * Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • Patient does not have metabolic acidosis | 1/day |
| Synjardy XR® | NP | * Diagnosis of Type 2 Diabetes; **AND** * Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • Clinically valid reason as to why patient cannot use Synjardy | 1/day (25/1000 mg);  2/day (all other strengths) |
| Trijardy XR® | NP | * Diagnosis of Type 2 Diabetes; **AND** * Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** * Clinically valid reason as to why patient cannot use the patient cannot use Glyxambi and metformin ER as separate agents | 10/5/1000 mg, 2.5/5/1000 mg: 1/day;  5/2.5/1000 mg,  12.5/2.5/1000 mg: 2/day |
|  |  | **Diabetes: Sulfonylureas and Combinations** |  |  |
| glimepiride | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Glucotrol XL® | NP | * Trial and failure, contraindication, or intolerance to, metformin monotherapy; **AND** * Trial and failure, contraindication, or intolerance of TWO preferred agents |  |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Diabetes: TZDs and Combinations** | |  |  |
| pioglitazone | P | • Trial and failure, contraindication, or intolerance to metformin or a metformin containing product | 1/day | [TZD and Combos](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/TZD%20and%20Combos%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/TZD%20and%20Combos%20PA%20Form.pdf) |
| pioglitazone/ metformin | P | • Trial and failure, contraindication, or intolerance to metformin or a metformin containing product | 2/day |
| Actos® | NP | * Trial and failure, contraindication, or intolerance to metformin or a metformin containing product; **AND** * Patient must have an allergy or intolerance to an inactive ingredient in the generic equivalent | 1/day |
| ACTOplus Met® | NP | See Actos®prior authorization criteria | 2/day |
| Duetact® | NP | * Trial and failure, contraindication, or intolerance to metformin or a metformin containing product; **AND** * Trial and failure, contraindication, or intolerance to pioglitazone; **AND** * Clinically valid reason why the patient cannot use pioglitazone and glimepiride as separate agents | 1/day |
| pioglitazone/ glimepiride | NP | See Duetact® prior authorization criteria | 1/day |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Diabetes: Glucagon Agents** | |  |  |
| Baqsimi® | P |  | 2/Rx | [**General PA Form**](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Gvoke | P |  | 2/Rx |
| Zegalogue® | NP |  | 2/Rx |
|  | **GLP-1 Agonists** | |  |  |
| Ozempic® | P | **Initial Criteria:**   * Diagnosis of type 2 diabetes; **AND** * Submission of lab test for one of the following:   + HbA1C level\*   + Oral glucose tolerance test o Random plasma glucose ≥ 200 mg/dL with classic symptoms of hyperglycemia or hyperglycemic crisis; **AND** * One of the following:   + Patient has or is at high-risk of atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), or heart failure (HF); **OR**   + Trial and failure, contraindication, or intolerance TWO of the following;   ­ Metformin or metformin containing product  ­ SGLT2 or combination product  ­ TZD  ­ Sulfonylurea  ­ Insulin; **AND**   * GLP-1 Receptor Agonists will NOT be covered for the following:   + Diagnosis of Type I diabetes; **OR** o Treatment of diabetic ketoacidosis; **OR** o Use for weight loss; **OR**   + Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2) **Renewal Criteria**: * Submission of recent medical records (e.g., chart notes and/or labs) documenting one of the following:   + Reduction of HbA1c from baseline   + Achievement or maintenance of therapeutic HbA1c goal o Improvement in fasting blood glucose levels o Patient is at increased risk of ASCVD, CKD, or HF   **Note\***: HbA1c level can be from early stages in patient treatment. If original HbA1c is unknown, or current HbA1c is controlled due to another current diabetic regimen, please include current regimen and current HbA1c. | 5 mcg:  1.2 mL/ 30 days    10 mcg: 2.4 mL/30 days | [GLP-1](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/GLP-1%20Agonist%20PA%20Form.pdf)  [Agonist PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/GLP-1%20Agonist%20PA%20Form.pdf) |
| Victoza® | P | See Ozempic®prior authorization criteria |  |
| Rybelsus® | NP | See Ozempic®prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to 2 preferred drugs (e.g., Ozempic, Victoza) | 1/day | [GLP-1 Agonist PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/GLP-1%20Agonist%20PA%20Form.pdf) |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Soliqua® | NP | See Ozempic®prior authorization criteria; **AND**   * Trial and failure, contraindication, or intolerance to 2 preferred drugs (e.g., Ozempic, Victoza); **AND** * Patient is currently taking, but inadequately controlled on, a long-acting insulin documented per TennCare paid claims | 5 pens/30 days | [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/GLP-1%20Agonist%20PA%20Form.pdf) |
| Trulicity® | NP | See Ozempic®prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to 2 preferred drugs (e.g., Ozempic, Victoza) | 2 mL/28 days |
| Mounjaro® | NP | See Ozempic®prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to 2 preferred drugs (e.g., Ozempic, Victoza) | 2 mL/28 days |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Wegovy® | NP | **Initial Criteria**   * Treatment is being requested to reduce the risk of major adverse cardiovascular events; **AND** * Patient is 21 years of age or older; **AND** * Submitted medical documentation (e.g. chart notes) of initial body mass index (BMI) of ≥ 27 kg/m2; **AND** * Submitted medical documentation (e.g. chart notes) of ONE of the following:   + Prior myocardial infarction   + Prior stroke (ischemic and hemorrhagic stroke)   + Symptomatic peripheral arterial disease as evidenced by intermittent claudication with ankle–brachial index < 0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; **AND** • Submitted documentation HbA1C ≤ 6.5%; **AND** * Patient is on optimized guideline-directed therapy including beta-blockers, RAS inhibitors, and lipid lowering agents to ensure reduced cardiovascular risk unless contraindicated (supported by medical documentation or claims history);**AND** * Prescriber attests patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND** * Patient does not have any of the following:   + Diagnosis of type 1 or type 2 diabetes   + New York Heart Association class IV heart failure; o Personal or family history of medullary thyroid carcinoma (MTC) OR MEN 2 o History or presence of chronic pancreatitis o End-stage renal disease or currently receiving dialysis; **AND** * For female patients of reproductive potential, the following has been addressed:   + Patient is not pregnant or breastfeeding o Patient has been counseled to use highly effective contraceptive method during treatment; **AND** * Will not be co-administered with another GLP-1 receptor agonists (e.g. Byetta, Ozempic, Victoza)   **Renewal Criteria**   * Prescriber attests to ALL of the following:   + Patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity   + Patient does not have Type 1 or 2 Diabetes * Will not being co-administered with another GLP-1 receptor agonists (e.g. Byetta, Ozempic, Victoza); AND * Patient is on optimized guideline-directed therapy including beta-blockers, RAS inhibitors, and lipid lowering agents to ensure reduced cardiovascular risk unless contraindicated (supported by medical documentation or claims history); **AND** * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., patient has not had a major cardiovascular event within the past 12 months, decreased body weight or waist circumference from baseline, decrease blood pressure, total cholesterol, LDL, or triglyceride levels from baseline); **AND** * Patient has absence of contraindications or serious adverse effects (e.g., acute gallbladder disease, acute kidney injury) **Note:** If patient’s HbA1C is ≥ 6.5% the patient should use a GLP-1 Agonists FDA approved for the treatment of diabetes (e.g., Ozempic, Victoza).   **Note:** Prior authorization criteria related to weight management will be found on the “Criteria for Non-PDL Agents” document. | 4 injectors/28 days | [GLP-1](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/GLP-1%20Agonist%20PA%20Form.pdf)  [Agonist PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/GLP-1%20Agonist%20PA%20Form.pdf) |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Xultophy® | NP | See Ozempic®prior authorization criteria; **AND**   * Trial and failure, contraindication, or intolerance to 2 preferred drugs (e.g., Ozempic, Victoza); **AND** * Patient is currently taking, but inadequately controlled on, a long-acting insulin documented per TennCare paid claims | 5 pens/30 days |  |
|  | **GnRH Agonist/Antagonist & LNRH Analogs** | |  |  |
| Myfembree® | **P** | **Initial Criteria:**   * Patient age is ≥ 18 years; **AND** * Diagnosis of one of the following:   + Heavy menstrual bleeding associated with uterine leiomyomas/fibroids o Moderate to severe pain associated with endometriosis; **AND** * Patient must be premenopausal; **AND** * Patient has tried and failed 2 medications in the following drug classes:   + Hormonal contraceptives (including oral or transdermal formulations, vaginal ring, or intrauterine device) o NSAIDs   + Hemostatics (e.g., tranexamic acid) o Oral progesterone; **AND** * Prescribed by, or in consultation with, an obstetrics/gynecology or reproductive specialist; **AND** * Patient will use effective non‐hormonal contraception during treatment and 1 week after stopping therapy; **AND** • Total treatment duration should not exceed 24 months due to risk of continued bone loss **Renewal Criteria (only for 150 mg strength):** * Patient has positive response to therapy (e.g., reduction in pain and discomfort from baseline, sustained reduction in menstrual blood loss per cycle); **AND** * Patient will use effective non‐hormonal contraception during treatment and 1 week after stopping therapy; **AND** • Total treatment duration should not exceed 24 months | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Oriahnn® | **P** | See Myfembree® prior authorization criteria | 1 box/28 days |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Orilissa® | P | **Initial Criteria:**   * Patient age is ≥ 18 years; **AND** * Patient has confirmed diagnosis of endometriosis; **AND** * Patient has tried and failed 2 medications in the following drug classes:   + Hormonal contraceptives (including oral or transdermal formulations, vaginal ring, or intrauterine device) o NSAIDs   + Hemostatics (e.g., tranexamic acid) o Oral progesterone; **AND** * Prescribed by, or in consultation with, an obstetrics/gynecology or reproductive specialist; **AND** * Pregnancy is excluded prior to initiating treatment**; AND** * Total treatment duration should not exceed 24 months due to risk of continued bone loss **Renewal Criteria (only for 150 mg strength):** * Patient continues to meet the initial criteria; **AND** * Patient is considered to have clinically meaningful response to treatment | 1/day: 150 mg; 2/day: 200 mg | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **GnRH Agonists / LHRH Analogs** | |  |  |
| leuprolide | P | • Diagnosis of prostate cancer in male patient; **OR**  Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 [girls] or 9 years of age [boys]) |  |  |
| Fensolvi® | NP | See leuprolide prior authorization criteria |  |  |
| Lupron Ped-Depot® | NP | Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 years of age [girls] or 9 years of age [boys]) |  |  |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| [**Growth Hormone Agents PA**](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Criteria-PDL.pdf) | | | | |
| Genotropin® | P | **NOTE**: **Growth hormone therapy will NOT be approved for idiopathic short stature (ISS)** Criteria**:**   * Agent is prescribed by, or in consultation with, an endocrinologist; **AND** * Daily dose within approved dosage range for somatotropin for requested indication per clinical compendium; **AND** * Daily dose based on weight of the enrollee, supported by submitted growth charts; **AND** * Approval will be based on dosage form resulting in least wastage of product   **For patients < 21 years old**, **will be approved if ANY of the following criteria are met:**   * Patient has failed two GH stimulation tests (defined as peak GH level < 10 ng/mL) OR has failed one GH stimulation test and has a documented low IGF-1 level based on age normal values o Continuation of therapy will be approved only if height velocity is within normal range for patient’s age or bone age o Therapy will not be approved once epiphyseal closure occurs * Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, head trauma, or cranial irradiation and meets any of the following: o Failed a GH stimulation test (peak GH level <10ng/mL) o Documented low IGF-1 level (below normal for patient’s age) o Has deficiencies in 3 or more pituitary axes * Patient is a newborn infant and has evidence of hypoglycemia AND either a low GH level (<20 ng/mL) or a low for age IGF1/IGFBP-3 level * Diagnosis of short stature associated with Turner Syndrome or Noonan Syndrome * Diagnosis of short stature associated with short stature homeobox (SHOX) gene deficiency * Diagnosis of Prader-Willi Syndrome * Patient has chronic renal insufficiency (CrCl < 30 mL/min/1.73 m2) * Diagnosis of Small for Gestational Age (SGA) or Intrauterine Growth Retardation (IGR) and patient is > 2 years old with a height at least 2 standard deviations below the population mean for age **Patients ≥ 21 years old, will be approved for ANY of the following:** * Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation (can be diagnosed in childhood or adulthood); **AND** o One of the following:   ­ Failed at least one GH stimulation test  ­ Has at least one documented low IGF-1 level  ­ Has deficiencies in 3 or more pituitary axes o Note: For recipients diagnosed in childhood with hypothalamic-pituitary disease or structural lesions/trauma to the pituitary who have a past history of GH use, no retesting is necessary; **OR**   * Failure of 2 GH stimulation tests (peak level < 5 ng/mL) or failure of one GH stimulation test and documented low IGF-1; and epiphyses has not closed **Renewal Criteria:** * For diagnosis of Growth Hormone deficiency, Small for Gestational Age (SGA,) or Intrauterine Growth Retardation (IGR):   + Agent is prescribed by, or in consultation with, an endocrinologist; **AND**   + Patient has open epiphyses (therapy will NOT be approved once epiphyseal fusion occurs)**; AND**   + Documentation of positive clinical response to therapy (e.g., increased IGF-1 levels, linear growth improvement) • For all other diagnoses: Patient continues to meet initial criteria |  | [Growth](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [Hormone](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf) |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Egrifta SV® | NP | * Recipient must be at least 18 years of age, but less than 21 years old; **AND** * Diagnosis of Acquired Immunodeficiency Syndrome (AIDs) or Human Immunodeficiency Virus (HIV); **AND** * Prescribed by, or in consultation with, an endocrinologist or provider with expertise in HIV; **AND** * Waist circumference greater than or equal to 95 cm for males, or greater than or equal to 94 cm for females; **AND** * Waist to hip ratio greater than or equal to 0.94 for males, or greater than or equal to 0.88 for females **Note**: For recipients > 21 years of age, these agents are a non-covered benefit |  | [Growth](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [Hormone](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf) |
| Humatrope® | NP | See Genotropin® prior authorization criteria |  | [Growth](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [Hormone](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf) |
| Norditropin® | NP | See Genotropin® prior authorization criteria |  |
| Nutropin AQ® | NP | See Genotropin® prior authorization criteria |  |
| Ngenla® | NP | **Initial Criteria:**   * Patient is at least 3 years of age and less than 18 years of age; **AND** * Patient weighs at least 11.5kg; **AND** * Diagnosis of growth failure due to inadequate secretion of endogenous growth hormone (GH); **AND** * Agent is prescribed by, or in consultation with, an endocrinologist; **AND** * Documentation that diagnosis of growth hormone deficiency has been confirmed by two evidence-based diagnostics (e.g., imaging, measurement of insulin-like growth factor 1 (IGF-1) levels, growth hormone stimulation test); **AND** * Prescriber attests that a baseline fundoscopic eye examination to exclude preexisting papilledema; **AND** • Patient provides a clinically valid reason why preferred Genotropin injection cannot be used **Renewal Criteria:**   Patient continues to meet initial criteria; **AND**  Patient has open epiphyses; **AND**  Prescriber attests that patient has an annualized height velocity of > 2.5 cm/year |  | [Growth](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [Hormone](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf) |
| Omnitrope® | NP | See Genotropin® prior authorization criteria |  |  |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Serostim® | NP | **Initial Criteria:**   * Diagnosis of HIV-associated wasting syndrome or cachexia; **AND** * One of the following:   + Unintentional weight loss of >10% over the last 12 months o Unintentional weight loss of > 7.5% over the last 6-months o Loss of 5% body cell mass (BCM) within 6-months o Body mass index (BMI) < 20 kg/m2; AND   + Body cell mass (BCM) below 40% total body weight in males or 35% total body weight in females; **AND** • Nutritional evaluation since onset of wasting first occurred; **AND** * Patient has not had weight loss due to other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, malignancy); AND * Anti-retroviral therapy has been optimized to decrease the viral load and will be continued throughout the course of treatment; **AND** * Trial and failure of megestrol **Renewal Criteria:** * Evidence of positive response to therapy (i.e., > 2% increase in body weight and/or BCM); **AND** • A target goal has not been achieved (i.e., weight, BCM, BMI) |  | [Growth](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [Hormone](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf) |
| Skytrofa® | NP | **Initial Criteria:**   * Patient is at least 1 year of age and less than 18 years of age; **AND** * Patient weighs at least 11.5kg; **AND** * Diagnosis of growth failure due to inadequate secretion of endogenous growth hormone (GH); **AND** * Agent is prescribed by, or in consultation with, an endocrinologist; **AND** * Documentation that diagnosis of growth hormone deficiency has been confirmed by two evidence-based diagnostics (e.g., imaging, measurement of insulin-like growth factor 1 (IGF-1) levels, growth hormone stimulation test); **AND** * Prescriber attests that a baseline fundoscopic eye examination to exclude preexisting papilledema; **AND** • Patient provides a clinically valid reason why preferred Genotropin injection cannot be used **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has open epiphyses; **AND** * Prescriber attests that patient has an annualized height velocity of > 2.5 cm/year |  | [Growth](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [Hormone](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf) |

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| **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Sogroya® | NP | **Initial Criteria:**   * Agent is prescribed by, or in consultation with, an endocrinologist; **AND** * Daily dose based on weight of the enrollee, supported by submitted growth charts; **AND** * Clinically valid reason as to why the patient cannot take the preferred product Genotropin; **AND** * **For patients < 21 years old, will be approved if ANY of the following criteria are met:**    + Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation and meets any of the following:   ­ Failed a GH stimulation test (peak GH level <10ng/mL)  ­ Documented low IGF-1 level (below normal for patient’s age)  ­ Has deficiencies in 3 or more pituitary axes o Patient has failed two GH stimulation tests (defined as peak GH level < 10 ng/mL) OR has failed one GH stimulation test and has a documented low IGF-1 level based on age normal values  ­ Continuation of therapy will be approved only if height velocity is within normal range for patient’s age or bone age  ­ Therapy will not be approved once epiphyseal fusion occurs o **Note**: GH therapy will NOT be approved for idiopathic short stature   * **Patients ≥ 21 years old, will be approved for ANY of the following:**    + Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation (can be diagnosed either in childhood or adulthood) AND meets any one of the following: ­ Failed at least one GH stimulation test   ­ Has at least one documented low IGF-1 level ­ Has deficiencies in 3 or more pituitary axes  ­ Note: For recipients diagnosed in childhood with hypothalamic-pituitary disease or structural lesions/trauma to the pituitary who have a past history of GH use, no retesting is necessary o Failure of two GH stimulation tests (peak GH level < 5 ng/mL) or failure of one GH stimulation test and documented low IGF-1  ­ Therapy will NOT be approved once epiphyseal fusion occurs **Renewal Criteria:**   * For diagnosis of Growth Hormone deficiency:   + Agent is prescribed by, or in consultation with, an endocrinologist; **AND**   + Patient has open epiphyses (therapy will NOT be approved once epiphyseal fusion occurs)**; AND**   + Documentation of positive clinical response to therapy (e.g., increased IGF-1 levels, improvement in linear growth or body composition) * For all other diagnoses: Patient continues to meet initial criteria |  | [Growth](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [Hormone](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf)  [PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Growth%20Hormone%20PA%20Form.pdf) |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Voxzogo® | NP | **Initial Criteria:**   * Diagnosis of achondroplasia; **AND** * Prescribed by, or in consultation with, an endocrinologist; **AND** * Patient has open epiphyses; **AND** * Patient will not have limb-lengthening surgery during treatment with Voxzogo®; **AND** * Provider attests that patient/caregiver has been properly trained on preparation and administration of Voxzogo **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Provider attests that patient has an annualized growth velocity > 1.5 cm/year |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Zomacton® | NP | See Genotropin® prior authorization criteria |  |  |
|  | **Hematopoietic Agents** | |  |  |
| Retacrit® | P | See Epogen® prior authorization criteria |  |  |
| Aranesp® | NP | See Epogen® prior authorization criteria |  |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Epogen® | NP | **Initial Criteria:**   * Lab values obtained within 30 days of the date of administration; **AND** * Adequate iron stores demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20%; **AND** * Hemoglobin (Hb) < 10 g/dL and/or hematocrit (Hct) < 30% (unless otherwise specified); **AND** * One of the following:   o Anemia secondary to chemotherapy; **AND**  ­ Patient is at least 5 years of age and receiving concurrent myelosuppressive chemotherapy; **AND**  ­ Upon initiation, there is at least 2 additional months of planned chemotherapy; AND  ­ Patient’s chemotherapy is not intended to cure their disease (i.e., palliative treatment) o Anemia secondary to zidovudine treated, HIV-infected patient; **AND**  ­ Zidovudine dose is ≤ 4,200 mg/week; AND Endogenous serum erythropoietin (EPO) levels ≤ 500 mUnits/mL; **OR** o Anemia secondary to hepatitis C virus (HCV) treatment in patients receiving ribavirin and interferon-alfa therapy; **OR** o Anemia secondary to myelodysplastic syndrome (MDS); **AND**  ­ Treatment of lower risk disease associated with symptomatic anemia; **AND**  ­ Endogenous serum erythropoietin (EPO) level ≤ 500 mUnits/mL; **OR** o Anemia secondary to myeloproliferative neoplasms (MPN) – Myelofibrosis; **AND**  ­ Endogenous serum EPO ≤ 500 mUnits/mL; **OR** o Anemia secondary to multiple myeloma; **OR**  o Anemia of prematurity, in combination with iron supplementation; **OR** o Anemia secondary to rheumatoid arthritis; **OR** o Anemia secondary to chronic kidney disease (CKD) and hemoglobin (Hb) is ≤ 12.9 g/dL; **OR** o Reduction of allogeneic blood transfusions in elective noncardiac, nonvascular surgery; **AND**  ­ Hb > 10 g/dL to ≤ 13 g/dL and/or Hct is 30% to 39%; **AND**  ­ Patient is NOT willing to donate autologous blood pre-operatively; **AND**   * Other causes of anemia (e.g., hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out   **Renewal Criteria**   * Last dose < 60 days ago; **AND** * Lab values obtained within 30 days of the date of administration; **AND** * Adequate iron stores as demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20% measured within the previous 3 months; **AND** * The following criteria are met, depending on diagnosis:   o Anemia secondary to chronic kidney disease and Hb < 12 g/dL and/or Hct < 36% for children OR Hb < 11 g/dL and/or  Hct < 33% for adults o Anemia secondary to chemotherapy treatment and Hb <10 g/dL and/or Hct < 30%; **AND**  ­ Patient is receiving concurrent myelosuppressive chemotherapy o Anemia secondary to zidovudine treated, HIV-infected patients and Hb < 12 g/dL and/or Hct < 36%; **AND** ­ Patient is receiving zidovudine administered at ≤ 4200 mg/week; **AND**  ­ Endogenous serum EPO ≤ 500 mUnits/mL; o Anemia secondary to myelodysplastic syndrome (MDS) and Hb <12 g/dL and/or Hct <36% o Anemia secondary to myeloproliferative neoplasms and Hb <10 g/dL and/or Hct <30% o Anemia secondary to Hepatitis C treatment and Hb < 11 g/dL and/or Hct < 33%; **AND** ­ Patient must be receiving interferon AND ribavirin  All other indications: Hb < 11 g/dL and/or Hct < 33% |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Mircera® | NP | **Initial Criteria**   * Lab values obtained within 30 days of the date of administration; **AND** * Adequate iron stores demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20%; **AND** * One of the following:   + Diagnosis of anemia secondary to chronic kidney disease (CKD) in adult patients and BOTH of the following: ­ Patient is 18 years of age or older   ­ BaselineHemoglobin (Hb) is < 10 g/dL o Diagnosis of anemia secondary to CKD in pediatric patients and BOTH of the following: ­ Patient is between 3 months and 17 years of age  ­ Patient’s hemoglobin stabilized following administration of another erythropoietin stimulating agent (ESA) (e.g., Retacrit, Aranesp, Procrit, Epogen); **AND**   * Patient will not use Mircera in combination with another ESA agent; **AND** * Other causes of anemia (e.g., hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out   **Renewal Criteria**   * Last dose < 60 days ago; **AND** * Patient will not use Mircera in combination with another ESA agent; **AND** * Lab values obtained within 30 days of the date of administration demonstrating BOTH of the following:   + Adequate iron stores as demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20% measured within the previous 3 months; o Increase or stabilization of hemoglobin from baseline |  |  |
| Procrit® | NP | See Epogen® prior authorization criteria |  |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Vafseo® | NP | **Initial Criteria: (6-month duration)**   * Diagnosis of anemia due to CKD; **AND** * Patient has been receiving dialysis for ≥ 4 months; **AND** * Recent documentation (within 30 days or request) of ALL the following:   + Hemoglobin level <10 g/dL o Serum ferritin ≥ 100 ng/mL (mcg/L) o Transferrin saturation (TSAT) ≥ 20%; **AND** * Trial and failure, contraindication, or intolerance to erythropoiesis-stimulating agents (ESAs); **AND** * Prescriber attests to ALL of the following:   + Will not use in combination with ESAs   + Will not use in combination with strong CYP2C8 inhibitor such as gemfibrozil o Patient does not have uncontrolled hypertension **Renewal Criteria:** * Patient is receiving dialysis for anemia due to CKD; **AND** * Submitted documentation demonstrating an increase hemoglobin from baseline; **AND** • Recent documentation (within 30 days or request) of ALL the following:   + Serum ferritin ≥ 100 ng/mL (mcg/L) o Transferrin saturation (TSAT) ≥ 20%; **AND** * Prescriber attests to ALL of the following:   + Will not use in combination with ESAs o Will not use in combination with strong CYP2C8 inhibitor such as gemfibrozil Patient does not have uncontrolled hypertension | 100mg, 450mg: 1/day 300mg: 2/day |  |
|  | **Estrogen/Progestin, Oral** | |  | |
| Premphase® | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Prempro® | P |  | 1/day |
|  | **Estrogen / Progestin, Transdermal** | |  | |
| CombiPatch® | P |  | 8/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Climara Pro® | NP |  | 4/28 days |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Estrogens, Transdermal** | |  |  |
| estradiol biweekly patch | P |  | 8/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| estradiol weekly patch | P |  | 4/28 days |
| Dotti® | P |  | 4/28 days |
| Lyllana® | P |  | 4/28 days |
| Alora® | NP |  | 8/28 days |
| Climara® | NP |  | 4/28 days |
| Divigel® | NP |  | 1/day |
| Elestrin® | NP |  | 1/28 days |
| estradiol gel | NP |  | 1/day |
| Menostar® | NP |  | 4/28 days |
| Minivelle® | NP |  | 8/28 days |
| Vivelle-Dot® | NP |  | 8/28 days |
|  | **Estrogens, Vaginal** | |  |  |
| Premarin® cream | P |  | 2 grams/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Estrace® | NP |  | 42.5 g/Rx |
| estradiol cream | NP |  | 42.5 g/Rx |
|  | **Estrogen/SERM Combinations** | |  |  |
| Duavee® | NP | * Patient has an intact uterus with a diagnosis of moderate to severe vasomotor symptoms associated with menopause; **OR** * Patient has an intact uterus with a diagnosis of post-menopausal osteoporosis | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Progestins, Oral** | |  |  |
| megestrol suspension 40 mg/mL | P |  | 20 mL/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| norethindrone acetate | P | Diagnosis of endometriosis |  |
| Aygestin® | NP | Diagnosis of endometriosis |  |
| megestrol suspension 625 mg/5 mL | NP | Inability to swallow the 10 mL (400 mg) or 20 mL (800 mg) dose of the regular-strength suspension | 5 mL/day |

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|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Hyperparathyroid Agents** | |  |  |
| cinacalcet | P | * Secondary Hyperparathyroidism due to Chronic Kidney Disease (CKD), AND patient must be on dialysis; **OR** * Parathyroid Carcinoma resulting in hypercalcemia; **OR** * Severe Hypercalcemia in patients with primary HPT who are unable to undergo parathyroidectomy |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| doxercalciferol capsules | NP | * Recipients experiencing (or with a history of) hypercalcemia and/or hyperphosphatemia with calcitriol use; **AND** * Trial and failure, contraindication, or intolerance to cinacalcet | 0.5, 2.5 mcg: 1/day; 1 mcg: 3/day |
| paricalcitol capsules | NP | See doxercalciferol capsules prior authorization criteria | 1/day |
| Rayaldee® | NP | * Secondary Hyperparathyroidism due to Stage 3 or Stage 4 Chronic Kidney Disease (CKD); **AND** * Serum total 25-hydroxyvitamin D levels less than 30 ng/mL; **AND** * Trial and failure, contraindication, or intolerance of cinacalcet | 2/day |
| Sensipar® | NP | See cinacalcet prior authorization criteria; **AND**  • Clinically valid reason why the preferred cinacalcet agent cannot be used |  |
| Zemplar® capsules | NP | See doxercalciferol capsules prior authorization criteria | 1/day |
|  | **NK3 Antagonists** | |  |  |
| Veozah® | NP | * Diagnosis of moderate to severe vasomotor symptoms due to menopause; **AND** * Trial and failure, contraindication, or intolerance to TWO of the following:   + Gabapentin   + Menopausal hormone therapy (e.g., estrogen monotherapy or estrogen + progesterone) o Oxybutynin   + SSRI (e.g., paroxetine, escitalopram, citalopram) o SNRI (e.g., venlafaxine and desvenlafaxine) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **ENDOCRINE/METABOLIC AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Vasopressor Antagonists** | |  |  |
| Jynarque® | NP | **Initial Criteria** **(6-month duration):**   * Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD); **AND** * Patient is 18 years of age or older; **AND** * Prescribed by, or in consultation with, a nephrologist; **AND** * Prescriber and patient are enrolled in the Jynarque REMS program; **AND** • Patient does not have a known hypersensitivity to tolvaptan; **AND** * Patient does not have any of the following:   + History of symptoms of significant liver impairment or injury (not including uncomplicated polycystic liver disease) o Uncorrected abnormal blood sodium concentration   + Inability to sense or respond to thirst   + Hypovolemia   + Uncorrected urinary outflow obstruction o Anuria; **AND** * Patient does not concurrently use a strong CYP 3A inhibitors; **AND** * A baseline alanine aminotransferase (ALT), aspartate aminotransferase (AST), and bilirubin have been performed and are within normal range (results must be within 3 months of request). Labs must also be repeated 2 weeks and 4 weeks after initiation and then continued monthly for the first 18 months and every 3 months thereafter.   **Renewal Criteria (6-month duration):**   * Patients must continue to meet the initial criteria; **AND** * Patient’s most recent ALT, AST, and bilirubin are within normal range (results must be within 3 months of request) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Jynarque Pak® | NP | See Jynarque® prior authorization criteria |  |
| Samsca® | NP | * Diagnosis of hyponatremia; **AND** * Medication was initiated in a hospital setting |  |
| tolvaptan | NP | See Samsca® prior authorization criteria |  |

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|  | **GASTROINTESTINAL**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated*** | | ***.*** |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **5-ASA Derivatives, Oral** | |  |  |
| Apriso® | P |  | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Delzicol® | P |  | 6/day |
| sulfasalazine | P |  | 8/day |
| sulfasalazine EC | P |  | 8/day |
| Azulfidine® | NP |  | 8/day |
| Azulfidine® EN | NP |  | 8/day |
| balsalazide | NP |  | 9/day |
| Colazal® | NP |  | 9/day |
| Dipentum® | NP |  | 4/day |
| Lialda® | NP |  | 4/day |
| mesalamine DR caps | NP |  | 6/day |
| mesalamine DR tabs | NP |  | 800 mg: 6/day  1.2 gm: 4/day |
| mesalamine ER 24 Hour caps | NP |  | 4/day |
| mesalamine ER caps |  |  | 500 mg: 8/day |
| Pentasa® | NP |  | 250 mg: 16/day; 500 mg: 8/day |
|  | **Agents for Chronic Constipation** | |  |  |
| Linzess® | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| lubiprostone | P |  | 2/day |
| Movantik® | P | * Age ≥ 18 years; **AND** * One of the following:   + Diagnosis of opioid-induced constipation with chronic non-cancer pain   + Diagnosis of opioid-induced constipation with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; **AND** * Submission of medical records (e.g., chart notes, control substance monitoring data base) or confirmed pharmacy claims documenting at >1 of opioid therapy within the past 90 days; **AND** * Prescriber attests that Movantik® will be discontinued when opioid treatment is discontinued | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Amitiza® | NP |  | 2/day |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Motegrity® | NP | * Age ≥ 18 years; **AND** * Patient has diagnosis of chronic idiopathic constipation (CIC); **AND** * Patient does not have intestinal perforation or obstruction due to structural or functional disorder of the gut wall, obstructive ileus, or severe inflammatory conditions of the intestinal tract (e.g., Crohn’s disease, ulcerative colitis); **AND** • Trial and failure of, or contraindication, or intolerance to lubiprostone AND Linzess® | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| prucalopride | NP | See Motegrity® prior authorization criteria; **AND** • Clinically valid why Motegrity® cannot be used |  |  |
| Relistor® injectable | NP | * Age ≥ 18 years; **AND** * One of the following:   + Diagnosis of opioid-induced constipation with chronic non-cancer pain   + Diagnosis of opioid-induced constipation with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation   + Diagnosis of opioid-induced constipation with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care; **AND** * Submission of medical records (e.g., chart notes, control substance monitoring data base) or confirmed pharmacy claims documenting at >1 of opioid therapy within the past 90 days; **AND** * Prescriber attests that Relistor® will be discontinued when opioid treatment is discontinued |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Relistor® tablets | NP | * Age ≥ 18 years; **AND** * One of the following:   + Diagnosis of opioid-induced constipation with chronic non-cancer pain   + Diagnosis of opioid-induced constipation with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; **AND** * Submission of medical records (e.g., chart notes, control substance monitoring data base) or confirmed pharmacy claims documenting at >1 of opioid therapy within the past 90 days; **AND** * Prescriber attests that the requested drug will be discontinued when opioid treatment is discontinued • Trial and failure of, or contraindication, or intolerance to Movantik® | 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Symproic® | NP | See Relistor® tablets prior authorization criteria; **AND**  Patient does not have known or suspected gastrointestinal obstruction | 1/day |  |
| Trulance® | NP | * Age ≥ 18 years; **AND** * Diagnosis of one of the following:   o Chronic idiopathic constipation (CIC) o Irritable bowel syndrome with constipation (IBS-C); **AND**  Patient does not have a known or suspected mechanical gastrointestinal obstruction; **AND** Trial and failure of, or contraindication, or intolerance to, lubiprostone OR Linzess® | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  |  | **GASTROINTESTINAL**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated*** | ***.*** |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Agents for Irritable Bowel Syndrome (IBS)** |  |  |
| alosetron | P | **Initial Criteria:**   * Patient is female and ≥ 18 years of age; **AND** * Diagnosis of severe, diarrhea-predominant, irritable bowel syndrome (IBS); **AND** * Chronic IBS symptoms lasting 6-months or more; **AND** * Provider has ruled out anatomic or biochemical abnormalities of the GI tract; **AND** * Patient is not concomitantly using fluvoxamine; **AND** * Patient does not have a history of the following conditions:   + Chronic or severe constipation or sequalae from constipation o Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions o Ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state o Crohn’s disease or ulcerative colitis o Diverticulitis   + Severe hepatic impairment **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Patient has not experienced any treatment-restricting adverse effects (e.g., severe constipation); **AND** * Positive response to therapy (e.g., decrease stool frequency, frequent bowel urgency, and abdominal pain) | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Linzess® | P |  | 1/day |  |
| lubiprostone | P |  | 2/day |
| Amitiza® | NP |  | 2/day |
| Ibsrela® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * Diagnosis of irritable bowel syndrome with constipation (IBS-C); **AND** * Patient does not have known or suspected mechanical gastrointestinal obstruction; **AND** • Trial and failure, contraindication, or intolerance to lubiprostone AND Linzess® **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Patient has not experienced any treatment-restricting adverse effects (e.g., severe diarrhea); **AND** * Positive response to therapy (e.g., decrease stool frequency, frequent bowel urgency, and abdominal pain) | 2/day |
| Lotronex® | NP | • Clinically valid reason why the preferred generic alosetron cannot be used | 2/day |

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|  | **GASTROINTESTINAL**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated*** | | ***.*** |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Viberzi® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * Diagnosis of severe, diarrhea-predominant, irritable bowel syndrome (IBS); **AND** • Patient does not have history of the following:   + alcohol abuse/addiction or drink more than 3 alcoholic drinks per day o pancreatitis or structural diseases of the pancreas o severe hepatic impairment (Child Pugh Class-C) o severe constipation o absence of gallbladder   + biliary duct (gallbladder) obstruction or Sphincter of Oddi disease/dysfunction **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Patient has not experienced any treatment-restricting adverse effects (e.g., severe diarrhea); **AND** * Positive response to therapy (e.g., decrease stool frequency, frequent bowel urgency, and abdominal pain) | 2/day |  |
| Xifaxan® | NP | • One of the following:   * Treatment of uncomplicated traveler’s diarrhea (1-month approval duration); **AND** ­ Request is for Rifaximin 200 mg tablets; **AND**   ­ Trial and failure, contraindication, intolerance, or resistance to a fluoroquinolone or azithromycin o Treatment of diarrhea-predominant IBS (3-month approval duration)   * Documented use for reduction in risk of overt hepatic encephalopathy (12-month approval duration) | 3/day |  |
|  | **Antidiarrheals** | |  |  |
| Mytesi® | NP | * Patient has non-infectious diarrhea of at least one month duration; **AND** * Patient has a diagnosis of HIV or AIDS; **AND** * Patiently is currently receiving anti-retroviral therapy |  |  |
|  | **Antiemetics: 5-HT3 Receptor Antagonists** | |  |  |
| ondansetron tablets and ODT | P | **Note**: Prior authorization is not required for quantities up to 30 tablets per 90 days. For requests that exceed the quantity limit, one of the following must be met:   * Receiving highly or moderately emetogenic chemotherapy * Receiving radiation therapy * Treatment is for post-operative nausea and vomiting (PONV) * Nausea or vomiting associated with pregnancy and trial and failure of TWO conventional antiemetics (i.e., metoclopramide, prochlorperazine, dexamethasone, Diclegis) | 30/90 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Anzemet® |  | * ONEof the following:   o Receiving highly or moderately emetogenic chemotherapy o Receiving radiation therapy o Treated for post-operative nausea and vomiting (PONV); **AND**   * Trial and failure, contraindication, or intolerance to a preferred 5HT3 antagonist | 2/30 |
| granisetron | NP | See Anzemet® prior authorization criteria | Tabs: 60/30 days Inj: 2 mL/30 days |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| ondansetron solution | NP | * Patient < 6 years of age; **OR** * The requested dose is not achievable with ondansetron ODT; **OR** * Allergy or intolerance to inactive ingredient in ODT tab (e.g., dye, filler, excipient) |  |  |
| Sancuso® | NP | See Anzemet® prior authorization criteria | 1/30 days |
| **Antiemetics: Anticholinergics** | | | |  |
| promethazine | P | * Patients < 2 years of age; **AND** * Prescriber documents medical necessity; **AND** * Prescriber is aware of contraindication and agrees to accept risk   **Note**: Prior authorization is not required for patients 2 years of age or older |  | [Promethazine PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Promethazine%20PA%20Form.pdf) |
| Transderm-Scop® | P | • One of the following:   * Recipient has tried and failed, or is intolerant to TWO of the following agents: meclizine, promethazine, dimenhydrinate, diphenhydramine or metoclopramide * Unable to take oral medications * Therapy is needed for an extended period of time where taking short acting agents would not be feasible o Has a tracheotomy or is ventilator dependent | 10 patches/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Phenergan® | NP | • One of the following:  o Patient is > 2 years of age, **AND**  ­ Clinical reason as to why patient cannot use generic equivalent o Patients < 2 years of age; **AND**  ­ Prescriber documents medical necessity; **AND**  ­ Prescriber is aware of contraindication and agrees to accept risk; **AND** ­ Clinical reason as to why patient cannot use generic equivalent |  | [Promethazine PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Promethazine%20PA%20Form.pdf) |
| promethazine suppositories | NP | See promethazine prior authorization criteria  **Note**: Prior authorization is not required for patients 2 years of age or older |  |
| scopolamine patches | NP | See Transderm-Scop® prior authorization criteria; **AND**  • Clinically valid reason as to why preferred Transderm-Scop® cannot be used | 10 patches/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| **Antiemetics: Delta-9-THC Derivatives** | | | |  |
| dronabinol | NP | * Request is for the treatment of severe nausea/vomiting associated with cancer chemotherapy for patients actively being treated for cancer; **AND** o Trial and failure, intolerance, intolerance, medical reason, or contraindication that prohibits taking Emend + 5HT3 receptor antagonist + corticosteroid; **OR** * Request is for the treatment of AIDS-related wasting**; AND** o Trial and failure, intolerance, or contraindication to megestrol acetate oral suspension |  |  |
| Marinol® | NP | See dronabinol prior authorization criteria |  |
| Syndros® | NP | See dronabinol prior authorization criteria; **AND**  • Unable to swallow solid dosage forms |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antiemetics: NK-1 Antagonists** | | |  |
| aprepitant | P | * Receiving a highly emetogenic chemotherapy regimen; **OR** * Receiving a moderately emetogenic chemotherapy regimen and has failed two other antiemetic regimens; **OR** * Treatment for PONV with trial and failure or contraindication to a 5HT3-receptor antagonist; **OR** • Refractory nausea that would require hospitalization | 40 mg: 1/30 days  80 mg: 4/30 days  125 mg: 2/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Akynzeo® | NP | • ONE of the following:  o Receiving a highly emetogenic chemotherapy regimen o Receiving a moderately emetogenic chemotherapy regimen and has failed other previous antiemetic regimens; **AND** • Trial and failure, contraindication, or intolerance to aprepitant | 2/30 days |
| Emend® | NP | See aprepitant prior authorization criteria; **AND**  • Clinically valid reason preferred aprepitant cannot be used | 80 mg: 4/30 days  Tri-Pack: 2 packs/30 days |
|  | **Antiemetics: Miscellaneous** | | |  |
| Diclegis® | P |  | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Bonjesta® | NP | * Patient has a diagnosis of pregnancy-induced nausea or vomiting; **AND** * Patient has failed documented conservative measures (e.g., dietary changes, trigger avoidance); **AND** • Clinically valid reason as to why preferred Diclegis® cannot be used | 2/day |
| doxylamine/ pyridoxine | NP | • Clinically valid reason as to why preferred Diclegis® cannot be used | 4/day |
|  | **Antispasmodics/Anticholinergics** | | |  |
| glycopyrrolate solution | P | * Patients unable to swallow tablets; **OR** * Patient is < 8 years of age |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cuvposa® | NP | * Patients unable to swallow tablets; **OR** * Patient is < 8 years of age |  |
|  | **Combination Products for *H. pylori*** | | |  |
| Pylera® | P | • Documentation of recent positive *H. pylori* test | 1 box/Rx; 2 courses of therapy/year) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Talicia® | P | • Documentation of recent positive *H. pylori* test |
| bismuth subcitrate/ metronidazole/ tetracycline | NP | * Documentation of recent positive *H. pylori* test; **AND** * Trial and failure, contraindication, or intolerance to a preferred combination agent | 1 box/Rx; 2 courses of therapy/year) |
| lansoprazole/amox/ clarithromycin | NP | * Documentation of recent positive *H. pylori* test; **AND** * Trial and failure, contraindication, or intolerance to a preferred combination agent |
| Omeclamox-Pak® | NP | * Documentation of recent positive *H. pylori* test; **AND** * Trial and failure, contraindication, or intolerance to a preferred combination agent |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Voquezna Dual Pak® | NP | * Documentation of recent positive H. pylori test; **AND** * Trial and failure, contraindication, or intolerance to a preferred combination agent | 1 box/Rx; 2 courses of therapy/year) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Voquezna Triple Pak® | NP | * Documentation of recent positive H. pylori test; **AND** * Trial and failure, contraindication, or intolerance to a preferred combination agent | 1 box/Rx; 2 courses of therapy/year) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **Fecal Microbiota** | |  |
| Vowst® | NP | **Criteria: (2-month duration)**   * Patient is  18 years old; **AND** * Treatment is to prevent the recurrence of Clostridioides difficile infection (CDI); **AND** * Patient has had three or more episodes of CDI within the past year; **AND** * Submission of medical records (e.g. chart notes, lab test) of a positive C. difficile stool test with toxin A/B results within the previous 30 days; **AND** * Patient has completed a full treatment course with ONE of the following antibiotic therapies 2 to 4 days prior to initiating Vowst:   o Fidaxomicin o Vancomycin; **AND**   * Prescriber by or in consultation with an infectious disease specialist or gastroenterologist; **AND** * The agent will not to be used in combination with other products for prevention of CDI, such as Zinplava or Rebyota | 12 caps/year | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **Gallstone Solubilizing Agents** | |  |
| ursodiol | P |  | 200, 250, 300, & 400 mg: 3/day; 500 mg: 2/day: | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cholbam® | NP | • Diagnosis of Bile Acid Synthesis Disorders due to Single Enzyme Defects (SED); **OR** o Agent will be used as adjunctive treatment for manifestations of Peroxisomal Disorders (PDs); **AND** • Prescribed by a hepatologist or gastroenterologist |  |
| Iqirvo® | NP | * Patient has a diagnosis of primary biliary cholangitis (PBC) **AND** • Prescribed by a hepatologist or gastroenterologist **AND** * ONE of the following:   o Both of the following:  ­ Will be taken in combination withursodiol; **AND**  ­ Submitted lab documentation indicates the patient had an inadequate response (no reduction in ALP or total bilirubin after 1-year trial) to ursodiol; **OR** o Patient has a contraindication, or intolerance to ursodiol | 1/day |
| Լivdеlzi® | NP | See Iqirvo® prior authorization criteria |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Ocaliva® | NP | See Iqirvo® prior authorization criteria | 1/day |  |
| Reltone® | NP |  | 3/day |
| Urso Forte® | NP |  | 2/day |
|  | **Hepatotrophics** | |  |  |
| Rezdiffra® | NP | **Initial Criteria**   * Patient is 18 years of age or older; **AND** * Diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) or metabolic dysfunction associated steatohepatitis (MASH); **AND** * Submission of medical records (e.g. chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by ONE of the following:   + FibroScan   + Fibrosis-4 index (FIB-4)   + Magnetic Resonance Elastography (MRE) o Liver Biopsy; **AND** * Prescriber attests patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND** * Patient does not have decompensated cirrhosis (Child-Pugh Class B or C); **AND** * Prescribed by or in consultation with a gastroenterologist or hepatologist   **Renewal Criteria**   * Prescriber attest patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND** * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g. NASH resolution, fibrosis stage improvements) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Inflammatory Bowel Disease, Miscellaneous Agents** | |  |  |
| budesonide foam | P |  | 66.8 g/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Uceris® tablet | P |  | 1/day |
| hydrocortisone AC suppository | P |  | 12/30 days |
| budesonide ER tabs | NP | • Trialand failure of preferred Uceris tablets | 1/day |
| Uceris® foam | NP |  | 66.8 g/day |
|  | **Laxatives** | |  |  |
| Sutab**®** | NP |  | 24 tabs per colonoscopy | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **GASTROINTESTINAL**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Motility Agents** | | |  |
| metoclopramide | P |  | 12-week duration limit | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| metoclopramide solution | P |  | 12-week duration limit |
| Gimoti*®* | NP | * Patient must have acute and recurrent diabetic gastroparesis; **AND** * Patient is > 18 years of age; **AND** * Patient does not have a history of tardive dyskinesia (TD) or dystonic reaction to metoclopramide; **AND** • Clinically valid reason why metoclopramide tablets or solution cannot be used | 1 bottle per Rx |
| metoclopramide ODT | NP | * Unable to swallow, **OR** * Unable to absorb medications through the GI tract | 12-week duration  limit |
| Reglan® | NP |  | 12-week duration  limit |
|  | **Mucosal Protectants** | | |  |
| Carafate® suspension | NP | * Patient is < 13 years of age; **OR** * Trial and failure, or intolerance to, sucralfate tablets, **OR** * Has documented difficulty swallowing/dysphagia |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| sucralfate suspension | NP | See Carafate suspension prior authorization criteria |  |  |

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| **Medication** | | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** | |
| **Proton Pump Inhibitors** | | | | | | |
| |  | | --- | | **The quantity limit for proton pump inhibitors is 1 per day**. **If request is for twice daily dosing, one of the following must be met:** | | | | | | | |
|  | |  | | --- | | * Treatment of H. Pylori (1-month duration) * Treatment of GI Bleed/Hemorrhagic Gastritis (12-motnh duration) * Patient has a diagnosis of Barrett’s Esophagus with documentation of uncontrolled reflux symptoms or esophagitis (following a trial of once daily PPI therapy) * Uncontrolled symptoms following a 30-day trial of once daily PPI therapy (1-month duration); renewals will require member to attempt step down to once daily PPI therapy. If patient fails step down to once daily dosing, they will not be asked to step down again | | | | | | |
| Dexilant® | | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | |
| esomeprazole | | P |  | 1/day |
| lansoprazole | | P |  | 1/day |
| Nexium® pack | | P | • Unable to swallow solid dosage forms | 1/day |
| omeprazole | | P |  | 1/day |
| omeprazole ODT | | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | |
| omeprazole/sodium bicarbonate | | P |  | 1/day |
| pantoprazole | | P |  | 1/day |
| Protonix® packs | | P |  | 1/day |
| dexlansoprazole | | NP |  | 1/day |
| esomeprazole packs | | NP | * Unable to sallow solid dosage forms; **AND** * Trial, failure, contraindication, or intolerance to Protonix® suspension and Nexium granules | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | |
| First-Lansoprazole® | | NP | • Unable to sallow solid dosage forms; **AND** o Trial, failure, contraindication, or intolerance to Protonix suspension packets; **OR** • Patient is < 6 years of age | 1/day |
| Konvomep® | | NP | See First-Lansoprazole® prior authorization criteria | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | |
| lansoprazole ODT | | NP |  | 1/day |
| Nexium® | | NP |  | 1/day |
| pantoprazole pack | | NP | • Clinically valid reason why the preferred Protonix® suspension cannot be used | 1/day |
| Prevacid® | | NP |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | |
| Prevacid SoluTab® | | NP | * Unable to swallow solid oral dosage forms; **AND** * Trial, failure, contraindication, or intolerance to Protonix®suspension | 1/day |
|  | | **GASTROINTESTINAL**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Voquezna® | | NP | * Patient is 18 years of age or older; **AND** * One of the following diagnoses:   + Active treatment of erosive esophagitis **(2-month approval duration); OR**   + Maintenance treatment of healed erosive esophagitis **(6-month approval duration);** **AND**   ­ Request is for Voquezna 10 mg tablets; **OR** o Non-erosive gastroesophageal reflux disease (GERD) **(1-month approval duration); AND** ­ Request is for Voquezna 10 mg tablets; **AND**   * Trial and failure, contraindication, or intolerance to TWO preferred proton pump inhibitors | 1/day; **AND**  10 mg: 180 days/ year 20 mg: 60 days/ year |  |
| Prilosec® | | NP |  | 1/day |
| Protonix® tablets | | NP |  | 1/day |
| rabeprazole | | NP |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Zegerid® | | NP |  | 1/day |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Allergen Specific Immunotherapy** | | | | |
| Grastek® | NP | * Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND** * Documentation initial dose was administered in the physician office or medical facility; **AND** * Must be prescribed by an allergy/immunology specialist; **AND** * Patient’s diagnosis is confirmed with documentation of **ONE** of the following:   + A positive skin test to **ONE** of the pollen extracts contained in the requested agent   + Pollen specific IgE antibodies to **ONE** of the pollen extracts contained in the requested agent; **AND** * Trial and failure, contraindication, or intolerance to **ONE** agent from **TWO** of the following classes:   + Oral antihistamine o Intranasal antihistamine o Intranasal corticosteroid o Leukotriene receptor antagonist; **AND** * Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots) [Note: Failure defined as lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia]; **AND** * Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND** * Oral Anti-allergens will NOT be approved if patient meets ANY of the following:   + Patient experienced a severe reaction post initial dose administered in the physician’s office o Patient has concomitant allergen immunotherapy   + Patient has a history of severe, unstable, or uncontrolled asthma o Patient has a history of eosinophilic esophagitis; **AND** * Treatment is requested within 12 weeks prior to season of allergen being treated (Grass season: April-September)   **Note:** Prior authorizations may be processed for Grastek® between January 1 and March 31; with PA requests being accepted 2 weeks prior to this period. Requests received after March 31 will not be processed. | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Odactra® | NP | * Diagnosis of house dust mite (HDM) induced allergic rhinitis with or without conjunctivitis; **AND** * Patient’s diagnosis confirmed with documentation of ONE of the following:   + Confirmed in vitro IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus HDMs o Confirmed skin testing to licensed HDM allergen extracts; **AND** * Prescribed by or in consultation with an allergy/immunology specialist; **AND** * Documentation initial dose was administered in the physician office or medical facility; **AND** * Trial and failure, contraindication, or intolerance to ONE agent from TWO of the following classes:   + Oral antihistamine o Intranasal antihistamine o Intranasal corticosteroid o Leukotriene receptor antagonist; **AND** * Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND** * Oral Anti-allergens will NOT be approved if patient meets ANY of the following:   + Patient experienced a severe reaction post initial dose administered in the physician’s office o Patient has concomitant allergen immunotherapy   + Patient has a history of severe, unstable, or uncontrolled asthma o Patient has a history of eosinophilic esophagitis | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Oralair® | NP | * Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND** * Documentation initial dose was administered in the physician office or medical facility; **AND** * Must be prescribed by an allergy/immunology specialist; **AND** * Patient’s diagnosis is confirmed with documentation of **ONE** of the following:   + A positive skin test to **ONE** of the pollen extracts contained in the requested agent   + Pollen specific IgE antibodies to **ONE** of the pollen extracts contained in the requested agent; **AND** * Trial and failure, contraindication, or intolerance to **ONE** agent from **TWO** of the following classes:   + Oral antihistamine o Intranasal antihistamine o Intranasal corticosteroid o Leukotriene receptor antagonist; **AND** * Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots) [Note: Failure defined as lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia]; **AND** * Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND** * Oral Anti-allergens will NOT be approved if patient meets ANY of the following:   + Patient experienced a severe reaction post initial dose administered in the physician’s office o Patient has concomitant allergen immunotherapy   + Patient has a history of severe, unstable, or uncontrolled asthma o Patient has a history of eosinophilic esophagitis; **AND** * Treatment is requested within 4 months prior to season of allergen being treated (Grass season: April-September)   **Note:** Prior authorizations may be processed for Oralair® between December 1 and March 31; with PA requests being accepted 2 weeks prior to this period. Requests received after March 31 will not be processed. | tabs: 1/day;  Dose Pak: total max limit  100 mg IR/300 mg IR | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Palforzia® | NP | **Initial Criteria:**   * Diagnosis of peanut allergy confirmed by one of the following:   + Serum peanut-specific immunoglobulin E (IgE) of greater than or equal to 0.35 kUA/L   + Mean wheal diameter greater than or equal to 3 mm compared to control on skin prick testing for peanut; **AND** * Initial doses for each up-dose will be administered and monitored at the prescriber’s office and distributed by the specialty pharmacy; **AND** * Prescribed by, or in consultation with, an allergist or immunologist that is enrolled in Palforzia REMS Program; **AND** * Provider must prescribe injectable epinephrine, instruct, and train patients on its appropriate use; **AND** * Must be used in conjunction with a peanut-avoidant diet; **AND** * Patient must not have ANY of the following:   + Severe, persistent, or uncontrolled Asthma   + History of eosinophilic esophagitis or other eosinophilic gastrointestinal disease o History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months **Renewal Criteria:** * Documentation (medical records, chart notes, etc.) of tolerance to therapy during the initial dose escalation and up-dosing phases; **AND** * Documentation of positive clinical response to Palforzia therapy; **AND** * Patient continues to use in conjunction with a peanut-avoidant diet; **AND** * Prescribed by, or in consultation with, an allergist or immunologist that is enrolled in the Palforzia REMS Program |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Ragwitek® | NP | * Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND** * Documentation initial dose was administered in the physician office or medical facility; **AND** * Must be prescribed by an allergy/immunology specialist; **AND** * Patient’s diagnosis is confirmed with documentation of **ONE** of the following:   + A positive skin test to **ONE** of the pollen extracts contained in the requested agent   + Pollen specific IgE antibodies to **ONE** of the pollen extracts contained in the requested agent; **AND** * Trial and failure, contraindication, or intolerance to **ONE** agent from **TWO** of the following classes:   + Oral antihistamine o Intranasal antihistamine o Intranasal corticosteroid o Leukotriene receptor antagonist; **AND** * Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots) [Note: Failure defined as lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia] ; **AND** * Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND** * Oral Anti-allergens will NOT be approved if patient meets ANY of the following:   + Patient experienced a severe reaction post initial dose administered in the physician’s office o Patient has concomitant allergen immunotherapy   + Patient has a history of severe, unstable, or uncontrolled asthma o Patient has a history of eosinophilic esophagitis; **AND** * Treatment is requested within 12 wks prior to season of allergen being treated (Ragweed season: August-December) **Note:** Prior authorizations may be processed for Ragwitek® between May 1st thru July 31st; with PA requests being accepted 2 weeks prior to this period. Requests received after July 31st will not be processed. | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Anti-Rheumatic: Kinase Inhibitors** | |  |  |
| Rinvoq® | P | **Initial Criteria (6-month duration):**   * Prescriber attests to each of the following:   + Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**   + Benefits of using this agent outweigh the risks of heart-related events (heart attack, stroke, blood clots, etc.) or cardiovascular risk factors; **AND**   + Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND** * One of the following:   + Diagnosis of moderately to severely active rheumatoid arthritis (RA) or active polyarticular juvenile idiopathic arthritis   (pJIA); **AND**  ­ Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND**  ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **OR** o Diagnosis of active psoriatic arthritis (PSA); **AND**  ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **OR** o Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**  ­ Trial and failure, contraindication, or intolerance to TNF-inhibitor (e.g. Humira, Enbrel) o Diagnosis of moderately to severely active Crohn’s Disease; **AND**  ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g., Humira); **OR** o Diagnosis of moderate to severe Atopic Dermatitis; **AND**  ­ Trial and failure, contraindication, or intolerance to 1 topical corticosteroid of medium-to-high potency; **AND**  ­ Trial and failure, contraindication, or intolerance to a topical calcineurin inhibitor; **OR** o Diagnosis of active ankylosing spondylitis; **AND**  ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **AND** o Diagnosis of active non-radiographic axial spondylarthritis (nr-axSpA) with objective signs of inflammation; **AND** ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel) **Renewal Criteria:**  • Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, lower UC disease activity index) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Rinvoq LQ® | P | **Initial Criteria (6-month duration):**   * Prescriber attests to each of the following:   + Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**   + Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; **AND**   + Risk of malignancy has been considered, and it has been determined that Jak inhibitor therapy is appropriate; **AND** * One of the following:   + Diagnosis of active Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND**   ­ Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **OR** o Diagnosis of active psoriatic arthritis (PSA); **AND**  ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **AND**   * One of the following:   + Patient weighs <30 kg o Patient is unable to swallow solid dosage forms **Renewal criteria:** * One of the following:   + Patient weighs <30 kg   + Patient is unable to swallow oral dosage forms; **AND** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts) | 30 mL/day |  |
| Xeljanz® tablet | P | **Initial Criteria (6-month duration):**   * Prescriber attests to each of the following:   + Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**   + Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; **AND**   + Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND** * One of the following:   + Diagnosis of moderately to severely active Rheumatoid Arthritis (RA), or active Polyarticular Course Juvenile Idiopathic   Arthritis (pcJIA); **AND**  ­ Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND**  ­ Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel) o Diagnosis of active Psoriatic Arthritis (PsA); **AND**  ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **OR** o Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**  ­ Trial and failure, contraindication, or intolerance to Humira o Diagnosis of Ankylosing spondylitis; **AND**  ­ Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel) **Renewal Criteria:**  Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index) | 2/day |  |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Olumiant® | NP | **Initial Criteria (6-month duration):**   * Prescriber attests to each of the following:   + Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**   + Benefits of using this agent outweigh heart-related events or cardiovascular risk factors o Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND** * One of the following:   + Diagnosis of moderately to severely active Rheumatoid Arthritis; **AND**   ­ Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND**  ­ Trial and failure, contraindication, or intolerance a preferred TNF-inhibitors (e.g., Enbrel, Humira); **AND**  ­ Trial and failure, contraindication, or intolerance to ONE preferred agent; **OR** o Diagnosis of Severe alopecia areata; **AND**  ­ Patient is at > 18 years old but less than 21 years old (indication is not a covered benefit in patients > 21 years old);  **AND**  ­ Recipient has ≥ 50% scalp hair loss; **AND**  ­ Prescriber attest patient does not have other underlying causes of hair loss (e.g. male pattern hair loss  (androgenic alopecia), female pattern hair loss, telogen effluvium, traction alopecia, and tinea capitis); **AND**  ­ Recipient must be evaluated every 4 months by a physician and submit chart documentation indicating patient has had improved hair growth/decreased hair loss **Renewal Criteria:**  • Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index, Alopecia areata: improvement in extent and density of scalp hair loss ) **Note**: Will not be covered for COVID-19 treatment in post hospitalized patients | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Xeljanz® solution | NP | **Initial Criteria:**   * Prescriber attests to each of the following:   + Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND** o Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; AND   + Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND** * Diagnosis of active Polyarticular Juvenile Idiopathic Arthritis (pcJIA); **AND** * Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND** * Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **AND** * One of the following:   + Patient weighs <40 kg o Patient is unable to swallow oral dosage forms   **Renewal Criteria**   * One of the following:   + Patient weighs <40 kg o Patient is unable to swallow oral dosage forms   Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index) | 10 mL/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Xeljanz® XR 11 mg | NP | • See Xeljanz® tablet prior authorization criteria; **AND**  Clinically valid reason why the preferred Xeljanz immediate release product cannot be used | 1/day |  |
| Xeljanz® XR 22 mg | NP | **Initial Criteria (6-month duration):**   * Prescriber attests to each of the following:   + Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND** o Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; AND   + Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND** * Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND** * Trial and failure, contraindication, or intolerance a preferred adalimumab product; **AND** * Clinically valid reason why the preferred Xeljanz immediate release product cannot be used **Renewal Criteria:**   Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| **Disease Modifying Anti-Rheumatic Drugs (DMARDs)** | | | | |
| sulfasalazine | P |  | 8/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| sulfasalazine EC | P |  | 8/day |
| Azulfidine® | NP |  | 8/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Azulfidine EN® | NP |  |  |
| Jylamvo® | NP | * Dosing that will not allow the use of preferred methotrexate tablets; **OR** * Patient unable to swallow methotrexate tablets | 4 syringes/28 days |
| Otrexup® | NP | * Diagnosis of Rheumatoid Arthritis (RA) or polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** o Trial/failure of TWO preferred DMARD agents; **AND**   + Must have an allergy or contraindication to benzoyl alcohol or other preservative contained in injectable methotrexate that is not in requested agent; **OR**   + Patient is experiencing dexterity issues without assistance to a caregiver who can administer the requested agent; **OR** * Diagnosis of psoriasis:   + Trial and failure of TWO topical antipsoriatic agents; **AND** o Clinically valid reason why oral methotrexate cannot be used; **AND** o One of the following:   ­ Patient has an allergy or contraindication to benzoyl alcohol or other preservative in injectable methotrexate that is not in requested agent  ­ Patient is experiencing dexterity issues without assistance to a caregiver who can administer the requested agent | 4 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rasuvo® | NP | See Otrexup® prior authorization criteria | 4 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Xatmep® | NP | * Age ≤ 12 years; **AND** * One of the following:   o Dosing that will not allow the use of preferred methotrexate tablets o Patient unable to swallow methotrexate tablet |  |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Immunomodulators: TNF Inhibitors** | | | | |
| Enbrel®;  Enbrel Mini  Cartridge®;  Enbrel Sureclick® | P | **Initial Criteria (6-month duration):**   * Diagnosis of Ankylosing Spondylitis; **OR** * Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND** o Trial and failure of ONE topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**   o Trial and failure, or contraindication, of ONE oral treatment with acitretin, methotrexate, OR cyclosporine; **OR**   * Diagnosis of active Psoriatic Arthritis (PsA); **OR** * Diagnosis of active Juvenile Psoriatic arthritis (JPsA); **OR** * Diagnosis of Rheumatoid Arthritis (RA) or Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** o Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine **Renewal Criteria**: * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, a 50% reduction of total Psoriasis Area Severity Index (PASI) score) | 25 mg dose:  8 syringes/28 days    50 mg dose:  4 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Humira®;  Hadlima®;  Simlandi® | P | **Initial Criteria (6-month duration):**   * Diagnosis of Ankylosing Spondylitis (AS); **OR** * Diagnosis of chronic, moderate to severe Plaque Psoriasis and both the following:   + Trial and failure of ONE topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**   + Trial and failure, or contraindication, of ONE oral treatment with acitretin, methotrexate, OR cyclosporine; **OR** * Diagnosis of Generalized pustular psoriasis (GPP) confirmed by ONE of the following:   + Presence of sterile, macroscopically visible pustules on non-acral skin and pustulation is NOT restricted to psoriatic plaques (i.e. occurs outside of psoriatic plaques)   + Skin biopsy confirming presence of Kogoj’s spongiform pustules o Genetic confirmation of IL36RN, CARD14, or AP1S3 mutation; **OR** * Diagnosis of active Psoriatic Arthritis (PsA); **OR** * Diagnosis of active Juvenile Psoriatic arthritis (JPsA); **OR** * Diagnosis of Rheumatoid Arthritis (RA) or Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** o Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **OR** * Diagnosis of moderate*ly* to severely activeUlcerative Colitis (UC); **OR** * Diagnosis of moderately to severely active Crohn’s Disease (CD) and ONE of the following:   + Previous trial and failure of infliximab in the past 365 days o Crohn’s disease is classified as moderate, severe, or fistulizing   + > 90 days of drug therapy with one of the following: azathioprine, mercaptopurine, mesalamine, methotrexate, or systemic glucocorticoid; **OR** * Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **OR** * Diagnosis of non-infectious intermediate, posterior or panuveitis (UV); **AND** o Diagnosis of Uveitis must be by, or in consultation with, an ophthalmologist; **AND**   + > 90 days of drug therapy with one of the following: oral/injectable steroid therapy, methotrexate, mycophenolate, azathioprine, cyclosporine, tacrolimus, cyclophosphamide **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, <UC disease activity index, reduction in inflammatory bumps/abscesses, decreases in flares) | 2 syringes/28 days    Starter Packs:  1 kit/28 days    Hidradenitis  Suppurativa (HS) diagnosis only:  4 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Abrilada® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of one of the following:   ­ Ankylosing Spondylitis (AS)  ­ Active Psoriatic Arthritis (PsA)  ­ Rheumatoid Arthritis (RA)  ­ Polyarticular Juvenile Idiopathic Arthritis (pJIA)  ­ Plaque Psoriasis (PsO)  ­ Moderately to severely active Crohn’s Disease (CD)  ­ Hidradenitis Suppurativa (HS)  ­ Moderately to severely active Ulcerative Colitis (UC)  ­ Non-infectious intermediate, posterior or panuveitis (UV); **AND**   * Clinically valid reason why ALL the preferred adalimumab products cannot be used **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, endoscopic remission) | 2 injectors/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| adalimumab | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Amjevita® | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days |
| Cimzia® | NP | **Initial Criteria (6-month duration):**   * One of the following:   o Diagnosis of one of the following:  ­ Ankylosing spondylitis (AS)  ­ Axial spondyloarthritis, nonradiographic (nr-axSpA)  ­ Active psoriatic arthritis (PsA)  ­ Rheumatoid arthritis (RA)  ­ Plaque psoriasis (PsO);  ­ Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** o Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication; **OR**   * Diagnosis of moderately to severely active Crohn’s disease; **AND** o Trial and failure, contraindication, or intolerance to a preferred adalimumab product Entyvio, or infliximab **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, endoscopic remission) | 2 kits/28 days  (4 syringes) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cyltezo® | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Hulio® | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days |
| Hyrimoz® | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days |
| Idacio® | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days |

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|  | **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Simponi® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of Ankylosing Spondylitis, active Psoriatic Arthritis (PsA), or Rheumatoid Arthritis (RA):   + Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication; **OR** * Diagnosis of moderately to severely active Ulcerative Colitis (UC):   + Trial and failure to two of the following (or have an intolerance or contraindication to all agents): ­ A preferred adalimumab product   ­ Entyvio  ­ Infliximab  ­ A preferred JAK inhibitor (e.g. Xeljanz and Rinvoq) **Renewal Criteria:**   * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, endoscopic remission) | 1 syringe /28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Yuflyma® | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Yusimry® | NP | See Abrilada® prior authorization criteria | 2 injectors/28 days |
| Zymfentra® | NP | **Initial Criteria**   * Patient is 18 years of age or older; **AND** * Diagnosis of ONE of the following:   + Moderately to severely active Crohn’s disease o Moderately to severely active Ulcerative Colitis; **AND** * Prescriber attests that patient has received three IV doses of infliximab prior to transitioning to subcutaneous therapy; **AND** * Submission of medical records demonstrating a positive clinical response following a treatment minimum of 10 weeks of infliximab IV   **Renewal Criteria**   * Diagnosis of ONE of the following:   + Moderately to severely active Crohn’s disease o Moderately to severely active Ulcerative Colitis; **AND** * Disease response to therapy and tolerability compared to baseline (e.g., decreased UC disease activity index, endoscopic remission, decreased number of soft stools, decreased abdominal pain) | 2/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Immunomodulators: Interleukin Inhibitors** | |  |  |
| Kineret® | P | **Initial Criteria (6-month duration):**   * Diagnosis of Rheumatoid Arthritis; AND o Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **OR** * Diagnosis of Neonatal-Onset Multisystem Inflammatory Disease (NOMID) * Diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA) **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts) | 1 syringe/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Taltz® | P | **Initial Criteria (6-month duration):**   * Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND** o Trial and failure to ONE topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**   o Trial and failure, or contraindication, to ONE oral treatment with acitretin, methotrexate, OR cyclosporine; **OR**   * Diagnosis of active Psoriatic Arthritis (PsA); **OR** * Diagnosis of Axial spondyloarthritis (axSpA), Active Ankylosing Spondylitis (AS), or Active non-radiographic axial spondyloarthritis (nr-axSpA) **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score) | 1 syringe/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Tyenne® | P | **Initial Criteria: (6-month duration)**   * Diagnosis of Rheumatoid Arthritis; **AND** o Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **OR** • Diagnosis of active Systemic Juvenile Idiopathic Arthritis (SJIA); **OR** * Diagnosis of Giant Cell Arteritis (GCA) and ONE of the following:   + Trial and failure of > 90 days of therapy with systemic glucocorticoids, azathioprine, or methotrexate unless contraindicated or intolerance; **OR**   + Occurrence of GCA relapse while patient on prednisone doses greater than 20 mg/day, **OR** o Patient will be utilizing systemic glucocorticoids with tocilizumab **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease number of tender/swollen joint course) | 4 injections (3.6mL)/ 28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Actemra®,  Actemra ACTPen® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of Rheumatoid Arthritis or active Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** o Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **AND** o Clinically valid reason why the preferred product Tyenne cannot be used*;* **OR** * Diagnosis of active Systemic Juvenile Idiopathic Arthritis; **AND** o Clinically valid reason why the preferred product Tyenne cannot be used; **OR** * Diagnosis of Giant Cell Arteritis (CGA); **AND** o One of the following:   ­ Trial and failure of > 90 days of drug therapy with systemic glucocorticoids, azathioprine, or methotrexate  ­ Occurrence of GCA relapse while patient on prednisone doses greater than 20 mg/day  ­ Patient will be utilizing systemic glucocorticoid with tocilizumab; **AND** o Clinically valid reason why the preferred product Tyenne cannot be used   * Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD); **AND** o Patient is 18 years of age or older; **AND**   + Patient’s onset of disease was 5 years ago or less; **AND**   + Patient has active disease with elevated inflammatory markers or platelets **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts) | 3.6 mL/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Arcalyst® | NP | * Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS), and Muckle-Wells Syndrome (MWS); **OR** * Diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA); **AND** o Patient has tried and failed or have contraindication or intolerance to preferred agent Kineret; **OR** • Diagnosis of recurrent pericarditis (RP) and meets all of the following; **AND** • Trial and failure, contraindication, or intolerance to ONE of the following:   + Colchicine   + Corticosteroids o NSAIDS | 8 vials/month | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Bimzelx® | NP | **Initial Criteria:**   * Diagnosis of moderate to severe Plaque Psoriasis (PsO), Active Psoriatic Arthritis (PsA), or Ankylosing Spondylitis (AS); **AND** o Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with the same indication; **OR** * Diagnosis of Non-Radiographic Axial Spondyloarthritis (nr-axSpA); **AND** o Trial and failure, contraindication, or intolerance to Taltz; **OR** * Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **AND**o Trial and failure, contraindication, or intolerance of a preferred adalimumab product **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., reduction of total PASI score, reduction in inflammatory bumps/abscesses) | 1 injections/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cosentyx® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of chronic, moderate to severe Plaque Psoriasis(PsO), Ankylosing Spondylitis (AS), active Psoriatic Arthritis (PsA);   **AND**  o Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication; **OR**   * Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; **AND** o Trial and failure, contraindication, or intolerance of Taltz; **OR** * Diagnosis of Active Enthesitis-related arthritis (ERA); **AND** o Failed an adequate trial of ONE NSAID (unless contraindicated); **AND** * Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **AND** o Trial and failure, contraindication, or intolerance of a preferred adalimumab product **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, a 50% reduction of total PASI score, reduction in inflammatory bumps/abscesses, decreases in flares) | 300 mg dose:  2 pens/28 days;    150 mg dose:  1 pen /28 days    Hidradenitis  Suppurativa (HS) diagnosis only- 300 mg dose:  4 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Kevzara® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of Rheumatoid Arthritis (RA) or active Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** o Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication: **OR** * Diagnosis of Polymyalgia Rheumatic (PR); **AND** o Trial and failure, contraindication, or intolerance to systemic corticosteroids; **AND** **Renewal Criteria (6-month duration):** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts) | 2 pens or syringes /30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Omvoh® Autoinjector | NP | **Initial Criteria: (6-month duration)**   * Diagnosis of Ulcerative Colitis; **AND**  o Trial and failure to two of the following (or have an intolerance or contraindication to all agents): ­ A preferred adalimumab product   ­ Entyvio  ­ Infliximab  ­ A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq); OR   * Diagnosis of moderately to severely active Crohn’s disease (CD); **AND** o Trial and failure, contraindication, or intolerance to a preferred adalimumab product, Entyvio, or infliximab; **AND** o Prescriber attests that patient has received three IV doses of Omvoh prior to transitioning to subcutaneous therapy **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., endoscopic remission) | 2 auto-injectors/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Otulfi® | NP | See prior authorization criteria for Stelara® | See Stelara® | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Pyzchiva® | NP | See prior authorization criteria for Stelara® | See Stelara® |
| Selarsdi® | NP | See prior authorization criteria for Stelara® | See Stelara® |
| Siliq® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of moderate to severe plaque psoriasis (PsO); **AND** * Patient has a contraindication, drug-drug interaction, or adverse reaction to TWO preferred immunomodulator agents with same indication; **AND** * Patient does not have a history of Crohn’s disease; **AND** * Prescriber and patient have met the requirements of the Siliq REMS program **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., a 50% reduction of total PASI score) | 2 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Skyrizi® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of Plaque Psoriasis (PsO) or active psoriatic arthritis (PsA); **AND** o Trial and failure to ALL preferred immunomodulator agents with the same indication; **OR** * Diagnosis of moderately to severely active Crohn’s disease (CD); **AND** o Trial and failure, contraindication, or intolerance to a preferred adalimumab product, Entyvio, or infliximab; **OR** * Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND** o Trial and failure to two of the following (or have an intolerance or contraindication to all agents):   + A preferred adalimumab product o Entyvio o Infliximab   + A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq) **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score) | Cartridge: 1 per 8 weeks    Auto-injector, prefilled syringe, and pre-  filled syringe kit: 2 per  84 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Steqeyma® | NP | See prior authorization criteria for Stelara® | See Stelara® |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Spevigo® | NP | **Initial Criteria:**   * Diagnosis of Generalized pustular psoriasis (GPP) confirmed by ONE of the following:   + Presence of sterile, macroscopically visible pustules on non-acral skin and pustulation is NOT restricted to psoriatic plaques (i.e. occurs outside of psoriatic plaques)   + Skin biopsy confirming presence of Kogoj’s spongiform pustules; o Genetic confirmation of IL36RN, CARD14, or AP1S3 mutation; **AND** • Patient is 12 years of age and older and weights at least 40 kg; **AND** * Prescriber attest to ALL of the following:   + Treatment is NOT for an active GPP flare   + Patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment o Patient will not receive live vaccines during therapy and 16 weeks after treatment; **AND** * Trial and failure to BOTH of the following (or have an intolerance or contraindication to all agents):   + A TNF inhibitor (e.g. adalimumab, infliximab, and etanercept) o Taltz; **AND** * Prescribed by, or in consultation with, a dermatologist **Renewal Criteria:** * Submission of medical records (e.g. chart notes) documenting disease response to therapy and tolerability compared to baseline (e.g., decreased number of GPP flares)   **Note**: The Spevigo subcutaneous formulation is not FDA approved for the treatment of GPP flare and will not be approved for that diagnosis. A SQ loading dose is not required following treatment of a GPP flare with IV Spevigo | 2/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Stelara® prefilled syringe and 45 mg/0.5 mL vial | NP | **Initial Criteria (6-month duration):**   * Diagnosis of Plaque Psoriasis (PsO) or active Psoriatic Arthritis (PsA); **AND** o Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication; **OR** * Diagnosis of moderately to severely active Crohn’s disease (CD); **AND** o Trial and failure, contraindication, or intolerance to a preferred adalimumab product, Entyvio, or infliximab; **OR** * Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**  o Trial and failure to two of the following (or have an intolerance or contraindication to all agents): ­ A preferred adalimumab product   ­ Entyvio  ­ Infliximab  ­ A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq) **Renewal Criteria:**   * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score) | Plaque Psoriasis, Psoriatic Arthritis:  1 injection/84 days    Crohn's Disease and Ulcerative Colitis:  1 injection/56 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tremfya® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of Plaque Psoriasis (PsO) or active psoriatic arthritis (PsA); **AND** o Trial and failure to ALL preferred immunomodulator agents with the same indication; **OR** * Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND** o Trial and failure to two of the following (or have an intolerance or contraindication to all agents): ­ A preferred adalimumab product   ­ Entyvio  ­ Infliximab  ­ A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq) **Renewal Criteria:**   * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score) | 1 syringe (1 mL) /  56 days  1 autoinjector/ 56 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| ustekinumab | NP | See prior authorization criteria for Stelara® | See Stelara® |  |
| Yesintek® | NP | See prior authorization criteria for Stelara® | See Stelara® |  |
|  | **Immunomodulators: Miscellaneous** | |  |  |
| Orencia® | P | **Initial Criteria (6-month duration):**   * Diagnosis of Rheumatoid Arthritis (RA) or Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** o Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, or sulfasalazine; **OR** • Diagnosis of active Psoriatic Arthritis PsA) **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score) | 4 mL/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Otezla® | P | **Initial Criteria (6-month duration):**   * Diagnosis of Plaque Psoriasis (PsO); **AND** o Trial and failure to a topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**   o Trial and failure, or contraindication, to oral treatment with Soriatane®, methotrexate, cyclosporine; **OR**   * Diagnosis of active severe Psoriatic Arthritis (PsA); **OR** * Diagnosis of oral lesions associated with Behçet’s Disease; **AND** o Patient has active oral ulcers; **AND** o Trial and failure, contraindication, or intolerance to colchicine **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score) | 30 mg: 2/day  Starter Pack: 1/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Entyvio® | NP | **Initial Criteria: (4-month duration)**   * One of the following:   o Diagnosis of moderate to severe Crohn’s disease o Diagnosis of moderate to severe ulcerative colitis (UC); **AND**   * Trial and failure, contraindication, or intolerance of a TNF- inhibitor (e.g., Humira, Infliximab) supported by paid claims or chart notes; **AND** * Prescriber attests that patient has or will receive > 2 intravenous doses of Entyvio prior to transitioning to subcutaneous therapy   **Renewal Criteria:**   * Patient is established on Entyvio therapy for > 14 weeks (supported by paid claims or chart notes); **AND** * Documentation of positive disease response to therapy and tolerability compared to baseline (e.g., decreased UC disease activity index, endoscopic remission, decreased stool frequency) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Sotyktu® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of moderate to severe Plaque Psoriasis (PsO); **AND** * Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., a 50% reduction of total PASI score) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Velsipity® | NP | **Initial Criteria (3-month duration)**   * Diagnosis of moderately to severely active ulcerative colitis (UC); **AND** * Patient is ≥ 18 years old; **AND** * Trial and failure to two of the following (or have an intolerance or contraindication to all agents):   o A preferred adalimumab product o Entyvio o Infliximab o A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq); **AND**   * Patient does not have a recent (within the previous 6 months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure; **AND** * Patient does not have a history or presence of Mobitz Type II second-degree, or third-degree atrioventricular block, sick sinus syndrome, or sino-atrial block (unless treated with a functioning pacemaker)   **Renewal Criteria**   * Disease response to therapy and tolerability compared to baseline (e.g., endoscopic remission, decreased stool frequency, decreased rectal bleeding) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Immunosuppressants** | |  |  |
| Astagraf XL® | NP | • Trial and failure, contraindication, or intolerance to ONE preferred agent  **Note**: The PA requirement may be overridden at POS via an ICD-10 code override. |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Azasan® | NP | * Diagnosis of rheumatoid arthritis; **AND** o Trial and failure of ONE preferred agent with the same indication (e.g., azathioprine); **OR** * All transplant recipients will be allowed a prior authorization for any drug   **Note**: The PA requirement may be overridden at POS via an ICD-10 code override. |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| CellCept® tablets | NP | All transplant recipients will be allowed a prior authorization for any drug.  **Note**: The PA requirement may be overridden at POS via an ICD-10 code override. |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| CellCept® capsules | NP | See CellCept® tablets prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Envarsus® XR | NP | • Trial and failure, contraindication, or intolerance to ONE preferred agent  **Note**: The PA requirement may be overridden at POS via an ICD-10 code override. |  |
| Imuran® | NP | See Azasan® prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Myfortic® | NP | See CellCept® tablets prior authorization criteria |  |
| Neoral® | NP | * Diagnosis of rheumatoid arthritis or plaque psoriasis; **AND** o Trial and failure of ONE preferred agent with the same indication (e.g., cyclosporine, GENGRAF); **OR** * All transplant recipients will be allowed a prior authorization for any drug   **Note**: The PA requirement may be overridden at POS via an ICD-10 code override. |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Prograf® capsules | NP | See CellCept® tablets prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Prograf® packets | NP | • Trial and failure, contraindication, or intolerance to ONE preferred agent  **Note**: The PA requirement may be overridden at POS via an ICD-10 code override. |  |
| Sandimmune® caps | NP | See CellCept® tablets prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Zortress® | NP | See CellCept® tablets prior authorization criteria |  |
|  | **Lupus and Lupus Nephritis Agents** | |  |  |
| Benlysta® | NP | **Initial Criteria: (6-month duration)**   * Patient is > 5 years of age; **AND** * Diagnosis of one of the following: o Active systemic lupus erythematosus (SLE); **OR** o Active lupus nephritis; **AND**   ­ Diagnosis has been confirmed by biopsy or biopsy is contraindicated in the patient*;* **AND**   * Prescribed by, or consultation with, a rheumatologist or nephrologist; **AND** * Must be used in combination with standard treatment regimens (e.g., corticosteroids, mycophenolate, azathioprine); **AND** • Patient does not have severe active central nervous system lupus **Renewal Criteria:** * Patient meets the initial criteria; **AND** * Positive clinical response to therapy (e.g., reduction in corticosteroid dose, reduction in flares, improvement in organ dysfunction) | 4 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Lupkynis® | NP | **Initial Criteria:**   * Patient is > 18 years of age; **AND** * Diagnosis of active lupus nephritis; **AND** * Diagnosis has been confirmed by biopsy or biopsy is contraindicated in the patient; **AND** * Must take in combination with mycophenolate mofetil and corticosteroids; **AND** * Will NOT take in combination with cyclophosphamide or Benlysta; **AND** * Prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND** * Will not be used concomitantly with strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin); **AND** • Patient is not pregnant **Renewal Criteria:** * Must take in combination with mycophenolate mofetil and corticosteroids; **AND** * Will NOT take in combination with cyclophosphamide or Benlysta; **AND** * Prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND** * Patient has experienced a positive response to therapy (evidence of long-term preservation of kidney function, prevention of disease flares, prevention of organ damage); **AND** * Patient has not experienced treatment-limiting adverse effects (eGFR decline, blood pressure increase, hypertensive crisis) | 6/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Multiple Sclerosis Agents, Injectable** | | |  |
| Avonex® | P |  | 4/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Avonex Pack® | P |  | 4/28 days |
| Copaxone® | P |  | 20mg: 1 mL/day  40mg: 12 mL/30 days |
| Betaseron® | NP |  | 14/28 days |
| glatiramer | NP |  | 20mg: 1 mL/day  40mg: 12 mL/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Glatopa® | NP |  | 1/day |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Kesimpta® | NP | **Initial Criteria:**   * Patient is > 18 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting Multiple Sclerosis [RRMS], active secondary progressive disease [SPMS]); **AND** * Prescriber attests that initial dose was administered under the guidance of a healthcare professional; **AND** * Patient meets ONE of the following:   + Patient has active secondary progressive disease (SPMS); **OR** o Trial and failure, contraindication, or intolerance to one disease modifying therapy for MS; **OR**   + Submission of medical records (e.g., chart notes) documenting clinical features of highly active MS such as high radiological burden of disease, high relapse frequency, severe relapse(s) requiring corticosteroids and/or hospitalization, severe physical or cognitive impairment; **AND** * Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment; **AND** * For patients of reproductive potential, the following has been addressed:   + Patient has been counseled to use effective contraception during treatment and for 6-months after the last dose; **AND** o Lactating women will be counseled to discontinue breast feeding during treatment; **AND** o Provider has confirmed (via pregnancy test) that the patient is not pregnant prior to receiving treatment **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | Initiation: 3 pens the  1st month    Maintenance: 1 pen/month | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Plegridy® | NP | * Patient is ≥ 18 years old; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Diagnosis of relapsing forms of Multiple Sclerosis which include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; **AND** * Trial and failure, contraindication, or intolerance of 2 preferred injectable MS agents | 2 pens/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rebif® | NP |  | 6 mL /28 days |  |
| **Multiple Sclerosis (MS) Agents, Oral** | | | | |
| dalfampridine ER | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| dimethyl fumarate | P | **Initial Criteria:**   * Patient must be the labeled age minimum; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has a relapsing form of multiple sclerosis (i.e., clinically isolated syndrome, relapsing-remitting disease, active secondary progressive disease) **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 2/day |
| fingolimod | P | See dimethyl fumarate prior authorization criteria | 1/day |
| teriflunomide | P | See dimethyl fumarate prior authorization criteria |  |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Ampyra® | NP | • Clinically valid reason why preferred dalfampridine cannot be used | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Aubagio® | NP | See dimethyl fumarate prior authorization criteria; **AND**  • Clinically valid reason why preferred dalfampridine cannot be used |  |
| Bafiertam® | NP | **Initial Criteria:**   * Patient is ≥ 18 years old; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** * Trial and failure, contraindication, or intolerance of teriflunomide or fingolimod; **AND** • Trial and failure, contraindication, or intolerance of dimethyl fumarate; **AND**  **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Gilenya® | NP | **Initial Criteria:**   * Patient is ≥ 10 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Diagnosis of a relapsing form of multiple sclerosis (i.e., clinically isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** * Clinically valid reason why preferred fingolimod cannot be used **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Mavenclad® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * ONE of the following:   + Diagnosis of relapsing-remitting multiple sclerosis [RRMS]; **AND**   ­ Trial and failure, contraindication, or intolerance to teriflunomide, dimethyl fumarate, or fingolimod; **OR** o Diagnosis of active secondary progressive disease [SPMS]; **AND**   * For patients of reproductive potential:   + Provider has counseled patient to use contraception during treatment and for 6-months after the last dose o Lactating women will be counseled to discontinue breast feeding during treatment o Provider has confirmed (via pregnancy test) that the patient is not pregnant prior to receiving treatment; **AND** * Prescriber attests to ALL of the following:   + Patient does not have a currently malignancy   + Patient does not have serious active chronic infections such as HIV, tuberculosis, and active hepatitis o Patient has been screened for the presence of tuberculosis **Renewal Criteria:** * At least 43 weeks (approx. 10 months) has/will have elapsed since the end of the first treatment course; **AND** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 40 tabs/2 years | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Mayzent® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** * Patient does NOT have any of the following:   + Recent (within 6-months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure; **OR**   + Prolonged QTc interval at baseline (> 500 msec); **OR**   + History of Mobitz Type II second- or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker) ; **OR**   + CYP2C9\*3/\*3 genotype; **OR**   + Active infection (including clinically important localized infections); **AND** * Patient will not be initiating therapy after previous treatment with alemtuzumab (Lemtrada); **AND** * For female patients of reproductive potential, the following has been addressed:   + Provider has counseled patient to use effective contraception during treatment with therapy o Lactating patient has been counseled on the risks versus benefits of breastfeeding while on treatment **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | Starter pack: 1 pack/Rx;  0.25 mg:  4 tabs/day;  2 mg: 1 tab/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ponvory® | NP | **Initial Criteria:**   * Patient ≥ 18 years old; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * ONE of the following:   + Diagnosis of relapsing-remitting multiple sclerosis [RRMS]; **AND**   ­ Trial and failure, contraindication, or intolerance to teriflunomide, dimethyl fumarate, or fingolimod; **OR** o Diagnosis of active secondary progressive disease [SPMS]; **AND**   * Patient must NOT meet any of the following:   + Recent (within 6-months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure; **OR**   + Presence of Mobitz type II second-degree, third degree atrioventricular (AV) block, sick sinus syndrome unless the patient has a functioning pacemaker; **AND** * For female patients of reproductive potential, all the following has been addressed:   + Provider has counseled patient to use effective contraception during treatment   + Lactating patients have been counseled on the risks versus benefits of breastfeeding while on treatment **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tascenso ODT® | NP | **Initial Criteria:**   * Patient is ≥ 10 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** * Patient is unable to swallow sold dosage forms **Renewal Criteria:** * Patient is unable to swallow sold dosage forms; **AND** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Tecfidera® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** * Clinically valid reason why preferred dimethyl fumarate cannot be used **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vumerity® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** * Trial and failure, contraindication, or intolerance of teriflunomide or fingolimod; **AND** • Trial and failure, contraindication, or intolerance of dimethyl fumarate **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression) | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Zeposia® | NP | **Initial Criteria:**   * Patient is ≥ 18 years of age; **AND** * ONE of the following:   o Diagnosis of relapsing forms of multiple sclerosis, including clinical isolated syndrome, relapsing-remitting disease, and active secondary progressive disease: **AND**  ­ Prescribed by, or in consultation with, a neurologist; **AND**  ­ Trial and failure, contraindication, or intolerance to teriflunomide, dimethyl fumarate, OR fingolimod (not required for SPMS); **OR** o Diagnosis of moderately to severely active ulcerative colitis (UC) in adults; **AND**  ­ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):   * A preferred adalimumab product * Entyvio * Infliximab * A preferred JAK inhibitor (e.g. Xeljanz and Rinvoq); **AND** * Patient does NOT have any of the following: * Recent (within the previous 6-months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure * Severe untreated sleep apnea * History or presence of Mobitz Type II second-degree, or third-degree atrioventricular block, sick sinus syndrome, or sino-atrial block (unless treated with a functioning pacemaker) * Concomitantly taking a monoamine oxidase (MAO) inhibitor; **AND** * For female patients of reproductive potential, all the following has been addressed:   o Patient has been counseled to use effective contraception during treatment o Lactating patients have been counseled on the risks versus benefits of breastfeeding while on treatment **Renewal Criteria:**   * Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression, endoscopic remission) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Respiratory and Allergy Biologics** | |  |  |
| Adbry® | P | **Initial Criteria (6-month duration):**   * Patient is ≥ 12 years of age; **AND** * Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:   + Involvement of at least 10% of body surface area (BSA) o Scoring Atopic Dermatitis (SCORAD) score of 20 or more o Investigator’s Global Assessment (IGA) with a score ≥ 3o Eczema Area and Severity Index (EASI) score of ≥ 16   + Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND** * Trial and failure (documented by claims) or contraindication to both of the following:   + A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) o A topical calcineurin inhibitor; **AND** * Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist **Renewal Criteria:** * Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD) | Initial month:  6 syringes    Maintenance:  4 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ebglyss® | P | See Adbry prior authorization criteria | Initial 6 months:  4 pens Maintenance:  1 pens/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Dupixent® | P | **Asthma**  **Initial Criteria (6-month duration):**   * Diagnosis of moderate to severe asthma; **AND** • Patient is ≥ 6 years old; **AND** * One of the following:   + Asthma is an eosinophilic phenotype as defined by a baseline (pre- treatment) peripheral blood eosinophil level ≥ 150 cells/μL or peripheral blood eosinophil levels > 300 cells/mcL; **OR**   + Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Asthma is inadequately controlled as shown by one of the following:   + Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR**   + Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation in the past 12 months; **OR**   + Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Patient is currently being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including BOTH of the following:   ­ One medium or high dose inhaled corticosteroid (ICS); **AND**  ­ One additional asthma controller medication [e.g., LABA, leukotriene antagonist, theophylline]; **OR** o One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product; **AND**   * Will be used as adjunct therapy along with above asthma treatment; **AND** * Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist **Renewal Criteria:** * Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND** * Patient is being treated with ONE of the following, unless there is a contraindication: o Combination therapy including both a high-dose ICS and an additional asthma controller medication o One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product   **Atopic Dermatitis Diagnosis**  **Initial Criteria (6-month duration):**   * Patient is ≥ 6-months of age; **AND** * Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:   + Involvement of at least 10% of body surface area (BSA) o Scoring Atopic Dermatitis (SCORAD) score of 20 or more o Investigator’s Global Assessment (IGA) with a score ≥ 3o Eczema Area and Severity Index (EASI) score of ≥ 16   + Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND** * Trial and failure (documented by claims) or contraindication to both of the following:   + A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) o A topical calcineurin inhibitor; **AND** * Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist **Renewal Criteria:** * Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD) | 2 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Dupixent®*(continued)* | P | **Chronic Idiopathic Urticaria (CIU) Initial Criteria** **(6-month duration):**   * Patient is ≥ 12 years of age; **AND** * Diagnosis of chronic spontaneous idiopathic urticaria (CSU) or chronic idiopathic urticaria (CIU); **AND** • Patient remains symptomatic despite a 2-week trial to BOTH the following taken in combination:   + A second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine); **AND** o One of the following:   ­ Different second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine)  ­ First generation H1-antihistamine (e.g., diphenhydramine, chlorpheniramine, hydroxyzine)  ­ H2-receptor antihistamine (e.g., famotidine, cimetidine, ranitidine)  ­ Leukotriene modifier (e.g., montelukast); **AND**   * Prescribed by, or in consultation with, an allergist, dermatologist, or immunologist **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, itch severity, hives)     **Chronic rhinosinusitis with nasal polyposis (CRSwNP) Initial Criteria (6-month duration):**   * Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) confirmed by ONE of the following:   + Presence of bilateral nasal polyps o Patient has previously required surgical removal of bilateral nasal polyps; **AND** * Patient is ≥ 12 years of age; **AND** * One of the following:   + Patient has required prior sinus surgery; **OR**   + Patient has required systemic corticosteroids for CRSwNP o Symptoms persist after trial of TWO of the following classes of agents:   ­ Nasal saline irrigations  ­ Intranasal corticosteroids  ­ Antileukotriene agents; **AND**   * Must be used in combination with intranasal corticosteroid, unless contraindication or intolerance; **AND** • Prescribed by, or in consultation with, an allergist, immunologist, otolaryngologist, or pulmonologist **Renewal Criteria:** * Documentation of positive clinical response to therapy; **AND** * Will continue to use in combination withintranasal corticosteroids | 2 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Dupixent®*(continued)* |  | **Chronic Obstructive Pulmonary Disease (COPD) Initial Criteria (6-month duration):**   * Diagnosis of COPD; **AND** * Patient is ≥ 18 years of age; **AND** * Eosinophilic phenotype confirmed byperipheral blood eosinophil levels > 300 cells/mcL; **AND** * COPD is inadequately controlled as shown by one of the following:   + Two or more exacerbations requiring systemic corticosteroids and/or antibiotics within the past 12 months; **OR** o COPD-related emergency treatment (e.g., hospitalization in the past 12 months, mechanical ventilation); **AND** * Patient is currently receiving standard of care COPD treatment, unless contraindicated (i.e., ICS/LAMA/LABA); **AND** * Post-bronchodilator FEV1/FVC ratio <0.7 and FEV1 < 79%; **AND** * Medication will be used as maintenance add-on therapy **Renewal Criteria** * Positive clinical response to treatment (e.g., improved FEV1 from baseline, reduction in COPD exacerbations); **AND** * Patient is currently receiving standard of care COPD treatment, unless contraindicated (i.e., ICS/LAMA/LABA); **AND** Medication will be used as maintenance add-on therapy   **Eosinophilic Esophagitis (EoE)**  **Initial Criteria** **(6-month duration):**   * Diagnosis of eosinophilic esophagitis (EOE) as confirmed by an esophageal biopsy demonstrating ≥ 15 intraepithelial eosinophils per high power field (documentation required); **AND** * Patient is ≥ 1 years of age and weighs at least 15 kg; **AND** * Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that may not respond to antacids, gastroesophageal reflux disease-like symptoms); **AND** * Symptoms are inadequately controlled after a trial of ONE of the following: o Proton pump inhibitor (e.g., pantoprazole, omeprazole); **OR**   + Topical esophageal corticosteroids (e.g., budesonide, fluticasone); **AND** * Prescribed by, or in consultation with, a gastroenterologist, allergist, or immunologist **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., reduction of eosinophil count, improvement of symptoms)   **Prurigo Nodularis (PN) Initial Criteria:**   * Diagnosis of Prurigo Nodularis (PN); **AND** * Patient age ≥ 18 years; **AND** * Patient has 20 or more nodular lesions (IGA PN-S > 3); **AND** * Inadequate response, intolerance, or contraindication to a topical steroid; **AND** • Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist **Renewal Criteria:** * Documentation of positive clinical response (e.g., improved symptoms or IGA PN-S) | 2 syringes/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Fasenra® | P | **Asthma**  **Initial Criteria (6-month duration):**   * Diagnosis of moderate to severe asthma; **AND** • Patient is ≥ 6 years old; **AND** * One of the following:   + Asthma is an eosinophilic phenotype as defined by a baseline (pre- treatment) peripheral blood eosinophil level ≥ 150 cells/μL or peripheral blood eosinophil levels > 300 cells/mcL; **OR**   + Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Asthma is inadequately controlled as shown by one of the following:   + Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR** o Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation); **OR** o Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Patient is currently being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both of the following: ­ One high dose inhaled corticosteroid (ICS)   ­ One additional asthma controller medication [e.g., LABA, leukotriene receptor antagonist, theophylline]; **OR** o One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product; **AND**   * Will be used as adjunct therapy along with above asthma treatment; **AND** * Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist **Renewal Criteria:** * Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND** * Patient is being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both a high-dose ICS and an additional asthma controller medication o One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product   **Eosinophilic granulomatosis with polyangiitis (EGPA) Initial Criteria (6-month duration):**   * Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); **AND** * Patient is ≥ 18 years of age; **AND** * Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisolone, prednisone) with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab)]; **AND** * One of the following:   + Patient has relapsing disease (defined as a relapse requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization); **OR**   + Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens; **AND** * Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy); **AND** * Prescribed by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., reduced frequency or severity of relapses, reduction or discontinuation of corticosteroids or immunosuppressants) | Initial (first 3 doses):  1/30 days    Maintenance:  1/56 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nemluvio® | P | **Atopic Dermatitis Diagnosis**  **Initial Criteria (6-month duration):**   * Patient is ≥ 12 years of age; **AND** * Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:   + Involvement of at least 10% of body surface area (BSA) o Scoring Atopic Dermatitis (SCORAD) score of 20 or more o Investigator’s Global Assessment (IGA) with a score ≥ 3o Eczema Area and Severity Index (EASI) score of ≥ 16   + Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND** * Trial and failure (documented by claims) or contraindication to both of the following:   + A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) o A topical calcineurin inhibitor; **AND** * Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist **Renewal Criteria:** * Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD)   **Prurigo Nodularis (PN) Initial Criteria:**   * Diagnosis of Prurigo Nodularis (PN); **AND** * Patient age ≥ 18 years; **AND** * Patient has 20 or more nodular lesions (IGA PN-S > 3); **AND** * Inadequate response, intolerance, or contraindication to a topical steroid; **AND** * Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist; **AND** • Trial and failure, contraindication, or intolerance to Dupixent **Renewal Criteria:** * Documentation of positive clinical response (e.g., improved symptoms or IGA PN-S) | 2 injections/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nucala® | P | **Asthma**  **Initial Criteria (6-month duration):**   * Diagnosis of moderate to severe asthma; **AND** • Patient is ≥ 6 years old; **AND** * One of the following:   + Asthma is an eosinophilic phenotype as defined by a baseline (pre- treatment) peripheral blood eosinophil level ≥ 150 cells/μL or peripheral blood eosinophil levels > 300 cells/mcL; **OR**   + Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Asthma is inadequately controlled as shown by one of the following:   + Two more exacerbations requiring systemic corticosteroids within the past 12 months   + Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation) o Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Patient is currently being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both of the following: ­ One high dose inhaled corticosteroid (ICS)   ­ One additional asthma controller medication [e.g., LABA, leukotriene receptor antagonist, theophylline]; **OR** o One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product; **AND**   * Will be used as adjunct therapy along with above asthma treatment; **AND** * Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist **Renewal Criteria:** * Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND** * Patient is being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both a high-dose ICS and an additional asthma controller medication o One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product   **Eosinophilic granulomatosis with polyangiitis (EGPA) Initial Criteria (6-month duration):**   * Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); **AND** * Patient is ≥ 18 years of age; **AND** * Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisolone, prednisone) with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab)]; **AND** * One of the following:   + Patient has relapsing disease (defined as a relapse requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization); **OR**   + Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens; **AND** * Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy); **AND** * Prescribed by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., reduced frequency or severity of relapses, reduction or discontinuation of corticosteroids or immunosuppressants) | 3 pens or syringes / 28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nucala®  *(continued)* | P | **Hypereosinophilic syndrome (HES) Initial Criteria (6-month duration):**   * Patient is > 12 years of age; **AND** * Patient has had HES for > 6-months without an identifiable non-hematologic secondary cause (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy, etc.); **AND** * Patient does not have FIP1L1-PDGFRα kinase-positive HES; **AND** * Baseline (pre-Nucala treatment) blood eosinophil level ≥1000 cells/µL (documentation required); **AND** * Patient is currently receiving a stable dose of background HES therapy (e.g., oral corticosteroid, immunosuppressor, or cytotoxic therapy); **AND** * Prescribed by, or in consultation with a pulmonologist, rheumatologist, allergist, or immunologist; **AND** **Renewal Criteria:** * Documentation of positive clinical response to therapy   **Chronic rhinosinusitis with nasal polyps (CRSwNP) Diagnosis Initial Criteria (6-month duration):**   * Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) confirmed by ONE of the following:   + Presence of bilateral nasal polyps o Patient has previously required surgical removal of bilateral nasal polyps; **AND** * Patient is ≥ 18 years of age; **AND** * One of the following:   + Patient has required prior sinus surgery; **OR** o Patient has required systemic corticosteroids for CRSwNP; **OR** o Symptoms persist after trial of TWO of the following classes of agents:   ­ Nasal saline irrigations  ­ Intranasal corticosteroids  ­ Antileukotriene agents; **AND**   * Must be used in combination with intranasal corticosteroid, unless contraindication or intolerance; **AND** • Prescribed by, or in consultation with, an allergist, immunologist, otolaryngologist, or pulmonologist **Renewal Criteria:** * Documentation of positive clinical response to therapy; **AND** * Will continue to use in combination withintranasal corticosteroids | 3 pens or syringes /28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tezspire® | P | **Asthma**  **Initial Criteria (6-month duration):**   * Diagnosis of severe asthma; **AND** * Patient is ≥ 12 years old; **AND** * Patient has inadequately controlled asthma as shown by one of the following:   + Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR**   + Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation); **OR** o Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Patient is currently being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both of the following:   ­ One medium or high dose inhaled corticosteroid (ICS); **AND**  ­ One additional asthma controller medication [e.g., LABA, leukotriene antagonist, theophylline]; **OR** o One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product; **AND**   * Will be used as adjunct therapy along with above asthma treatment; **AND** * Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist **Renewal Criteria:** * Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND** * Patient is being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both a high-dose ICS and an additional asthma controller medication o One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product | 4 pens or syringes /28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Xolair® | P | **Asthma**  **Initial Criteria (6-month duration):**   * Diagnosis of moderate to severe persistent; **AND** * Patient is ≥ 6 years old; **AND** * Dose requested is consistent with corresponding weight and IgE level per manufacturer’s dosing chart; **AND** * Baseline (pre-treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL; **AND** • Positive skin test or in vitro reactivity to a perennial aeroallergen; **AND** * Patient has inadequately controlled asthma as shown by one of the following:   + Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR**   + Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation; **OR** * Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND** * Patient is currently being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both of the following:   ­ One medium or high dose inhaled corticosteroid (ICS); **AND**  ­ One additional asthma controller medication [e.g., LABA, leukotriene antagonist, theophylline]; **OR** o One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product; **AND**   * Will be used as adjunct therapy along with above asthma treatment; **AND** * Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist **Renewal Criteria:** * Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND** * Patient is being treated with ONE of the following, unless there is a contraindication:   + Combination therapy including both a high-dose ICS and an additional asthma controller medication One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product   **Chronic Idiopathic Urticaria (CIU) Initial Criteria** **(6-month duration):**   * Patient is ≥ 12 years of age; **AND** * Diagnosis of chronic spontaneous idiopathic urticaria (CSU) or chronic idiopathic urticaria (CIU); **AND** • Patient remains symptomatic despite a 2-week trial to BOTH the following taken in combination:   + A second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine); **AND** o One of the following:   ­ Different second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine)  ­ First generation H1-antihistamine (e.g., diphenhydramine, chlorpheniramine, hydroxyzine)  ­ H2-receptor antihistamine (e.g., famotidine, cimetidine, ranitidine)  ­ Leukotriene modifier (e.g., montelukast); **AND**   * Prescribed by, or in consultation with, an allergist, dermatologist, or immunologist **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, itch severity, hives) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| **IMMUNOLOGICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Xolair®  *(continued)* |  | **IgE-mediated food allergy**   * Diagnosis of IgE-mediated food allergy confirmed by BOTH of the following:   + History of type I allergic reactions; **AND**   + Food specific skin prick testing (SPT) or IgE antibody in vitro testing; **AND** * Xolair is to be used in combination with food allergen avoidance; **AND** * Dose requested is consistent with corresponding weight and IgE level per manufacturer’s dosing chart; **AND** * Prescribed by, or in consultation with allergist or immunologist **Chronic rhinosinusitis with nasal polyps (CRSwNP)Initial Criteria (6-month duration):** * Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) confirmed by ONE of the following:   + Presence of bilateral nasal polyps o Patient has previously required surgical removal of bilateral nasal polyps; **AND** * Patient is ≥ 18 years of age; **AND** * One of the following:   + Patient has required prior sinus surgery; **OR** o Patient has required systemic corticosteroids for CRSwNP; **OR** o Symptoms persist after trial of TWO of the following classes of agents:   ­ Nasal saline irrigations  ­ Intranasal corticosteroids  ­ Antileukotriene agents; **AND**   * Must be used in combination with intranasal corticosteroid, unless contraindication or intolerance; **AND** • Prescribed by, or in consultation with, an allergist, immunologist, otolaryngologist, or pulmonologist **Renewal Criteria:** * Documentation of positive clinical response to therapy; **AND** * Will continue to use in combination withintranasal corticosteroids |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cibinqo® | NP | **Initial criteria (6-month duration):**   * Patient is ≥ 12 years of age; **AND** * Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:   + Involvement of at least 10% of body surface area (BSA) o Scoring Atopic Dermatitis (SCORAD) score of 20 or more o Investigator’s Global Assessment (IGA) with a score ≥ 3o Eczema Area and Severity Index (EASI) score of ≥ 16   + Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND** * Trial and failure (documented by claims) or contraindication to both of the following:   + A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) o A topical calcineurin inhibitor; **AND** * Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist * Trial and failure, contraindication, or intolerance of a preferred agent indicated for atopic dermatitis (e.g., Adbry, Dupixent, Ebglyss, Nemluvio) **Renewal Criteria:** * Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **MISCELLANEOUS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicate*** | | ***d.*** |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Oral Iron Chelators** | |  |  |
| deferiprone | NP | * Patient has a diagnosis of ONE of the following:   + Transfusional iron overload due to thalassemia syndromes regardless of prior chelation exposure o Transfusional iron overload in patients with sickle cell disease or other anemias; AND • Patient is 8 years of age and up (tablets); OR 3 years of age and up (solution); AND * ONE of the following:   + Serum ferritin > 1,000 mcg/L   + Liver iron concentration is > 3.2 Fe/g dw L; **AND** * Clinically valid reason as to why patient cannot use Exjade® |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| deferasirox | NP | See Exjade® prior authorization criteria; **AND**  • Clinically valid reason as to why patient cannot use Exjade® |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Exjade® | NP | • Patient has a diagnosis of ONE of the following:   * Chronic iron overload due to blood transfusions in patients 2 years of age and older o Non-transfusion-dependent thalassemia (NTDT) in patients aged 10 and older; **AND**  ONE of the following: * Serum ferritin > 1,000 mcg/L; OR * Liver iron concentration is > 3.2 Fe/g dw L   If platelet count is less than 50x109/L., creatinine clearance is greater than 40 mL/min |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ferriprox® | NP | See deferiprone prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ferriprox  Twice-A-Day® | NP | See deferiprone prior authorization criteria |  |
| Jadenu® | NP | See Exjade® prior authorization criteria; **AND**  • Clinically valid reason as to why patient cannot use Exjade® |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Oral Iron Supplements** | |  |  |
| Accrufer® | NP | * Patient has iron deficiency; **AND** * Patient is 18 years of age or older; **AND** * Patient must NOT meet any of the following:   + Hemochromatosis and other iron overload syndromes   + Receiving repeated blood transfusions or intravenous iron supplementation o Irritable bowel disease (IBD) flare o Concomitant use of dimercaprol | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Saliva Stimulating Agents** | |  |  |
| pilocarpine | P |  | 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| cevimeline | NP | Trial and failure, contraindication, or intolerance of pilocarpine | 3/day |
| Evoxac® | NP | Trial and failure, contraindication, or intolerance of pilocarpine | 3/day |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Acute Myeloid Leukemia (AML) Agents** | | |  |
| Venclexta® | P |  | Ramp-Up Phase Dosing: Dispense 7day supply of 10mg  tabs (for 20mg dose); followed by 7-day supply of 50mg tabs | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Daurismo® | NP | **Initial Approval Criteria (6-month duration):**   * ONE of the following:   o Patient ≥ 75 years of ageo Patient has comorbidities that preclude the use of intensive induction chemotherapy (i.e., Severe Cardiac Disease, Baseline serum creatinine > 1.3 mg/dL, or Baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2); **AND**   * Women of child-bearing potential must have a negative pregnancy test; **AND** * Female patients of reproductive potential and males undergoing treatment with female partners of reproductive should use effective contraception during treatment and for at least 30 days after treatment; **AND** * Daurismo® will be used in conjunction with low-dose subcutaneous cytarabine; **AND Renewal Criteria (6-month duration):**   Patient continues to meet initial criteria; **AND**  Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., QTc- interval prolongation) | 25 mg:  84/28 days; 100 mg:  28/28 days | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Onureg® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of acute myeloid leukemia; **AND** * Patient has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy; **AND** * Female patients of child-bearing potential have a negative pregnancy test and have been advised that:   o Female patients should use effective contraception during treatment and for at least 6-months after treatment o Males undergoing treatment with female partners of reproductive age should use effective contraception during treatment and for at least 3 months after treatment due to male mediated teratogenicity; **AND Renewal Criteria:**  Patient must continue to meet the initial criteria; **AND**  Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., myelosuppression, renal impairment, hepatic impairment) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Vanflyta® | NP | **Initial Criteria:**   * Patient has newly diagnosed acute myeloid leukemia (AML); **AND** * AML is FLT3 internal tandem duplication (ITD)-positive as detected by an FDA-approved test; **AND** * Vanflyta will be used in combination with cytarabine and anthracycline induction and high dose cytarabine consolidation therapy followed by maintenance monotherapy therapy; **AND** * Vanflyta will not be used as maintenance monotherapy following allogeneic hematopoietic stem cell transplantation (HSCT); **AND** * Patient and prescriber are enrolled in the Vanflyta REMS program **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hypokalemia, hypomagnesemia, long QT syndrome) | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Xospata® | NP | **Initial Criteria:**  Patient has a diagnosis of acute myeloid leukemia (AML); **AND**  AML is positive for FLT3 mutation as detected by an FDA‐approved; **AND**  Females of child-bearing potential had a negative pregnancy test within 7 days before starting Xospata®; **AND**  Female and male patients of reproductive potential have been advised to use effective contraception during treatment and for at least 6 and 4 months, respectively, after the last dose **Renewal Criteria:**  Patient continues to meet initial criteria; **AND**  Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., QT prolongation) | 3/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antimetabolites** | |  |  |
| Inqovi® | NP | **Initial Criteria:** **(3-month duration)**   * Diagnosis ofmyelodysplastic syndromes (MDS), patients previously treated and untreated, de novo and secondary MDS with the following French American-British subtypes: o Refractory anemiao Refractory anemia with ringed sideroblastso Refractory anemia with excess blastso Chronic myelomonocytic leukemia [CMML])   o Intermediate-1, intermediate-2, and high-risk international prognostic IPSS groups; **AND**   * Patient has tried and failed or is not a candidate for Allogenic stem cell transplantation**; AND** * Prescriber will obtain baseline CBC, creatinine clearance (CrCl), and liver enzymes prior to therapy and prior to each cycle;   **AND**   * Patient must not be pregnant or breastfeeding; **AND** * Female patients should use effective contraception during treatment and for at least 6-months after treatment; **AND** * Males undergoing treatment with female partners of reproductive age should use effective contraception during treatment and 3 months after treatment due to male mediated teratogenicity; **AND** * Will not be used concomitantly with drugs metabolized by cytidine deaminase enzyme (i.e., gemcitabine, capecitabine, cytarabine, azacytidine)   **Renewal Criteria: (3-month duration)**  Continues to meet initial criteria; **AND**  Patient has positive disease response, defined as disease stabilization; **AND**  Prescriber attests to delay next cycle and reduce dose if patient experiences elevated liver enzymes or renal impairment OR if patient’s absolute neutrophil count (ANC) is less than 1,000 cells/microL and platelet count is less than 50,000 cell/microL | 5 per 28-day cycle | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Purixan® | NP | * Diagnosis of acute lymphocytic leukemia (ALL); **AND** * ONE of the following:   + For patients ≤ 11 years of age, no prior authorization required   + For patients > 11 years of age, Purixan will be approved for patients unable to swallow tablets |  | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Colorectal Cancer Agents, Miscellaneous** | |  |  |
| Lonsurf® | P |  | 8/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Fruzaqla® | NP | **Initial Criteria:**   * Diagnosis of metastatic colorectal cancer; **AND** * Patient has tried and failed, contraindication, or intolerance to ALL of the following chemotherapy-based regimens:   o Fluoropyrimidine, o Oxaliplatin o Irinotecan o Anti- vascular endothelial growth factor (VEGF) therapy (e.g., bevacizumab); **AND**   * If RAS wild-type, patient has tried and failed, contraindication, or intolerance to anti-epidermal growth factor receptor (EGFR) therapy (e.g., cetuximab, panitumumab); **AND** * Prescribed by or in consultation with an oncologist **Renewal Criteria:**   Patient continues to meet initial criteria; **AND**  Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread;  **AND**  Patient does not have unacceptable toxicity (e.g., hypertension, hemorrhagic events) | 5 mg: 21/28 days  1 mg: 84/28 days |
|  | **EGFR Inhibitors** | |  |  |
| Lazcluze® | NP | **Initial Criteria**   * Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC); **AND** * Disease is positive for epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations as detected by an FDA-approved test; **AND** * Lazcluze will be used in combination with Rybrevant; **AND** * Prescribed by, or in consultation with, an oncologist   **Renewal Criteria**   * Patient continues to meet the initial criteria; **AND** * Patient does not have unacceptable toxicity (e.g., interstitial lung disease, keratitis, venous thromboembolic events) | 80mg: 2/day  240mg: /day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vizimpro® | NP | * Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC); **AND** * Disease is positive for EGFR mutations as confirmed by FDA approved Test (e.g. cobas® EGFR Mutation Test v2); **AND** • Requested agent will be prescribed by, or in consultation with, an oncologist | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Enzyme Inhibitors: ALK** | |  |  |
| Lorbrena® | P |  | 3/day: 25 mg;  1/day: 100 mg | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
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| Xalkori sprinkles® | NP | Patient is unable to swallow oral dosage forms |  |  |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Enzyme Inhibitors: BCR-ABL Kinase** | |  |  |
| dasatinib | NP | • Clinically valid reason why preferred Sprycel cannot be used |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Imkeldi® | NP | * Patient is <8 years old; **OR** * Patient is unable to swallow oral dosage forms | 10mL/day |
| Scemblix® | NP | • Patient has ONE of the following:  Newly diagnosed Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase; **OR** Philadelphia chromosome-positive CML in chronic phase (Ph+ CML-CP) previously treated with two or more tyrosine kinase inhibitors (TKIs); **OR**  Ph+ CML-CP with the T315I mutation; **AND**  Prescribed by, or in consultation with, an oncologist; **AND**  Females of reproductive potential will use effective contraception during treatment and for 1 week after receiving the last dose of Scemblix; **AND**  Patient will not breastfeed during treatment with Scemblix and for 1 week after the last dose |  |
|  | **Enzyme Inhibitors: BRAF Kinase & MEK** | |  |  |
| Braftovi® | P | **Initial Criteria:**  Prescribed by, or in consultation with, an oncologist; **AND**  • One of the following:  o Diagnosis of unresectable or metastatic melanoma; **AND**  ­ Patient is positive for BRAF V600E or V600K mutation as confirmed by an FDA-approved test; **AND**  ­ Prescribed in combination with Mektovi®o Diagnosis of metastatic colorectal cancer (CRC); **AND**  ­ Cancer is positive for BRAF V600E mutation as confirmed by an FDA-approved test after prior therapy o Diagnosis of metastatic non-small cell lung cancer (NSCLC);  ­ Cancer is positive for BRAF V600E mutation, as detected by an FDA-approved test; **AND** ­ Prescribed in combination with Mektovi®  **Renewal Criteria:**  Patient continues to meet initial criteria; **AND**  No unacceptable disease progression or unacceptable toxicity | 6/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Mektovi® | P | **Initial Criteria:**   * Prescribed by, or in consultation with, an oncologist; **AND** • Prescribed in combination with Braftovi®; **AND** * One of the following:   o Diagnosis of unresectable or metastatic melanoma; **AND**  ­ Patient is positive for BRAF V600E or V600K mutation as confirmed by an FDA-approved test; **AND** o Diagnosis of metastatic non-small cell lung cancer (NSCLC);  ­ Cancer is positive for BRAF V600E mutation as detected by an FDA-approved test; **AND** **Renewal Criteria:**  Patient continues to meet initial criteria; **AND**  No unacceptable disease progression or unacceptable toxicity | 6/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Gomekli® | NP | **Initial Criteria:**   * Diagnosis of neurofibromatosis type 1 (NF1); **AND** * Patient has plexiform neurofibromas that are BOTH of the following:   + Inoperable   + Causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment); **AND** * Prescribed by, or in consultation with, an oncologist or neurologist; **AND** * If the request is for the tablets for oral suspension, patient is unable to swallow solid dosage forms **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Prescriber attests that patient has experienced improvement in disease severity and/or symptoms; **AND** * Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, ventricular dysfunction, rash) | 1mg tab: 6/day  2 mg: tab 4/day  1mg susp tab: 8/day |  |
| Koselugo® | NP | **Initial Criteria:**   * Diagnosis of neurofibromatosis type 1 (NF1); **AND** * Patient has symptomatic, inoperable plexiform neurofibromas (PN); **AND** * Prescribed by, or in consultation with, an oncologist or neurologist **Renewal Criteria:**   Patient continues to meet initial criteria; **AND**  Prescriber attests that patient has experienced improvement in disease severity and/or symptoms; **AND** Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, severe diarrhea, rash, increased bleeding, myalgia) | 10 mg: 10/day 25 mg: 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Mekinist® solution | NP | * Patient is <8 years old; **OR** * Patient is unable to swallow solid dosage forms |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Ojemda® | NP | **Initial Criteria:**   * Diagnosis of relapsed or refractory pediatric low-grade glioma (PLGG); **AND** * Patient has BRAF fusion or rearrangement or BRAF V600 mutation; **AND** * Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** * Patient demonstrates disease stabilization or clinical response to therapy (e.g., stabilized or decrease tumor size, decreased pain, improved vision, increased quality of life) | 24/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Tafinlar® solution | NP | * Patient is <8 years old; **OR** * Patient is unable to swallow solid dosage forms |  |
|  | **Enzyme Inhibitors: BTK** | |  |  |
| Brukinsa® | P |  | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Calquence® | P |  | 2/day |
| Imbruvica® suspension | NP | • Patient is unable to swallow capsules |  |
| Jaypirca® | NP | **Initial Criteria:**   * Diagnosis of mantle cell lymphoma (MCL); **AND** o Patient has received TWO prior therapies including a BTK inhibitor (e.g., Ibrutinib, acalabrutinib, zanubrutinib); **AND** o Jaypirca® will be used as monotherapy; **OR** * Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL); **AND** o Patient has received TWO prior therapies including a BTK inhibitor (e.g., Ibrutinib, acalabrutinib, zanubrutinib) and a   BCL-2 inhibitor (e.g., Venclexta); **AND** o Jaypirca® will be used as monotherapy **Renewal Criteria:**   * Patient continues to meet the initial criteria; **AND** * Absence of unacceptable toxicity from Jaypirca (e.g., hemorrhage, severe infections, myelosuppression (neutropenia, thrombocytopenia, anemia), atrial fibrillation/flutter, second primary malignancies); **AND** * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread | 50 mg: 1/day  100 mg: 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Enzyme Inhibitors: CDK** | |  |  |
| Kisqali® | P |  | 63 tabs/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Kisqali/Femara® | P |  | 200mg pack:  49 tabs/28 days; 400 mg pack:  70 tabs/28 days; 600 mg pack:  91 tabs/28 days |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Enzyme Inhibitors: FGFR** | |  |  |
| Balversa® | NP | **Initial Criteria:**   * Patient has a diagnosis of locally advanced or metastatic urothelial carcinoma; **AND** * Patient has a susceptible FGFR3 or FGFR2 genetic alteration as confirmed by an FDA-approved diagnostic; **AND** * Patient has progressed during or following ≥ 1 prior line of platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy; **AND** • Prescribed by, or in consultation with, an oncologist; **AND** * Provider attests to ALL the following:   + Patient has received a baseline ophthalmological examination (e.g., assessment of visual acuity, slit lamp examination, fundoscopy, and optical coherence tomography)   + Patient has had a baseline serum phosphate level measurement and it is within normal limits o Patient phosphate intake is restricted to < 800 mg per day   + Patient will not concomitantly take the requested agent with a strong CYP2C9 or CYP3A4 inhibitors (e.g., fluconazole, itraconazole) or with strong CYP2C9 or CYP3A4 inducers (e.g., rifampicin) or, if therapy is unavoidable, prescriber attestation that the patient will be monitored for adverse reactions **Renewal Criteria:**   Patient continues to meet initial criteria; **AND**   * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity (e.g., central serous retinopathy/retinal pigment epithelial detachment   (CSR/RPED), severe hyperphosphatemia) | 1. mg (3/day); 2. mg (2/day); 3. mg (1/day) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Lytgobi® | NP | **Initial Criteria (6-month duration):**   * Patient has diagnosis of unresectable, locally advanced, or metastatic intrahepatic cholangiocarcinoma; **AND** * Patient has fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements as detected by • FDA approved test; **AND** * The patient has progressed on at least one systemic therapy; **AND** * The prescriber attest to ALL of the following:   + Patient will have an ophthalmological examination including optical coherence tomography (OCT) o performed prior to initiation of therapy, every 2 months for the first 6-months of treatment and every 3 o months thereafter, and urgently at any time for visual symptoms   + Prescriber will obtain baseline phosphate levels and monitor for hyperphosphatemia throughout treatment o Patient is not pregnant   + Female patients of reproductive potential and males with female partners of reproductive age have been advised to use effective contraception during treatment and for at least 1 week after the last dose   + Patient is not concomitantly taking strong dual P-gp and CYP3A Inducers (e.g. rifampin) **Renewal Criteria:** * Positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, severe hyperphosphatemia) | 12 mg: 84/month  16 mg: 112/month  20 mg: 140/month | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Pemazyre® | NP | **Initial Criteria:**   * One of the following:   + Diagnosis of previously treated unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test   + Diagnosis of relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with FGFR1 rearrangement; **AND** * Prescriber attests to ALL the following:   + Patient will have an ophthalmological examination including optical coherence tomography (OCT) performed prior to initiation of therapy, every 2 months for the first 6-months of treatment and every 3 months thereafter, and urgently at any time for visual symptoms   + Prescriber will obtain baseline phosphate levels and monitoring for hyperphosphatemia   + Females and males with female partners will be advised to use effective contraception during treatment and for 1 week after the final dose due to embryo-fetal toxicity   + Patient is not concomitantly taking strong and moderate CYP3A Inducers **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, severe hyperphosphatemia) | 14 tablets/ 21 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Enzyme Inhibitors: HER2 Targeted Therapies** | |  |  |
| Tukysa® | NP | **Initial Criteria:**   * ONE of the following:   + Diagnosis of advanced unresectable or metastatic HER2-positive breast cancer and both of the following:   ­ Patient has received at least one or more prior anti-HER2 based regimen;  ­ Must be used in combination with trastuzumab and capecitabine; **OR** o Diagnosis of RAS wild-type, HER2-positive unresectable or metastatic colorectal cancer; **AND** ­ Must be used in combination with trastuzumab; **AND**  • Prescribed by, or in consultation with, an oncologist; **AND**   * Prescriber attests to ALL of the following:   + Patient has baseline ALT, AST, and bilirubin measured and within normal limits   + Patient continues to receive ALT/AST and bilirubin monitoring every 3 weeks during treatment **Renewal Criteria:**   Patient continues to meet initial criteria; **AND**  Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND**  Patient does not have unacceptable toxicity (e.g., diarrhea, hepatotoxicity) | 50 mg: 10/day  150 mg: 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Enzyme Inhibitors: Isocitrate Dehydrogenase (IDH)** | |  |  |
| Tibsovo® | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rezlidhia® | NP | **Initial Criteria (6-month duration):**   * Patient has diagnosis of relapsed or refractory acute myeloid leukemia (AML); AND * Patient has an isocitrate dehydrogenase-1 (IDH1) mutation, as detected by an FDA-approved test **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hepatoxicity, differentiation syndrome) | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rezlidhia® | NP | **Initial Criteria:**   * Diagnosis of grade 2 astrocytoma or oligodendroglioma; **AND** * Tumor has susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation; **AND** * Patient has had prior surgery including biopsy, sub-total resection, or gross total resection; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hepatoxicity) | 40mg: 1/day  10mg: 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Enzyme Inhibitors: KRAS** | |  |  |
| Krazati® | NP | * ONE of the following:   o Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) as confirmed by an FDA-approved test; **AND**  ­ Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitors [anti- PD-1, PD-L1 immunotherapy], platinum-based chemotherapy); **AND**  ­ Patient has at least one measurable lesion as defined by Response Evaluation Criteria in Solid Tumors (RECIST v1.1); **OR** o Diagnosis of KRAS G12C-mutated locally advanced or metastatic colorectal cancer (CRC) as confirmed by an FDAapproved test; **AND**  ­ Patient has tried and failed, contraindication, or intolerance to ALL the following chemotherapy-based regimens:   * Fluoropyrimidine * Oxaliplatin * Irinotecan; **AND**   ­ Krazati will be used in combination with cetuximab; **AND**  Prescribed by, or in consultation with, an oncologist; **AND**  Prescriber attests that patient is not pregnant or breastfeeding during treatment and for 1 week after the final dose; **AND** Prescriber attests that patient will be monitored for the following:  Hepatotoxicity: Monitor liver function tests ((ALT, AST, and total bilirubin) prior to the start of Krazati, every 3 weeks for the first 3 months of treatment then once monthly as clinically indicated  Interstitial Lung Disease (ILD)/Pneumonitis: Monitor for new or worsening pulmonary symptoms; **AND** Prescriber attests that Patient will not take Krazati with:  Acid-reducing agents (e.g., proton pump inhibitors, H2 receptor antagonists, antacids, etc.)   * Strong CYP3A4 inducers (e.g., rifampin, carbamazepine, etc.) | 6/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  |  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Lumakras® | NP | ONE of the following:  Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) as confirmed by an FDA-approved test for detection of KRAS G12C; **AND**  Patient has at least one measurable lesion as defined by Response Evaluation Criteria in Solid Tumors (RECIST v1.1); **AND**  Diagnosis of KRAS G12C-mutated locally advanced or metastatic colorectal cancer (CRC) as confirmed by an FDAapproved test; **AND**  Trial and failure, contraindication, or intolerance to ALL the following chemotherapy-based regimens: Fluoropyrimidine Oxaliplatin  Irinotecan; AND  Agent will be used in combination with panitumumab; **AND**  Prescribed by, or in consultation with, an oncologist; **AND**  Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitors [anti- PD-1, PD-L1 immunotherapy], platinum-based chemotherapy); **AND**  Prescriber attests that patient is not pregnant or breastfeeding during treatment with Lumakras and for 1 week after the final dose; **AND**  Prescriber attests that Patient will be monitored for the following:  Hepatotoxicity: Liver function tests ((ALT, AST, and total bilirubin) prior to the start of Lumakras, every 3 weeks for the first 3 months of treatment then once monthly as clinically indicated  Interstitial Lung Disease (ILD)/Pneumonitis: New or worsening pulmonary symptoms; **AND** Prescriber attests that the patient will not take Lumakras with:  Acid-reducing agents (e.g., proton pump inhibitors, H2 receptor antagonists, antacids.) Strong CYP3A4 inducers (e.g., rifampin, carbamazepine) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **Enzyme Inhibitors: MET** |  |  |
| Tabrecta® | P | **Initial Criteria:**  Patient must have metastatic non-small cell lung cancer (NSCLC); **AND** Prescribed by, or in consultation with, an oncologist; **AND**  Patient must have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping in tumor specimens as confirmed by an FDA-approved test; **AND** **Renewal Criteria:**  Patient continues to meet the initial criteria; **AND**  Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread;  **AND**  • Patient does not have unacceptable toxicity (e.g., interstitial lung disease, liver enzymes outside of normal limits) | 4/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Tepmetko® | NP | **Initial Criteria:**   * Diagnosis of metastatic non-small cell lung cancer (NSCLC); **AND** * Disease is harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity (e.g. interstitial lung disease, liver enzymes outside of normal limits) | 2/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Enzyme Inhibitors: MTOR** | |  |  |
| Afinitor Disperz® | NP | • Patient is unable to swallow solid dosage forms |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| everolimus soluble tabs | NP | • Patient is unable to swallow solid dosage forms |  |
|  | **Enzyme Inhibitors: PARP Inhibitors** | |  |  |
| Lynparza® | P |  | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rubraca® | P |  | 4/day |
| Talzenna® | P | **Initial Criteria (6-month duration):**   * One of the following:   o Diagnosis of HER2-negative locally advanced or metastatic breast cancer; **AND**  ­ Patient has a BRCA-positive mutated germline confirmed by an FDA-approved test (e.g., BRACAnalysis CDx); **AND**  ­ Patient must have received treatment with an anthracycline and/or a taxane (unless contraindicated) as neoadjuvant, adjuvant, and/or metastatic treatment; **AND**  ­ If patient received prior platinum-based chemotherapy, disease progression nor relapse were experienced within  6-months of receiving neoadjuvant or adjuvant platinum therapy; **OR** o Diagnosis of metastatic castration-resistant prostate cancer; **AND**  ­ Patient has homologous recombination repair (HRR) gene mutation; **AND**  ­ Patient must use in combination with Xtandi; **AND**  ­ Patient has had a bilateral orchiectomy OR will receive a gonadotropin-releasing hormone (GnRH)-analog (e.g., leuprolide, goserelin, triptorelin) ; **AND**   * Provider will monitor complete blood counts at baseline and monthly thereafter; **AND** * Patient does not have untreated CNS metastases (patient has completed definitive local therapy and may have stable CNS lesions on repeat brain imaging); **AND** * Patient will not use requested agent in combination with any other PARP inhibitors; **AND** • Patient has not received prior therapy with a PARP-inhibitor (e.g., Lynparza) **Renewal Criteria (6-month duration):** * Patient continues to meet initial criteria; **AND** * Tumor response has been demonstrated with either stabilization of disease or decrease in size of tumor or tumor spread;   **AND**   * Absence of unacceptable toxicity from; **AND** * Patient has not developed myelodysplastic syndrome (MDS)/acute myeloid leukemia (AML) | 1/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Zejula® | P |  | 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Enzyme Inhibitors: RET** | |  |  |
| Retevmo® | P | **Initial Criteria:**   * Patient must have ONE of the following diagnoses:   + Locally advanced or metastatic *RET* fusion-positive non-small cell lung cancer (NSCLC)   + Advanced or metastatic *RET*-mutant medullary thyroid cancer (MTC) who require systemic therapy   + Advanced or metastatic *RET* fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory   + Locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity (e.g., severe or life-threatening hemorrhaging, uncontrolled blood pressure, interstitial lung disease, elevated liver enzymes, QT interval prolongation) | 80mg: 4/day  40mg: 6/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Gavreto® | NP | **Initial Criteria:**   * Diagnosis of ONE of the following:   o Metastatic RET fusion-positive non-small cell lung cancer (NSCLC) that is detected by an FDA approved test o Advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate); **AND**   * Requested agent will be prescribed by, or in consultation with, an oncologist **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity (e.g., interstitial lung disease, elevated liver enzymes, severe or lifethreatening hemorrhaging, uncontrolled blood pressure) | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Enzyme Inhibitors: Tropomyosin Receptor Kinase (TRK)** | |  |  |
| Augtyro® | NP | **Initial Criteria: (6-month duration)**   * Patient has diagnosis of ONE of the following:   + Diagnosis of locally advanced or metastatic Non-Small Cell Lung Cancer (NSCLC); **AND**   ­ Tumor is ROS1 rearrangement positive; **OR ~~AND~~** o NTRK Gene Fusion-Positive Solid Tumor and BOTH of the following:  ­ Disease is locally advanced or metastatic or where surgical resection is likely to result in severe morbidity  ­ Disease has progressed following treatment or there is no satisfactory alternative treatment; **OR** o Diagnosis of secretory breast cancer or mammary analogue secretory cancer; **AND**   * Tumor is ROS1 rearrangement positive; **AND** * Prescribed by, or in consultation with, an oncologist; **AND** * For patients with reproductive potential, prescriber attest to all of the following:   + Patient is not pregnant prior to initiation of therapy   + Female patients have been advised to use effective contraception during treatment and for 2 months after the final dose   + Female patients have been advised to not breastfeed during treatment and 10 days after the final dose   + Male patients with female partners of reproductive potential have been advised to use effective contraception during treatment and for 4 months after the final dose **Renewal Criteria:** * Patient must continue to meet the initial criteria; **AND** * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity (e.g., hepatotoxicity, central nervous system effects, hyperuricemia, skeletal fractures, creatine phosphokinase elevation, interstitial lung disease/pneumonitis) | 8/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Rozlytrek® capsules | NP | **Initial Criteria (6-month duration):**  Patient meets ONE of the following disease specific criteria:  Diagnosis of recurrent, advanced, or metastatic Non-Small Cell Lung Cancer (NSCLC); **AND** Disease is ROS1 positive as detected by an FDA-approved test  NTRK Gene Fusion-Positive Solid Tumor; **AND**  Presence of a neurotrophic tyrosine receptor kinase (NTRK) gene fusion as detected by an FDA-approved test, without a known acquired resistance mutation; **AND**  Disease is metastatic or where surgical resection is likely to result in severe morbidity; **AND**  Disease has progressed following treatment or there is no satisfactory alternative treatment; **AND** Prescribed by, or in consultation with, an oncologist; **AND**  Patient does not have a history of prolonged QTc interval (e.g., QTc interval > 450 milliseconds); **AND**  Patient will not use therapy in combination with drugs which prolong QT-interval; **AND**  Patient will not use therapy with other NTRK-inhibitor therapy or ROS1-directed therapy; **AND**  Patient does not have signs and symptoms of hyperuricemia as evidenced by a baseline serum; **AND**  Patient will avoid concomitant use with moderate or strong CYP3A inducers or inhibitors; **AND**  Provider attests to perform ALL the following:  Assess left ventricular ejection fraction (LVEF) prior to initiation of Rozlytrek in patients with symptoms or known risk factors for CHF  Monitor liver tests, including ALT and AST, every 2 weeks during the first month of the patient’s treatment, then monthly thereafter, and as clinically indicated  Assess serum uric acid levels prior to initiation and periodically during treatment with Rozlytrek  Assess QT interval and electrolytes at baseline and periodically during treatment patients who have or who are at risk for QTc interval prolongation  Advise females of reproductive potential of the potential risk to a fetus and use of effective contraception during treatment and for 5 weeks following the final dose  Advise males with female partners of reproductive potential to use effective contraception during treatment and for 3 months after the final dose  **Renewal Criteria (6-month duration):**  Patient must continue to meet the initial criteria; **AND**  Documented disease response with treatment, as defined by stabilization of disease or decrease in size of tumor or tumor spread; **AND**  There is absence of unacceptable toxicity from the drug (e.g., congestive heart failure, hepatotoxicity, central nervous system  effects, hyperuricemia, QT-interval prolongation, visual disturbances) | 100 mg: 5/day; 200 mg: 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rozlytrek® pack | NP | See Rozlytrek capsules prior authorization criteria; **AND**  • Clinically valid reason why Rozlytrek capsules cannot be used | 600mg/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Vitrakvi® | NP | **Initial Criteria:**   * Patient has a solid tumor (e.g., soft tissue sarcoma, salivary gland, infantile fibrosarcoma, thyroid, lung, or gastrointestinal stromal tumors); **AND** * Prescribed by, or in consultation with, an oncologist; **AND** * Patient meets ALL the following:   + Presence of a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation   + Disease is metastatic or surgical resection is likely to result in severe morbidity   + Disease has progressed following treatment or there is no satisfactory alternative treatment; **AND** * Provider attests to ALL the following:   + Monitor liver tests including ALT and AST every 2 weeks during the first month of treatment, then monthly thereafter and as clinically indicated   + Advise females with reproductive potential and males with female partners of reproductive potential to use effective contraception during treatment and for 1 week after the final dose **Renewal Criteria:**   Patient continues to meet initial criteria; **AND**  Patient has tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND**  Patient does not have unacceptable toxicity such as severe neurotoxicity, hepatotoxicity; (adverse effects resolve following dose recommendations/no permanent discontinuation required) | 25*1* mg: 3*1* /day; 100 mg: 2/day; 20*1* mg/mL:  10 mL/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Hormonal Agents: Aromatase Inhibitors** | |  |  |
| anastrozole | P | * For male patients, diagnosis of breast cancer * For female patients, no PA required |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Hormonal Agents: Anti-Androgens Second Generation** | |  |  |
| Akeega® | NP | **Initial Criteria (6-month duration)**   * Diagnosis of metastatic castration-resistant prostate cancer (mCRPC); **AND** * Patient has a deleterious or suspected deleterious BRCA-mutated (BRCAm) germline confirmed by an FDA approved test;   **AND**   * Will be taken in combination with prednisone; **AND** * ONE of the following:   + Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix)   + Patient has had a bilateral orchiectomy   **Renewal Criteria**   * Patient continues to meet the initial criteria; **AND** * Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND** * Absence of unacceptable toxicity from the drug (e.g., hepatotoxicity, fractures, hypertension) | 2/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Erleada® | NP | **Initial Criteria (6-month duration):**   * Patient has diagnosis of ONE of the following:   + Non-metastatic castration-resistant disease prostate cancer (nmCRPC) o Metastatic castration-sensitive disease prostate cancer (mCSPC); **AND** * ONE of the following:   + Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix)   + Patient has had a bilateral orchiectomy **Renewal Criteria**:   Patient continues to meet the initial criteria; **AND**  Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND**   * Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include seizures, excessive falls and/or fractures and any other Grade 3 or above side effects that are intolerable to patient, etc. | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Nubeqa® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of ONE of the following:   + Non-metastatic castration-resistant prostate cancer (nmCRPC); **AND**  o Metastatic hormone-sensitive prostate cancer (mHSPC); **AND** * ONE of the following:   + Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix); **OR**   + Patient has had a bilateral orchiectomy **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND** * Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include elevated hepatic enzymes, hyperbilirubinemia, neutropenia, or any other Grade 3 or above side effects that are intolerable to patient, etc. | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Xtandi® tablets | NP | • Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT in the tablets |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Yonsa® | NP | **Initial Criteria (6-month duration):**   * Patient has metastatic castration-resistant prostate cancer (mCRPC); **AND** • Will be taken in combination with methylprednisolone; **AND** * ONE of the following:   + Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix)   + Patient has a bilateral orchiectomy; **AND** **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** * Tumor response with stabilization of disease or decrease in size of tumor or tumor spread * Absence of unacceptable toxicity from the drug (e.g., elevated hepatic enzymes, hypokalemia, fluid retention, hypertension) |  | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Hormonal Agents: GnRH Agonists & LNRH Analogs** | | |  |
| Eligard® | P | • Diagnosis of prostate cancer in male patient |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| leuprolide | P | • Leuprolide will be approved for patients meeting **ONE** of the following criteria:   * Diagnosis of prostate cancer in male patient * Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 [girls] or 9 years of age [boys]) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Lupron Depot® | NP | • Will be approved for self-administering patients with ONE of the following:  o Diagnosis of prostate cancer in male patient o Diagnosis of endometriosis in female patient o Diagnosis of uterine leiomyomas in female patient o Diagnosis of recurrent ovarian carcinoma |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Orgovyx® | NP | * Diagnosis of advanced prostate cancer in male patient; **AND** * Male patients with female partners of reproductive potential have been advised to use effective contraception during treatment and for two weeks after the last dose; **AND** * Patient will not take requested medication with ANY of the following:   o P-GP Inhibitors o Strong CYP3A Inducers o cisapride o pimozide o thioridazine | 30/month  (32 tablets for initial month of therapy) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Hormonal Agents: SERM/SERD** | | |  |
| Orserdu® | NP | **Initial Criteria (6-month duration):**   * Patient has hormone receptor-positive, HER2-negative advanced breast; **AND** * Patient has received at least one endocrine based regimen; **AND** * Patient has ESR1 mutation detected by FDA-approved test; **AND** * If female, patient is postmenopausal; **AND** * Orserdu will be used as monotherapy; **AND** * Prescribed by, or in consultation with, an oncologist; **AND** * Patient must not be pregnant or breastfeeding; **AND** * Females of reproductive potential and males undergoing treatment with female partners of reproductive age should be advised to use effective contraception during treatment and for 1 week after the final dose **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** • Patient does not have unacceptable toxicity (e.g., dyslipidemia, musculoskeletal pain) | 345 mg: 1/day  86 mg: 3/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Multikinase Inhibitors: Renal and Thyroid Cancers** | |  |  |
| Fotivda® | NP | **Initial Criteria (6-month duration):**   * Patient has diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC); **AND** * Patient has had two or more prior systemic therapies [two kinase inhibitors (KIs), a KI plus an immune checkpoint inhibitor, or a KI plus other systemic agents]; **AND** * Prescriber attests to ALL the following:   + Patient’s blood pressure will be assessed prior to and during therapy   + Patient will be closely monitored due to increased risk of Arterial and venous Thromboembolic Events, Hemorrhagic   Events, Proteinuria, and Thyroid Dysfunction o Fotivda will be withheld for at least 24 days before elective surgery and will not administer for at least 2 weeks following major surgery and adequate wound healing   * + Patient’s baseline liver function tests will be assessed   + Female and male patients of reproductive potential have been advised to use effective contraception during treatment and for one month after the last dose   + Agent will not be co-administered with strong CYP3A inducers   + Patient does not have a history of allergic reactions to tartrazine (only applies to requests for Fotivda 0.89 mg) o Female patients are not pregnant or breastfeeding; **AND** * Will not use in patients with any of the following: o Strong CYP3A inducers   + History of allergic reactions to tartrazine **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Prescriber attests to positive response to therapy indicated by tumor response with stabilization of disease OR decrease in size of tumor or tumor spread; **AND** * Patient has absence of unacceptable toxicity from the drug (e.g., uncontrolled hypertension, onset of cardiac failure, arterial and venous Thromboembolic Events, hemorrhagic events, proteinuria, thyroid dysfunction, onset of Reversible Posterior Leukoencephalopathy Syndrome (RPLS), or increased LFT’s) | 21/28 days | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Multiple Myeloma Agents** | |  |  |
| lenalidomide | NP | • Clinically valid reason why Revlimid cannot be used |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Xpovio® | NP | **Initial Criteria (6-month duration):**   * One of the following:   o Diagnosis of multiple myeloma; **AND**  ­ Patient has received at least one prior therapy o Diagnosis of diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma; **AND**  ­ Patient has relapsed or refractory disease; **AND**  ­ Patient has received at least 2 lines of systemic therapy; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:**   * Patient continues to meet initial criteria; **AND** * Prescriber attests that the patient has experienced lack of disease progression, and/or improvement in symptoms; **AND** * Patient has absence of unacceptable toxicity from the drug (e.g., thrombocytopenia, neutropenia, gastrointestinal toxicity, hyponatremia, neurological toxicity) | 4 packs/month | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| **Myelofibrosis** | | | | |
| Jakafi® | P |  | 2/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Besremi® | NP | * Diagnosis of polycythemia vera; **AND** * Prescribed by, or in consultation with, an oncologist or hematologist; **AND** • Patient does not have ANY of the following:   + Severe, acute, or unstable cardiovascular disease   + Existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation, or suicide attempt   + Hypersensitivity to interferon or to any component of BESREMI o Hepatic impairment (Child-Pugh B or C) o History or presence of active serious or untreated autoimmune disease; **AND** * Patient is not an immunosuppressed transplant recipient; **AND** * For women of childbearing age, provider has confirmed that the patient is not pregnant prior to receiving treatment; **AND** * Patients of reproductive potential will be counseled to use effective contraception during treatment and for at least 8 weeks after the final dose |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Inrebic® | NP | **Initial Criteria:**   * Patient has a diagnosis of primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis; **AND** * Patient is considered intermediate-2 risk or high-risk; **AND** * Patient’s platelet count ≥ 50 x 109/L; **AND** * Provider attests patient is not thiamine deficient (vitamin B1) and will monitor thiamine level during treatment **Renewal Criteria:**   Patient has positive clinical response to therapy (e.g., reduction in symptoms, decreased spleen size); AND Absence of unacceptable toxicity (e.g., encephalopathy, anemia, thrombocytopenia, hepatoxicity, major adverse cardiovascular events, thrombosis, and malignancies); **AND**   * Prescriber agrees to continue monitoring thiamine (vitamin B1) levels | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Ojjaara® | NP | **Initial Criteria:**   * Patient has a diagnosis of primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis; **AND** * Patient is considered intermediate-1, intermediate-2, or high-risk; **AND** * Patient is anemic (e.g., hemoglobin (Hb) < 10 g/dL and/or hematocrit (Hct) < 30%) **Renewal Criteria:** * Patient has positive clinical response to therapy (e.g., reduction in symptoms, decreased spleen size, decreased number of transfusion); **AND** * Absence of unacceptable toxicity (e.g., thrombocytopenia, neutropenia, hepatotoxicity, major adverse cardiovascular events, thrombosis, and malignancies) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vonjo® | NP | **Initial Criteria**   * Patient has a diagnosis of primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis; **AND** * Patient is considered intermediate risk or high-risk; **AND** * Platelet count is below 50 x 109/L **Renewal Criteria:** * Patient has positive clinical response to therapy (e.g., reduction in symptoms, decreased spleen size, decreased number of transfusions); **AND** * Absence of unacceptable toxicity (e.g., thrombocytopenia, major adverse cardiovascular events, thrombosis, malignancies) | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **PI3K Inhibitors** | |  |  |
| Itovebi® | NP | **Initial Criteria**   * Patient has hormone receptor-positive, HER2-negative locally advanced or metastatic breast cancer; **AND** * Patient has a PIK3CA mutation as detected by an FDA-approved test; **AND** * Patient has experienced disease recurrence on or after completing adjuvant endocrine therapy; **AND** * Agent is being given in combination with Ibrance and fulvestrant; **AND** * Agent is prescribed by, or in consultation with, an oncologist   **Renewal criteria**   * Patient continues to meet initial criteria; **AND** * Patient has clinical response defined as disease stabilization or decrease in size or spread of tumor; **AND** * Patient does not have unacceptable toxicity (e.g., hyperglycemia, diarrhea, stomatitis) | 3mg: 2/day  9mg: 1/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Piqray® | NP | **Initial Criteria:**   * Patient has hormone receptor-positive, HER2‐negative advanced breast cancer; **AND** * Agent is prescribed by, or in consultation with, an oncologist; **AND** * Patient has experienced disease progression on after an endocrine based regimen for advanced disease OR has relapsed disease within 12 months after completion of adjuvant endocrine therapy; **AND** * Patient has a PIK3CA-mutation as detected by an FDA-approved test; **AND** * Piqray® will be given in combination with fulvestrant; **AND**  **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has tumor response with stabilization of disease or decrease in the size of tumor or tumor spread; **AND** * Patient does not have unacceptable toxicity such as severe cutaneous reaction or pneumonitis |  | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Truqap® | NP | **Initial Criteria**   * Patient has hormone receptor-positive, HER2-negative locally advanced or metastatic breast cancer; **AND** * Patient has one or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test; **AND** * Patient has experienced disease progression on after an endocrine based regimen for advanced disease OR has relapsed disease within 12 months after completion of adjuvant endocrine therapy; **AND** * Agent is being given in combination with fulvestrant; **AND** * Agent is prescribed by, or in consultation with, an oncologist   **Renewal criteria**  Patient continues to meet initial criteria; **AND**  Patient has clinicalresponse defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** Patient does not have unacceptable toxicity (e.g., hyperglycemia, diarrhea, cutaneous adverse reactions) | 64/28 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **Rare/Miscellaneous Oncology Conditions** | |  |  |
| Ayvakit® | NP | **Initial Criteria:**   * Diagnosis of ONE of the following:   + Unresectable or metastatic gastrointestinal stromal tumors (GIST) with platelet-derived growth factor-alpha   (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations o Indolent systemic mastocytosis (ISM)   * + Advanced systemic mastocytosis (AdvSM) Note: Includes aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL); **AND** * Prescribed by, or in consultation with, an oncologist; **AND** **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., intracranial hemorrhage, cognitive dysfunction) | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Iwilfin® | NP | **Initial Criteria:**   * Diagnosis of high-risk neuroblastoma (HRNB); **AND** * Patient had a partial response to prior multiagent, multimodality therapy; **AND** * Patient has received anti-GD2 immunotherapy (e.g., dinutuximab); **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hepatotoxicity, hearing loss) |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ogsiveo® | NP | **Initial Criteria:**   * Diagnosis of progressingdesmoid tumor (also known as aggressive fibromatosis); **AND** * Prescriber has reviewed and evaluated appropriate treatment options and attests that the patient requires systemic therapy; **AND** * Prescribed by, or in consultation with, an oncology, hematology, or gastroenterology specialist **Renewal Criteria:** * Patient demonstrates disease stabilization or clinical response to therapy (e.g., decrease tumor size, decreased pain, improved physical function, increased quality of life) | 6/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Qinlock® | NP | **Initial Criteria:**   * Diagnosis of unresectable, locally advanced, or metastatic gastrointestinal stromal tumor (GIST); **AND** * Prescribed by, or in consultation with, an oncologist; **AND** * Patient has been previously treated with at least THREE kinase systemic therapies (e.g., imatinib, avapritinib, sunitinib, regorafenib)   **Renewal Criteria:**   * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., uncontrolled hypertension, cardiac dysfunction) | 3/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rezurock® | NP | **Initial Criteria (6-month duration):**   * Patient has diagnosis of Chronic Graft-Versus-Host Disease; **AND** * Patient is 12 years of age or older; **AND** * Patient has a history of allogenic hematopoietic cell transplant (HCT); **AND** * Agent is prescribed by, or in consultation with, an oncologist, hematologist, or bone marrow transplant specialist; **AND** * Patient has had a previous failure of at least one systemic corticosteroid therapy (i.e., methylprednisolone, prednisone, etc.); **AND** * Patient has had a previous failure of at least one non-steroidal systemic immunosuppressant therapy (e.g., abatacept, alemtuzumab, calcineurin inhibitor, etanercept, hydroxychloroquine, ibrutinib, imatinib, interleukin-2, low-dose methotrexate, mTOR inhibitor, mycophenolate mofetil, pentostatin, rituximab, ruxolitinib, etc.); **AND** * Prescriber attests, if applicable, that patient will be advised that effective contraception should be used during treatment and for at least one week after last dose **Renewal Criteria:** * Patient continues to meet the initial criteria; **AND** Patient is responding positively to treatment | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Romvimza® | NP | **Initial Criteria**   * Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT); **AND** * Patient has severe morbidity or functional limitations (e.g., worst stiffness numeric rating scale [NRS] of > 4); **AND** * Patient is not a candidate for surgical resection associated with potential worsening, functional limitation, or severe morbidity; **AND** * Prescribed by, or in consultation with, a hematologist or oncologist   **Renewal Criteria**   * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., hepatotoxicity) |  |  |
| Tazverik® | NP | **Initial Criteria:**   * Diagnosis of ONE of the following:   o Metastatic or locally advanced epithelioid sarcoma; **AND**  ­ Patient not eligible for complete resection o Relapsed or refractory follicular lymphoma; **AND**  ­ Tumor is positive for an EZH2 mutation as detected by an FDA approved test; **AND**  ­ Patient has received > 2 prior systemic therapies OR has not had satisfactory alternative treatment option; **AND**   * Prescribed by, or in consultation with, an oncologist; **AND** **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease and unacceptable toxicity (e.g. secondary malignancy) | 8/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Turalio® | NP | **Initial Criteria:**   * Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT); **AND** * Patient has severe morbidity or functional limitations (e.g., worst stiffness numeric rating scale [NRS] of > 4); **AND** * Patient is not a candidate for surgical resection associated with potential worsening, functional limitation, or severe morbidity; **AND** * Prescribed by, or in consultation with, a hematologist or oncologist; **AND** • Prescriber is enrolled in the Turalio REMS Program **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., hepatotoxicity) | 4/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  | **ONCOLOGY AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Welireg® | NP | **Initial Criteria:**   * ONE of the following:   o Diagnosis of Von Hippel-Lindau (VHL) disease and require therapy for ONE of the following VHL-associated cancers, not requiring immediate surgery:  ­ Renal cell carcinoma (RCC)  ­ Central nervous system (CNS) hemangioblastomas  ­ Pancreatic neuroendocrine tumors (pNET); **AND** o Diagnosis of advanced renal cell carcinoma (RCC) and patient has tried and failed, contraindication, or intolerance to ALL of the following:  ­ Programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor (e.g., nivolumab, avelumab, pembrolizumab)  ­ Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) (e.g., Cabometyx, Inlyta, Lenvima, Nexavar, Sutent); **AND**   * Prescribed by, or in consultation with, a hematologist or oncologist; **AND** * Patient is not pregnant or breastfeeding; **AND** * Females of reproductive potential and males with female partners of reproductive potential should be advised to use effective non-hormonal contraception during treatment and for 1 week after the last dose **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., anemia, hypoxia) | 3/day | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  | **OPHTHALMICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Dry Eye Disease Agents** | |  |  |
| Lacrisert | P |  | 60 inserts/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Restasis® | P | • Treatment of vernal keratoconjunctivitis (VKC) (i.e., severe atopic keratoconjunctivitis); **OR** • Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)] | 60 vials/30 days |
| Xiidra® | P | * Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)]; **AND** * Trial and failure or contraindication to Restasis® (trial duration > 12 weeks confirmed by paid claims) | 2 vials/day |
| Cequa® | NP | * Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)]; **AND** * Trial and failure, or contraindication, to both the following: o Restasis® (trial duration > 12 weeks confirmed by paid claims) o Xiidra® (trial duration > 12 weeks confirmed by paid claims) | 2 vials/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| cyclosporine emulsion 0.05% | NP | • One of the following:  o Treatment of vernal keratoconjunctivitis (VKC) (i.e., severe atopic keratoconjunctivitis) o Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)]; **AND** • Clinically valid reason why the preferred Restasis® cannot be used | 60 vials/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Meibo® | NP | See Cequa® prior authorization criteria | 3 bottles/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Restasis Multidose® |  | See cyclosporine emulsion 0.05% prior authorization criteria | 1 bottle/30 days |
| Tyrvaya® | NP | See Cequa® prior authorization criteria |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vevye® | NP | See Cequa® prior authorization criteria | 3 bottles/30 days |
|  | **Ophthalmic Alpha-2 Agonists** | |  |  |
| apraclonidine | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| brimonidine 0.2% | P |  | 1 package/Rx |
| Alphagan P® | P |  | 1 package/Rx |
| brimonidine 0.1%,  0.15% | NP |  | 1 package/Rx |
| Iopidine® | NP |  | 1 package/Rx |
|  | **Ophthalmic Antibiotics** | |  |  |
| ciprofloxacin | P |  | 10 mL/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| erythromycin | P |  | 1 package/Rx |
| moxifloxacin | P |  | 1 package/Rx |
| neomycin/bac/poly B | P |  | 1 package/Rx |  |
| neomycin/poly B/gramicidin | P |  | 1 package/Rx |
| polymyxin B/TMP | P |  | 1 package/Rx |
| sulfacetamide soln | P |  | 1 package/Rx |  |
| tobramycin | P |  | 1 package/Rx |
| AzaSite® | NP |  | 1 package/Rx |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Besivance® | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Ciloxan® | NP |  | 10 mL/Rx |
| gentamicin | NP |  | 15 mL/Rx |
| gatifloxacin 0.5% soln | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| levofloxacin 0.5% soln | NP |  | 1 package/Rx |
| moxifloxacin (3X Day) | NP |  | 1 package/Rx |
| sulfacetamide oint | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Tobrex® | NP |  | 1 package/Rx |
| **Ophthalmic Antibiotic/Steroid Combos** | | | | |
| neomycin/BAC/poly  B/HC | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| sulfacetamide/ prednisolone | P |  | 1 package/Rx |
| tobramycin/ dexamethasone | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Maxitrol® | NP |  | 1 package/Rx |
| neomycin/poly B/HC | NP |  | 1 package/Rx |
| TobraDex® | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| TobraDex ST® | NP |  | 1 package/Rx |
| Zylet® | NP | * Trial and failure, contraindication, or intolerance of TWO preferred agents; **OR** * There is concern over a potential increase in intra-ocular pressure (IOP) with other steroids (i.e., glaucoma, recipient is pre- or post-cataract surgery and a known steroid-responder) | 1 package/Rx |
| **Ophthalmic Antifungals** | | | | |
| [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  Natacyn® NP • Diagnosis of ophthalmic fungal infection 1 package/Rx  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) | | | | |
| **Ophthalmic Antivirals** | | | | |
| trifluridine | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Zirgan® | P |  | 1 package/Rx |
| **Ophthalmic Anti-Allergics** | | | | |
| azelastine | P |  | 6 mL/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Bepreve® | P |  | 10 mL/Rx |
| cromolyn sodium | P |  | 1 package/Rx |
| ketotifen | P |  | 10 mL/Rx |
| olopatadine | P |  | 5 mL/Rx |
| Alocril® | NP |  | 1 package/Rx | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Alomide® | NP |  |  | [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| epinastine | NP |  | 5 mL/Rx |
| Lastacaft® | NP |  | 3 mL/Rx |
| Pataday® | NP |  | 5 mL/Rx |
| Verkazia® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of moderate to severe vernal keratoconjunctivitis; **AND** * Trial and failure, contraindication, or intolerance of one agent in ALL the following categories:   + Ophthalmic antihistamines (e.g., azelastine, olopatadine) o Ophthalmic mast cell stabilizers (e.g., cromolyn sodium)   + Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone) **Renewal Criteria:** * Patient demonstrates positive clinical response to therapy as evidenced by an improvement in clinical signs and symptoms (e.g., itching, photophobia, papillary hypertrophy, mucus discharge, conjunctival hyperaemia) | 120/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Zerviate® | NP | • Clinically valid reason as to why patient cannot use a preferred ophthalmic antihistamine product | 30 vials/Rx |
|  | **Ophthalmic Beta Blockers** | |  |  |
| carteolol | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| timolol maleate | P |  | 1 package/Rx |
| Betaxolol | NP |  | 1 package/Rx |
| Betoptic-S® | NP |  | 1 package/Rx |
| Istalol® | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| levobunolol | NP |  | 1 package/Rx |
| timolol gel solution | NP |  | 1 package/Rx |
| Timoptic Ocudose® | NP |  | 1 package/Rx |
|  | **Ophthalmic Carbonic Anhydrase Inhibitors** | |  |  |
| Azopt® | P |  | 15 mL/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| dorzolamide | P |  | 10 mL/30 days |
| dorzolamide/timolol | P |  | 10 mL/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| brinzolamide | NP |  | 15 mL/30 days |
| Cosopt® | NP |  | 10 mL/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cosopt PF® | NP |  | 2 vials/day |
|  | **Ophthalmic Kinase Inhibitors** | |  |  |
| Rhopressa® | P | Patient has a diagnosis of ocular hypertension or open-angle glaucoma; **AND**  • Patient has tried/failed or is intolerant to BOTH a prostaglandin inhibitor AND beta-adrenergic antagonist | 5 ml/30 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Rocklatan® | P | See Rhopressa® prior authorization criteria | 5 ml/Rx |

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|  |  | **OPHTHALMICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Glaucoma Combinations** |  |  |
| Combigan® | P | • Patient is on simultaneous therapy with brimonidine and timolol for at least 60 days; **AND** • Patient demonstrates non-compliance with 2 products individually. | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Simbrinza® | P | • Patient is on simultaneous therapy with brimonidine and Azopt® for at least 60 days | 1 package/Rx |
| brimonidine/timolol | NP | • Patient is on simultaneous therapy with brimonidine and timolol for at least 60 days; **AND** • Trial and failure, contraindication, or intolerance of Combigan. | 1 package/Rx |
|  |  | **Miotics** |  |  |
| phospholine iodide | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vuity® | NP | * Diagnosis of presbyopia; **AND** * Patient is 18 years of age or older; **AND** * Patient is not a candidate for surgery or surgery was non-curative; **AND** * Clinically valid reason as to why the preferred pilocarpine cannot be used | 2.5 mL/30 days |
|  |  | **Miscellaneous Ophthalmics** |  |  |
| Cystaran® | NP | • Diagnosis of cystinosis | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Cystadrops® | NP | Patient is being treated for Corneal cystine crystal deposits with cystinosis; **AND** • Prescriber must provide a clinically valid reason as to why Cystaran cannot be used | 1 package/Rx |
| Oxervate® | NP | * Patient must be ≥ 2 years of age; **AND** * Patient must have a diagnosis of moderate to severe (stage 2 or stage 3) neurotrophic keratitis (NK); **AND** * Prescribed by, or in consultation with, an ophthalmologist; **AND** * Prescriber attests that patient or caregiver has been counseled on proper administration technique | 2 ml/day (lifetime therapy QL=112 ml for 8 weeks of therapy) | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Xdemvy® | NP | **Criteria: (2-month duration)**   * Diagnosis of Demodex blepharitis; **AND** * Patient has collarettes, cylindrical deposits at the base of eyelashes, confirmed by slit lamp examination; **AND** * Prescribed by or in consultation with an ophthalmologist or optometrist | 1 bottle (10 ml)/ 50 days | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
|  |  | **Ophthalmic NSAIDs**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of ONE preferred agent*** |  |  |
| diclofenac | P |  | 1 package/Rx | [Ophthalmic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Ophthalmic%20NSAID%20PA%20Form.pdf)  [NSAIDs PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Ophthalmic%20NSAID%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Ophthalmic%20NSAID%20PA%20Form.pdf) |
| flurbiprofen | P |  | 1 package/Rx |
| ketorolac | P |  | 1 package/Rx |
| Acular LS® | NP |  | 1 package/Rx |
| Acuvail® | NP |  | 1 package/Rx |
| BromSite® | NP |  | 1 package/Rx | [Ophthalmic](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Ophthalmic%20NSAID%20PA%20Form.pdf)  [NSAIDs PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Ophthalmic%20NSAID%20PA%20Form.pdf) |
| bromfenac | NP |  | 1 package/Rx |
| Ilevro® | NP |  | 1 package/Rx |
| Nevanac® | NP |  | 1 package/Rx |
| Prolensa® | NP |  | 1 package/Rx |

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|  | **OPHTHALMICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Ophthalmic Prostaglandin Agonists** | |  |  |
| latanoprost | P |  | 5 mL/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Lumigan® | P |  | 5 mL/Rx |
| Travatan Z® | P |  | 5 mL/Rx |
| Zioptan® | P |  | 1 container/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| bimatoprost | NP |  | 5 mL/ Rx |
| tafluprost | NP |  | 1 container/day |
| travoprost | NP | • Clinically valid reason why preferred Travatan Z® cannot be used | 5 mL/ Rx |
| Iyuzeh® | NP | • Clinically valid reason why preferred Travatan Z® cannot be used | 1 container/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Vyzulta® | NP |  | 5 mL/ Rx |
| Xalatan® | NP |  | 5 mL/ Rx |
| Xelpros® | NP |  | 5 mL/ Rx |
|  | **Ophthalmic Steroids** | |  |  |
| Alrex® | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| difluprednate | P |  | 1 package/Rx |
| fluorometholone | P |  | 1 package/Rx |
| Lotemax® suspension | P |  | 1 package/Rx |
| Pred Mild® | P |  | 1 package/Rx |
| prednisolone acetate | P |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| dexamethasone | NP |  | 1 package/Rx |
| Durezol® | NP |  | 1 package/Rx |
| Eysuvis® | NP | Patient is being treated for symptoms of Dry Eye disease; **AND**  Patient has had a trial and failure of Restasis; **AND**  Patient has had a trial and failure of a preferred loteprednol product (e.g., Alrex, Lotemax suspension) | 1 package/Rx |
| Flarex® | NP |  | 1 package/Rx |
| FML Forte® | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| FML Liquifilm® | NP |  | 1 package/Rx |
| Lotemax SM® gel | NP |  | 1 package/Rx |
| Lotemax ointment | NP |  | 1 package/Rx |
| loteprednol gel | NP |  | 1 package/Rx | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| loteprednol suspension | NP |  | 15 ml/Rx |
| Maxidex® | NP |  | 1 package/Rx |
| prednisolone sodium phosphate | NP |  | 1 package/Rx |
|  |  | **OPHTHALMICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Pred Forte® | NP |  | 1 package/Rx |  |
|  |  | **Ophthalmic Vasoconstrictors** |  |  |
| phenylephrine | P |  |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  |  | **OTICS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** | |
|  |  | **Otic Quinolones** |  |  | |
| ciprofloxacin otic | P |  | 14 mL/Rx |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| ofloxacin otic | P |  | 10 mL/Rx |  |
|  |  | **Otic Steroid/Antibiotic Combinations** |  |  | |
| HC/neomycin/ polymyxin B | P |  | 1 package/Rx |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| ciprofloxacindexamethasone | P |  | 7.5 mL/Rx |  |
| Cipro® HC | NP |  | 10 mL/Rx |  |
|  |  | **Miscellaneous Otics** |  |  | |
| acetic acid/HC | P |  | 10 mL/Rx |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| DermOtic® | P |  | 20 mL/Rx |  |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Activated PI3K Delta Syndrome (APDS)** | | |  | |
| **Initial Criteria (6-month duration):**   * Patient is ≥ 12 years of age and weighs > 45kg; **AND** * Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS); **AND** * Diagnosis has been confirmed by the presence of an APDS-associated genetic variant in either PIK3CD or PIK3R1; **AND** * Documentation of clinical findings and manifestations consistent with APDS (e.g., recurrent respiratory tract infections and viral infections, lymphadenopathy, hepatosplenomegaly, autoimmune cytopenia); **AND** * Prescribed by, or in consultation with, hematologist, allergist, or immunologist; **AND**   Joenja® NP • For patients with reproductive potential, the prescriber attests to all of the following: o Patient is not pregnant prior to initiation of therapy o Patient has been counseled on potential risk during pregnancy   * + Patient has been advised to use effective contraception during treatment and for 1 week after the last dose   + Patient has been advised to not breastfeed during treatment and for 1 week after the last dose **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decreased lymph node size, increased functional B cell counts, decreased infections/hospitalizations, and decreased utilization of immunoglobulin replacement therapy) | | | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) 2/day  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) | |
| **Amyotrophic Lateral Sclerosis (ALS)** | | |  | |
| Radicava ORS® | NP | **Initial Criteria (6-month duration):**   * Submission of medical records (e.g., chart notes, diagnostic tests, nerve conduction studies, lab values) to support a diagnosis of “definite” or “probable” ALS per the revised EL Escorial diagnostic criteria; **AND** * Prescribed by, or in consultation with, a neurologist; **AND** * Patient has scores > 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment; **AND** * Patient has a forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment • Patient must not be pregnant **Renewal Criteria (6-month duration):** * Prescribed by, or in consultation with, a neurologist; **AND** * Documentation of positive clinical response to therapy (e.g., slowing in the decline of functional abilities); **AND** • Patient is not dependent on invasive ventilation or tracheostomy |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Teglutik® | NP | * Diagnosis of Amyotrophic Lateral Sclerosis (ALS); **AND** * Patient is unable to swallow tablets*;* **AND** | 20 mL/day |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Antineutrophil Cytoplasmic Autoantibody (ANCA)** | |  |  |
| Tavneos® | NP | **Initial criteria (6-month duration):**   * Diagnosis of severe active anti-neutrophil cytoplasmic autoantibody ANCA-associated vasculitis (granulomatosis with polyangiitis [GPA] or microscopic polyangiitis [MPA]) confirmed by ONE of the following:   o ANCA test positive for proteinase 3 (PR3) antigen o ANCA test positive for myeloperoxidase (MPO) antigen o Tissue biopsy; **AND**   * Prescribed by, or in consultation with, a rheumatologist, nephrologist, pulmonologist, or a provider with expertise in vascular medicine; **AND** * Will be used as adjunctive therapy with standard therapy (e.g., cyclophosphamide, azathioprine, mycophenolate, rituximab); **AND** * Patient is concurrently on glucocorticoids or has an intolerance or contraindication to glucocorticoids **Renewal Criteria:** * Patient continues to meet initial approval criteria; **AND** * Disease response to therapy and tolerability compared to baseline | 6 caps/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **CHAPLE Disease** | |  |  |
| Veopoz® | NP | **Initial Criteria:**   * Diagnosis of CD55-deficient protein-losing enteropathy (CHAPLE disease); **AND** * Patient has documentation of genetic testing confirming biallelic CD55 loss-of-function mutation; **AND** • Prescriber attests to ALL of the following: o Patient has received *or will receive* Veopoz IV loading dose; o Patient has completed or updated meningococcal vaccination at least 2 weeks prior to administering the first dose of Veopoz unless the risk of delaying therapy outweighs the risk; **AND** * Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease management (e.g., geneticist, gastroenterologist, hematologist) **Renewal Criteria:** * Patient has positive clinical response to therapy (e.g., normalization of serum albumin, decreased abdominal pain, diarrhea, facial edema, and peripheral edema) | 8 vials/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Duchenne Muscular Dystrophy (DMD)** | | |  |
| Duvyzat® | NP | **Initial Criteria:**   * Documentation of a confirmed diagnosis of Duchenne muscular dystrophy (DMD); **AND**  • Age ≥ 6 years; **AND** * Patient retains meaningful voluntary motor function (e.g., patient can speak, manipulate objects using upper extremities, ambulate); **AND** * Will be used in combination with a stable dose of corticosteroids (e.g. prednisone, Emflaza, Agamree); **AND** • Prescribed by, or in consultation, with a neuromuscular specialist or medical geneticist **Renewal Criteria:** * Patient retains meaningful voluntary motor function (e.g., patient can speak, manipulate objects using upper extremities, ambulate); **AND** * Will be used in combination with a stable dose of corticosteroids (e.g. prednisone, Emflaza, Agamree); **AND** * Patient has received benefit from therapy [e.g., stability or slowing in the decline of symptoms (motor function, respiratory function, musculature strength), quality of life] | 12 mL/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Emflaza® | P | **Initial Criteria:**   * Documentation of a confirmed diagnosis of Duchenne muscular dystrophy (DMD); **AND**  • Age ≥ 2 years; **AND** * Patient has experienced > ONE of the following adverse reactions directly attributable to therapy with prednisone:   o Significant weight gain (e.g., crossing 2 percentile lines and/or reaching 98th percentile for age and sex) o Significant behavioral changes negatively impacting function at school, home, day care, etc.  **Renewal Criteria:**   * Patient has received benefit from therapy [e.g., stability or slowing in the decline of symptoms (motor function, respiratory function, musculature strength), quality of life] |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Agamree® | NP | See Emflaza prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to Emflaza | 3 bottles (300mL)/ month |
| deflazacort | NP | See Emflaza prior authorization criteria; **AND**  Clinically valid reason why preferred Emflaza cannot be used |  |
|  | **Fatty Acid Oxidation Disorder (FAOD)** | | |  |
| Dojolvi® | NP | **Initial Criteria:**   * Diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) as confirmed by two of the following:   o Acylcarnitine profileo Molecular/genetic testo Fibroblast test; AND   * Patient does not have pancreatic insufficiency; **AND** * Prescribed by, or in consultation with, a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.); **AND** * For patients receiving another medium-chain triglyceride product, discontinue prior to the first dose of Dojolvi® **Renewal Criteria:** * Evidence of positive clinical response from baseline (e.g., reduction in signs/symptoms such as hypoglycemia, hepatopathy, skeletal myopathy, rhabdomyolysis, cardiomyopathy, etc.) |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  |  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Fibrodysplasia ossificans progressive (FOP)** |  |  |
| Sohonos® | NP | * Diagnosis of fibrodysplasia ossificans progressive (FOP); **AND** * One of the following:   + Female aged ≥ 8 years of age o Male aged ≥ 10 years of age; **AND** * Diagnosis of FOP confirmed by one of the following:   + Mutation in the ALK2/ACVR1 gene   + Classic FOP clinical features such as malformation of big toe and progressive heterotopic endochondral ossification in ribbons, sheets, and plates   + Radiographic bone scans detecting heterotopic ossification (HO); **AND** * Prescriber attests to all of the following:   + Patient is not pregnant   + Female patients of reproductive potential will be counseled to use effective contraception during treatment with therapy and for at least 1 month after last dose o For pediatric patients, premature epiphyseal closure has not occurred |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  |  | **Friedreich's Ataxia** |  |  |
| Skyclarys® | NP | **Initial Criteria**   * Patient is ≥ 16 years old; **AND** * Patient has diagnosis of Friedreich's ataxia (FA); **AND** * Patient has documentation of genetic testing confirming frataxin (FXN) gene mutation; **AND** * Prescribed by, or in consultation with, a neurologist, geneticist, or cardiologist   **Renewal Criteria**   * Patient has disease stabilization or clinical response to therapy | 3/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  |  | **Glucagon-Like Peptide-2 (GLP-2) Analog** |  |  |
| Gattex® | NP | **Initial Criteria:**   * Diagnosis of short bowel syndrome, **AND** * Patient is dependent on parenteral nutrition and/or fluids/electrolytes; **AND** * Submission of medical records (e.g. chart notes) documenting that patient has been unable to significantly reduce PN/IV support   **Renewal Criteria:**   * Submission of medical records (e.g. chart notes) demonstrating a positive response to therapy (e.g. decreased frequency or volume of parenteral nutrition and/or fluids/electrolytes from baseline) |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Hereditary Angioedema (HAE) Agents** | | | | |
| Sajazir® | P | * Prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or genetics; **AND** • Patient is ≥ 18 years of age; **AND** * Submission of medical records (e.g. chart notes and labs) documenting a diagnosisconsistent with 1 of the following HAE subtypes:   o Type I:  ­ Low C1 inhibitor (C1-INH) antigenic level (below the limit of normal defined by the lab performing the test); **AND**  ­ Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **OR** o Type II:  ­ Normal to elevated C1-INH antigenic level; **AND**  ­ Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **OR** o Type III:  ­ Normal C1-INH antigenic level; **AND** ­ One of the following:   * Confirmed presence of a FXII, angiopoietin-1, plasminogen, KNG1, MYOF, or HS3ST6 gene mutation; **OR** * Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema; **AND** * Medication will be using to treat acute HAE attacks; **AND** * Medication will not be used in combination with other approved treatments for acute HAE attacks; **AND** • Prescriber attests patient is avoiding all possible triggers for HAE attacks | 6 injections/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Takhzyro® | P | **Initial Criteria:**   * Prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or genetics; **AND** * Patient must be ≥ the labeled age minimum (Haegarda ≥6 years; Orladeyo ≥12 years; Takhzyro ≥2 years); **AND** * Submission of medical records (e.g. chart notes and labs) documenting a diagnosis consistent with 1 of the following HAE subtypes:   o Type I:  ­ Low C1 inhibitor (C1-INH) antigenic level (below the limit of normal defined by the lab performing the test); **AND**  ­ Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **OR** o Type II:  ­ Normal to elevated C1-INH antigenic level; **AND**  ­ Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **AND** o Type III:  ­ Normal C1-INH antigenic level; **AND** ­ One of the following:   * Confirmed presence of a FXII, angiopoietin-1, plasminogen, KNG1, MYOF, or HS3ST6 gene mutation; **OR** * Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema; **AND** * Will not be used in combination with other routine prophylaxis HAE agents (e.g., Haegarda, Takhzyro, Orladeyo); **AND** • Prescriber attests patient is avoiding all possible triggers for HAE attacks **Renewal Criteria:** * Improvement in severity and duration of attacks have been achieved and sustained; **AND** * Absence of unacceptable toxicity from the drug (e.g., severe hypersensitivity reactions, thromboembolic events) | 2 injections /28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Firazyr® | NP | See Sajazir® prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to 2 preferred agents | 6 injections/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Haegarda® | NP | See Takhzyro® prior authorization criteria | 2 injections/28 days |
| icatibant | NP | See Sajazir® prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance to 2 preferred agents | 6 injections/28 days |
| Orladeyo® | NP | See Takhzyro® prior authorization criteria | 1/day |
|  | **Homocystinuria Agents** | | |  |
| Cystadane® | P | * Diagnosis of moderate to severe hyperhomocysteinemia * Genetic test confirming ONE of the following:   + cystathionine beta-synthase (CBS) deficiency   + 5,10-methylenetetrahydrofolate reductase (MTHRF) deficiency o cobalamin cofactor metabolism (cbl) defect; AND ; **AND** * Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders; **AND** * Patient had an inadequate response or is unable to be managed by diet and vitamin supplementation with folic acid, vitamin B12, and vitamin B6 | 6 g/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| betaine anhydrous powder | NP | See Cystadane® prior authorization criteria; **AND**  • Clinically valid reason why preferred Cystadane® cannot be used | 6 g/day |  |
|  | **Hutchinson-Gilford Progeria Syndrome** | | |  |
| Zokinvy® | NP | **Initial Criteria (6-month duration):**   * Patient has a diagnosis of Hutchinson-Gilford Progeria Syndrome; **OR** * Patient has processing deficient Progeroid Laminopathies with either: o Heterozygous LMNA mutation with progerin-like protein accumulation o Homozygous or compound heterozygous ZMPSTE24 mutations; **AND** * Patient must be 12 months of age or older; **AND** * Patient must have a body surface area (BSA) of 0.39 m2 and above; **AND** • Females must use effective contraception due to embryo-fetal toxicity; **AND** • Patient must not meet any of the following:   + Other Progeroid Syndromes or processing proficient Progeroid Laminopathies o Concomitant use of strong or moderate CYP3A inhibitors or inducers o Concomitant use of midazolam   + Concomitant use of lovastatin, simvastatin, and atorvastatin o Patient is pregnant **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has experienced a positive response to therapy, as documented by provider; **AND** * Patient has not experienced treatment-limiting adverse effects (e.g., laboratory Abnormalities: changes in electrolytes, complete blood counts, and liver enzymes, decrease in renal function, retinal toxicity) |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Hyperoxaluria Agents** | |  |  |
| Rivfloza® | NP | **Initial Criteria: (6-month duration)**   * Patient is 9 years of age or older; **AND** * Diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by ONE of the following:   + Genetic testing demonstrating mutation in the alanine-glyoxylate aminotransferase (AGXT) gene o Liver biopsy demonstrating absent or reduced alanine-glyoxylate aminotransferase (AGT) activity; **AND** * Patient has ONE of the following*:*   + Elevated urinary oxalate excretion o Elevated plasma oxalate levels   + Urinary oxalate creatinine ratio above the age-specific upper limit of normal * Patient has relatively preserved kidney function (e.g., eGFR ≥ 30 mL/min/1.73 m2); **AND** * Prescribed by, or in consultation with, a hematologist, nephrologist, urologist, or geneticist **Renewal Criteria:**   Patient has positive clinical response to therapy (e.g., decreased urinary oxalate excretion or plasma concentration, decreased number or size of kidney stones, improved kidney function) | 1/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Hypophosphatasia (HPP) Agents** | |  |  |
| Strensiq® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of perinatal, infantile, or juvenile-onset hypophosphatasia (HPP); **AND** * Onset of clinical signs and symptoms of HPP prior to age 19 years (e.g., rickets, skeletal deformities, fractures, respiratory compromise, vitamin B6 dependent seizure, craniosynostosis, dental abnormalities, severe osteopenia); **AND** * Clinical diagnosis of HPP evidenced by one of the following:   + Serum alkaline phosphatase (ALP) below age-adjusted normal range o Genetic confirmation of ALPL mutation;   + Elevated plasma pyridoxal 5'-phosphate (PLP) levels; **AND** * Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders **Note**: 80 mg/0.8 mL vial will not be approved for pediatric patients weighing < 40 kg **Renewal Criteria**: * Documentation of positive clinical response to therapy (e.g., healing of the skeletal manifestations, improved respiratory, motor function, and linear growth); **AND** * Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  |  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **IBAT (Ileal Bile Acid Transporter) Inhibitors** |  |  |
| Bylvay® | NP | * One of the following:   + Diagnosis of progressive familial intrahepatic cholestasis (PFIC); **AND**   ­ Patient does not have ABCB11 variant resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3) o Diagnosis of Alagille syndrome (ALGS) confirmed by presence of the JAG1 or Notch2 gene mutation; **AND**   * Prescribed by, or in consultation with, hepatologist or gastroenterologist; **AND** * Patient is experiencing moderate to severe pruritus confirmed by ONE of the following:   + Total serum bile acid > 3x the upper limit of normal o Conjugated bilirubin > 1 mg/dL. o Fat soluble vitamin deficiency otherwise unexplainable. o GGT > 3x the upper limit of normal o Intractable pruritus explainable only by liver disease; **AND** * Trial and failure to at TWO other conventional treatments for the symptomatic relief of pruritus (e.g., bile acid-binding agents, naltrexone, phenobarbital, rifampin, ursodiol); **AND** * Provider attests to monitor the following:   + Liver-function tests at baseline and during treatment   + Fat-soluble vitamin (FSV) levels at baseline and during treatment |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Livmarli® | NP | See Bylvay® prior authorization criteria |  |
|  |  | **IgA Nephropathy (IgAN)** |  |  |
| Fabhalta® | NP | **Initial Criteria (6-month duration)**   * One of the following:   + Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND**   ­ Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND**  ­ Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor; **AND**  ­ Patient has an eGFR > 20 mL/min/1.73 m2; **OR** o Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND**  ­ Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND**   * Prescribed by, or in consultation with, a hematologist, nephrologist, or oncologist; **AND** * Prescriber is enrolled in the Fabhalta REMS Program; **AND** * One of the following:   + Will not be used concurrently with another complement inhibitor; **OR**   + Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the FDA approved labeling **Renewal Criteria:** * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH); **AND** * Prescribed by, or in consultation with, a hematologist or oncologist; **AND** * Patient is not receiving Empaveli in combination with another complement inhibitor | 2/day |  |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Filspari® | NP | **Initial Criteria: (6-month duration)**   * Patient is 18 years of age or older; **AND** * Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND** * Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND** * Patient has an eGFR > 30 mL/min/1.73 m2; **AND** * Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor; **AND** * Use of renin-angiotensin-aldosterone system (RAAS) inhibitors (e.g., ACE inhibitors, ARBs), endothelin receptor antagonists (e.g., Letairis, Opsumit, Tracleer), and aliskiren will be discontinued prior to initiating treatment; **AND** * Prescribed by, or in consultation with, a nephrologist; **AND** * Prescriber and patient have met the requirements of Filspari REMS Program **Renewal Criteria:** * Patient has positive clinical response to Filspari therapy (e.g., reduction of proteinuria from baseline, decreased UPCR) | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Tarpeyo® | NP | * Patient is 18 years of age or older; **AND** * Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND** * Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND** * Patient has an eGFR > 30 mL/min/1.73 m2; **AND** * Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor, unless contraindicated; **AND** • Prescribed by, or in consultation with, a nephrologist | 4/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Vanrafia® |  | See Filspari® prior authorization criteria | 1/day |  |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **IGF-1 Deficiency** | | |  | |
| **Initial Criteria:**  P   * Patient is < 21 years old; **AND** * Epiphyses is open (therapy will not be approved once epiphyseal fusion occurs); **AND** * One of the following:   o Diagnosis of growth failure due to severe primary IGF-1 deficiency defined by the following (documentation required):  ­ Height standard deviation score ≤ -3  ­ Basal IGF-1 standard deviation score ≤ -3  ­ Normal or elevated growth hormone o Diagnosis of growth hormone (GH) gene deletion in a patient who has developed neutralizing antibodies to GH; **AND**  ­ Secondary causes of IGF-1 deficiency have been ruled out (e.g., hypothyroidism, malnutrition, hepatic disease,  Increlex® GHD, chronic corticosteroid treatment); **AND**   * Secondary causes of IGF-1 deficiency have been ruled out (e.g., hypothyroidism, malnutrition, hepatic disease, GHD, chronic corticosteroid treatment); **AND** * Patient will not be treated with concurrent growth hormone therapy   **Note**: Will not be approved for patients with active or secondary neoplasms, secondary forms of IGF-1 deficiency, weight loss management, nor as a substitute for growth hormone.  **Renewal Criteria:**   * Patient is < 21 years old; **AND** * Prescriber attests patient has had a height increase of > 2 cm/year over the previous year of treatment; **AND** • Epiphyses is open; **AND** * Patient is not treated with concurrent growth hormone therapy | | | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)    [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) | |
| **Lambert-Eaton Myasthenic Syndrome (LEMS)** | | |  | |
| Firdapse® | NP | **Initial Criteria:**   * Diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) confirmed by a positive anti-P/Q type voltage-gated calcium ch annel antibody test; **AND** * Patient is ≥ 6 years old; **AND** * Patient does not have a history of seizures; **AND** * Patient does not have a hypersensitivity to amifampridine or another aminopyridine (such as dalfampridine [Ampyra®]) **Renewal Criteria:** * Patient has not experienced any treatment-restricting adverse effects; **AND** * Patient must demonstrate disease improvement, stabilization, and/or slowing in the rate of decline due to the medication | 10/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Leptin Deficiency** | |  |  |
| Myalept® | NP | **Initial Criteria:**   * Diagnosis of congenital or acquired lipodystrophy**; AND** * Leptin deficiency confirmed by laboratory testing; **AND** * Patient has one of the following complications of lipodystrophy:   + Diabetes mellitus o Hypertriglyceridemia o Hepatic steatosis   + Polycystic ovarian syndrome o Acanthosis nigricans; **AND** * Requested agent will be used as adjunct to dietary management of lipodystrophy; **AND** * Documented baseline HbA1C, fasting glucose, triglycerides, and liver enzymes provided; **AND** * Patient does NOT have HIV-related or partial lipodystrophy or metabolic disease without concurrent evidence of generalized lipodystrophy; **AND** * Prescriber is enrolled in the Myalept REMS program **Renewal Criteria:** * Documented positive clinical response to therapy (e.g., improved glycemic control, decrease in triglycerides) |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Lysosomal Storage Disease** | |  |  |
| Aqneursa® | NP | **Initial Criteria**   * Patient weighs at least 15 kg; **AND** * Diagnosis of Niemann-Pick disease type C confirmed by one of the following:   + Genetically confirmed mutations in both alleles of NPC1 or NPC2; **OR**   + Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal); **AND** * Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia); **AND** * Prescribed by, or in consultation with, a neurologist, a medical geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders   **Renewal Criteria**   * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., improvement or stabilization in neurological symptoms of disease) |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Cerdelga® | NP |  | 2/day |  |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Galafold® | NP | **Initial Criteria** **(6-month duration):**   * Patient is ≥ 18 years old; **AND** * Documented diagnosis of Fabry disease with biochemical/genetic confirmation by 1 of the following:   o Males only: α-galactosidase A (α-Gal A) activity in plasma, isolated leukocytes, and/or cultured cells o Plasma or urinary globotriaosylceramide(Gb3/GL-3) or globotriaosylsphingosine (lyso-Gb3) o Detection of pathogenic mutations in the GALA/GLA gene by molecular genetic testing; **AND**   * Patient has an amenable GLA mutation (as defined in the migalastat labeling or determined by a clinical genetics professional); **AND** * Will NOT be used in combination with agalsidase beta or Elfabrio (pegunigalsidase alfa); **AND** * Prescribed by, or in consultation with, clinical genetics professional with knowledge in management of Fabry disease **Renewal Criteria**: * Patient continues to meet initial criteria; **AND** * Prescriber attests to patient compliance with therapy; **AND** * Disease response to treatment as defined by a reduction in urine GL-3 and/or GL-3 inclusions compared to pre-treatment baseline or there has been improvement in clinical symptoms (e.g. stabilization of kidney function, slow or prevention of organ function decline); **AND** * Absence of unacceptable toxicity (e.g., kidney infections); **AND** | 14/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Miplyffa® | NP | **Initial Criteria:**   * Patient is 2 years of age or older; **AND** * Diagnosis of Niemann-Pick disease type C confirmed by ONE of the following:   + Genetically confirmed mutations in both alleles of NPC1 or NPC2; **OR**   + Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal); **AND** * Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, dysphagia); **AND** * Miplyffa will be used in combination with miglustat; **AND** * Prescribed by, or in consultation with, a neurologist, a medical geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders **Renewal Criteria:** * Patient continued to meet initial criteria; **AND** * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., improvement or stabilization in neurological symptoms of disease) |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Opfolda® | NP | * Patient is ≥ 18 years old and weighs at least 40 kg; **AND** * Diagnosis of late-onset Pompe disease confirmed by ONE of the following:   o Documentation demonstrating deficiency of acid alpha-glucosidase (GAA) enzyme activity o Molecular genetic test demonstrating pathogenic variants in GAA; **AND**   * Prescriber attest patient did not have clinical improvement on enzyme replacement therapy (e.g., Լumizуme, Νехviazуme, Elfabrio); **AND** * Must be used in combination with Pombiliti (cipaglucosidase alfa); **AND**   Prescribed by, or in consultation with, a neurologist, a medical geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders | 8/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Procysbi® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of nephropathic cystinosis; **AND** * Patient is ≥ 1 year old; **AND** * Trial and failure, contraindication, or intolerance to Cystagon®; **AND** * WBC cystine levels or plasma cysteamine concentration will be monitored **Renewal Criteria:** * Documentation of positive clinical response to therapy; **AND**   WBC cystine levels or plasma cysteamine concentration will be monitored |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| **Neuromyelitis Optica Spectrum Disorder (NMOSD)** | | | | |
| **Initial Criteria (6-month duration):**  NP   * Diagnosis of neuromyelitis optica spectrum disorder (NMOSD); **AND** * Patient > 12 years old of age; **AND** * Patient is anti-aquaporin-4 (AQP4) antibody positive; **AND** Loading Dose: * Patient has been screened, and does not have any of the following: 3 syringes/28 days [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)   Enspryng® o Active Hepatitis B infection  o Active or untreated latent tuberculosis Maintenance: [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) o Active infection; **AND** 1/28 days   * Prescribed by or in consultation with a neurologist or ophthalmologist **Renewal criteria:** * Patient has demonstrated positive response to therapy | | | | |
| **Myasthenia Gravis** | | | | |
| Zilbrysq® | NP | **Initial Criteria: (6- month duration)**   * Diagnosis of generalized myasthenia gravis (gMG); **AND** * Documented positive serology for acetylcholine receptor (AChR) autoantibodies; **AND** * Patient has a baseline MG-Activities of Daily Living (MG-ADL) total score of ≥6; **AND** * Patient has tried and failed, or has contraindication, or intolerance to TWO of the following:   o Corticosteroids o Azathioprine o Cyclosporine o mycophenolate mofetil o methotrexate o tacrolimus; **AND**   * Prescribed by, or in consultation with, a neurologist or neuromuscular specialist; **AND** * Prescriber is enrolled in the Zilbrysq REMS Program; **AND** * Patient has not failed a previous course of Zilbrysq, Ultomiris, or Soliris therapy; **AND** * Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) **Renewal Criteria:** * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., reduction in MG-ADL score or improvement in talking, chewing, swallowing, breathing, double vision, eyelid drop, movement) | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Paroxysmal Nocturnal Hemoglobinuria (PNH)** | |  |  |
| Empaveli® | NP | **Initial Criteria:**   * Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND** * Prescribed by, or in consultation with, a hematologist or oncologist; **AND** * Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND** * One of the following:   + Will not be used concurrently combination with another complement inhibitor (e.g., Soliris, Ultomiris) o Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the FDA approved labeling; **AND** * One of the following:   + The requested quantity does not exceed 1,080 mg twice weekly   + The requested quantity is for 1,080 mg every 3 days and lactate dehydrogenase (LDH) is >2 the upper limit of the normal range (LDH level documentation is required) **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH); **AND** * Prescribed by, or in consultation with, a hematologist or oncologist; **AND** * Patient is not receiving Empaveli in combination with another complement inhibitor; **AND** * One of the following:   + The requested quantity does not exceed 1,080 mg twice weekly   + The requested quantity is for 1,080 mg every 3 days and lactate dehydrogenase (LDH) is >2 the upper limit of the normal range (LDH level documentation is required) | 200 mL/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Fabhalta® | NP | **Initial Criteria: (6-month duration)**   * One of the following:   + Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND**   ­ Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND**  ­ Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor; **AND**  ­ Patient has an eGFR > 20 mL/min/1.73 m2; **OR** o Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND**  ­ Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND**   * Prescribed by, or in consultation with, a hematologist, nephrologist, or oncologist; **AND** * Prescriber is enrolled in the Fabhalta REMS Program; **AND** * One of the following:   + Will not be used concurrently with another complement inhibitor; **OR**   + Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the FDA approved labeling **Renewal Criteria:** * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH); **AND** * Prescribed by, or in consultation with, a hematologist or oncologist; **AND** * Patient is not receiving Empaveli in combination with another complement inhibitor | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Voydeya® | NP | **Initial Criteria: (6-month duration)**   * Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND** * Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND** * Patient is experiencing extravascular hemolysis (EVH) while on complement C5 inhibitor Ultomiris or Soliris; **AND** * Prescriber attests Voydeya will be used in combination with Ultomiris or Soliris; **AND** * Prescriber is enrolled in the Voydeya REMS Program; **AND** * Prescribed by, or in consultation with, a hematologist or oncologist **Renewal Criteria:** * Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g. hemoglobin stabilization, decreased number of blood transfusions, improvement in signs and symptoms of the disease); **AND** * Prescribed by, or in consultation with, a hematologist or oncologist; **AND** * Patient will continue to use Voydeya in combination with Ultomiris or Soliris | 6/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  |  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Phenylketonuria (PKU)** |  |  |
| Palynziq® | P | * Diagnosis of Phenylketonuria (PKU); **AND** * Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders; **AND** * Patient will receive first dose of Palynziq® in prescribing MD’s office; **AND** * Patient meets ONE of the following:   + Patient has blood phenylalanine (Phe) concentrations > 600 μmol/L; **OR** o Prescriber attests patient cannot maintain a healthy diet with Phe restriction; **OR** o Patient has neurocognitive deficits; **OR**   + Trial and failure, contraindication, or intolerance of sapropterin |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| sapropterin | P | * Patient has diagnosis of Phenylketonuria (PKU); **AND** * Prescribed by, or in consultation with, a metabolic specialist; **AND** * Prescriber attests that Phenylalanine (Phe) levels cannot be maintained within recommended range (120-360 umol/L) with dietary intervention alone; **AND** * Medication will be used in conjunction with a phenylalanine restricted diet |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Javygtor® | NP | See sapropterin prior authorization criteria; **AND**  • Clinically valid reason why the preferred sapropterin agents cannot be used |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Kuvan® | NP | See sapropterin prior authorization criteria; **AND**  • Clinically valid reason why the preferred sapropterin agents cannot be used |  |
|  |  | **PIK3CA-Related Overgrowth Spectrum (PROS)** |  |  |
| Vijoice® | NP | **Initial Criteria (6-month duration)**:   * Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS); **AND** * Patient has a mutation of the PIK3CA gene; **AND** * Patient is 2 years of age or older; **AND** * Patient has severe manifestations of PROS and requires systemic therapy; **AND** * Vijoice will NOT be used for an oncology diagnosis; **AND** * Prescriber attests to monitor, and potentially discontinue Vijoice treatment, if patient shows any of the following:   + Signs or symptoms of severe cutaneous adverse reactions (SCARs)   + New or worsening respiratory symptoms or is suspected to have developed pneumonitis o Severe diarrhea o Severe hyperglycemia o Severe hypersensitivity; **AND** * Female and male patients of reproductive potential have been advised to use effective contraception during treatment and for one week after the last dose **Renewal Criteria**: * Patient continues to meet initial criteria; **AND**   Prescriber attests patient has had ≥ 20% reduction from baseline in the measurable target lesion volume confirmed by at least one subsequent imaging assessment |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Pyruvate Kinase (PK) Deficiency** | |  |  |
| Pyrukynd® | NP | **Initial Criteria (6-month duration):**   * Patient has diagnosis of hemolytic anemia with pyruvate kinase (PK) deficiency*;* **AND** * Patient has at least 2 variant alleles in the PK liver and red blood cell gene of which at least 1 was a missense variant; **AND** • Hemoglobin is <10 g/dL; **AND** * One of the following:   + Patient has symptomatic anemia o Patient is transfusion dependent; **AND** * Prescribed by or in consultation with a hematologist **Renewal Criteria:** * Documentation of positive clinical response to therapy as evidenced by one of the following:   + Hemoglobin increase ≥ 1.5 g/dL from baseline   + Reduction in the number of red blood cell units transfused from baseline | 2 tabs/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Rett Syndrome** | |  |  |
| Daybue® | NP | **Initial Criteria**:   * Patient is > 2 years old; AND * Diagnosis of Rett Syndrome; AND * Prescribed by, or in consultation with, a neurologist, clinical geneticist, or developmental pediatrician **Renewal Criteria**: * Documentation of positive clinical response to Daybue® (e.g. improvement or stabilization in purposeful hand skills, spoken language, repetitive hand movements, and gait abnormalities) | 120 mL/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Sickle Cell Disease** | |  |  |
| Endari® | NP | **Initial Criteria:**  Diagnosis of sickle cell disease; **AND** Patient meetsONE of the following:  Endari will be used in combination with hydroxyurea; **OR**  Trial and failure, contraindications, or intolerance to hydroxyurea; **AND** Dosed according to weight-based dosing found in package insert:  < 30 kg, up to 2 packets per day  30-65 kg, up to 4 packets per day  > 65 kg, up to 6 packets per day **Renewal Criteria:**  Documentation of positive clinical response to therapy(e.g., decrease in number of days in crisis, number of days in hospital, occurrence of Acute Chest Syndrome) | 6 packs/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| L-glutamine pack | NP | See Endari prior authorization criteria; **AND**  • Trial and failure, contraindications, or intolerance to Endari® | 6 packs/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  |  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Siklos® | NP | • Patient has a diagnosis of sickle cell anemia with recurrent moderate to severe painful crisis; **AND** • ONE of the following:  o Documentation of need for dosing that will not allow the use of a preferred hydroxyurea agento Patient unable to swallow hydroxyurea capsules |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Xromi® | NP | * Diagnosis of sickle cell anemia with recurrent moderate to severe painful crises; **AND** * One of the following:   o Documentation of need for dosing that will not allow the use of a preferred hydroxyurea agent; **OR** o Patient is unable to swallow solid oral dosage forms of hydroxyurea |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  |  | **Somatostatins and Related Agents** |  |  |
| Korlym® | P | * Diagnosis of Cushing’s Syndrome; **AND** * Patient has type 2 diabetes mellitus or glucose intolerance; **AND** * Patient has failed surgical treatment **OR** is not candidate for surgery; **AND** • Will NOT be approved for use during pregnancy |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| octreotide | P | * Diagnosis of acromegaly; **OR** * Treatment is for severe diarrhea/flushing episodes associated with metastatic carcinoid tumors; **OR** * Treatment is for profuse watery diarrhea associated with VIP-secreting tumors |  |
| Isturisa® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of Cushing’s disease; **AND** * Patient has failed surgical treatment **OR** is not candidate for surgery; **AND** * Trial and failure (trial duration > 90 days) or intolerance to oral ketoconazole; **AND** * Patient is 18 years of age or older; **AND** * Prescribed by, or in consultation with, an endocrinologist**Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., normalization or reduction of urinary free cortisol, improvement in signs or symptoms of the disease) | *1*  1 mg: 4/day  5 mg: 2/day  10 mg: 6/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Mifepristone 300 mg tablet | NP | See Korlym prior authorization criteria; **AND**  Clinically valid reason why the preferred Korlym® cannot be used |  |
| Mycapssa® | NP | * Diagnosis of acromegaly; **AND** * Patient has previously taken, responded to, and tolerated treatment with octreotide or lanreotide; **AND** * Clinically valid reason why the patient is unable to be maintained on current octreotide or lanreotide therapy | *4*  4/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Recorlev® | NP | **Initial Criteria:**   * Diagnosis of Cushing’s Syndrome; **AND** * Patient is being treated for endogenous hypercortisolemia (e.g., pituitary adenoma, ectopic tumor, adrenal • adenoma); **AND** * Surgery is not an option or has not been curative; **AND** * Trial and failure (trial duration > 90 days) or intolerance to oral ketoconazole; **AN**D * Patient is 18 years of age or older; **AND** * Prescribed by or in consultation with an endocrinologist; AND * Patient has had baseline liver enzymes and an electrocardiogram prior to initiating therapy, and prescriber attests to monitor regularly thereafter; **AND** * Patient does not have hypokalemia and hypomagnesemia, or has been corrected prior to therapy **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., normalization or reduction of urinary free cortisol, improvement in signs or symptoms of the disease) | 8/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Sandostatin® | NP | See prior authorization criteria for octreotide; **AND**  • Clinically valid reason why preferred octreotide cannot be used |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Signifor® | NP | * Diagnosis of Cushing’s Disease; **AND** * Surgery is not an option or has not been curative; **AND** * Prescribed by, or in consultation with, an endocrinologist | 2 injections/day |
| Somavert® | NP | * Diagnosis of acromegaly; **AND** * Tral and failure, intolerance, or contraindication to octreotide |  |  |
| Xermelo® | NP | **Initial Criteria:**   * Patient has a carcinoid/neuroendocrine tumor and has been diagnosed with carcinoid syndrome; **AND** * Patient has had an inadequate treatment response to at least a 3-month trial of SSA (somatostatin analog) therapy at the highest tolerated dose; **AND** * Patient will continue to receive somatostatin analog therapy; **AND** * Patient has tried and received an inadequate response to antidiarrheals (e.g., loperamide); **AND** * Patient has at least 4 bowel movements per day **Renewal Criteria:** * Documentation of positive clinical response to therapy (e.g., decrease in number of bowel movements per day) | 3/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Spinal Muscular Atrophy (SMA)** | |  |  |
| Evrysdi® | NP | **Initial Criteria:**   * Diagnosis of Spinal Muscular Atrophy (SMA); **AND** * Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q confirming in one of the following:   + Homozygous gene deletion or mutation of SMN1 gene; **OR** o Compound heterozygous mutation of SMN1 gene; **AND** * Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis and treatment of SMA; **AND** * Patient will not receive concomitant survival motor neuron (SMN) modifying therapy (e.g., Spinraza); **AND** * One of the following:   + Patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma); **OR** o Both of the following:   ­ Patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma); **AND**  ­ Provider attests that there has been an inadequate response to gene therapy (e.g., sustained decrease in > 1 motor test score over a period of 6-months); **AND**   * Advise female patients of reproductive potential to use effective contraception during treatment and for at least 1 month after the last dose   **Renewal criteria**   * Patient continues to meet initial criteria; **AND** * Patient has clinically significant improvement in SMA associated signs and symptoms (progression, stabilization, or decreased decline in motor function) | Tabs: 1/day  Soln:3 bottles/ 28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Transthyretin Amyloidosis Agents** | |  |  |
| Attruby® | NP | **Initial Criteria**   * Patient is 18 years of age or older; **AND** * Prescribed by or in consultation with a cardiologist; **AND** * Diagnosis of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with cardiomyopathy; **AND** * Patient has New York Heart Association Class I, II or III heart failure; **AND** * Patient does not meet have any of the following:   + Impaired renal function (glomerular filtration rate < 15 mL/min/1.73 m2) o History of heart transplantation   + New York Heart Association Class IV; **AND** * Patient will not use in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Vyndaqel, Vyndamax)   **Renewal Criteria**   * Patient meets initial criteria; **AND** * Patient has demonstrated a positive benefit from therapy (e.g., improved clinical symptoms of heart failure) | 4/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Vyndamax® | NP | **Initial Criteria:**   * Patient is 18 years of age or older; **AND** * Must beprescribed in consultation with a cardiologist; **AND** * Diagnosis of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with cardiomyopathy; **AND** * Patient has New York Heart Association Class I, II or III heart failure; **AND** * Patient does not have any of the following:   + Impaired renal function (glomerular filtration rate < 25 mL/min/1.73 m2) o History of liver or heart transplantation   + Implanted left ventricular assist device (LVAD) [pacemaker or cardiac defibrillator allowed] o Patient is pregnant or breastfeeding o New York Heart Association Class IV; **AND** * Patient will not use in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Attruby) **Renewal Criteria:** * Patient continues to meet initial criteria; **AND** * Patient has demonstrated a positive benefit from therapy (e.g., improved clinical symptoms of heart failure) | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Vyndaqel® | NP | See prior authorization criteria for Vyndamax | 4/day |
| Wainua® | NP | **Initial Criteria:**   * Patient is 18 years of age or older; **AND** * Diagnosis of hereditary transthyretin-mediated amyloidosis (ATTRv amyloidosis) with polyneuropathy; **AND** * Documentation that patient has a transthyretin (TTR) mutation (e.g., V30M); **AND** * Prescribed by, or in consultation with, a neurologist, cardiologist, or specialist with knowledge of ATTRv; **AND** * Documentation of ONE of the following:   o Patient has a baseline polyneuropathy disability (PND) score ≤ IIIb o Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2 o Patient has a baseline neuropathy impairment score (NIS) between 10 and 130; **AND** • Patient has not had a liver transplant; **AND**   * Will not be used in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Attruby, Vyndaqel, Vyndamax) **Renewal Criteria:** * Patient has demonstrated a benefit from therapy (e.g., improved neurologic impairment, motor function, slowing of disease progression, quality of life assessment); **AND** * Will not be used in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Attruby, Vyndaqel, Vyndamax) | 1 injector/28 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| **Tyrosinemia Type 1** | | | | |
| Orfadin® suspension | NP | * Diagnosis of hereditary tyrosinemia type 1; **AND** * Agent is prescribed by a physician specializing in the condition being treated; **AND** * Patient has a clinically valid reason as to why the Orfadin® capsules cannot be utilized |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| nitisinone capsule | NP | See Orfadin® suspension prior authorization criteria |  |
|  |  | **RARE CONDITIONS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Nityr® tablet | NP | See Orfadin® suspension prior authorization criteria |  |  |
|  |  | **Urea Cycle Disorders** |  |  |
| Carbaglu® | P | • Diagnosis of urea cycle disorders |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Pheburane® | P | • Diagnosis of urea cycle disorders |  |
| carglumic acid | NP | * Diagnosis of urea cycle disorders; **AND** * Trial and failure, contraindication, or intolerance of Carbaglu® |  |
| Olpruva® | NP | * Diagnosis of urea cycle disorders; **AND** * Trial and failure, contraindication, or intolerance of Pheburane® |  |
| Ravicti® | NP | See Olpruva® prior authorization criteria |  |
| sodium phenylbutyrate | NP | * Diagnosis of urea cycle disorders; **AND** * Trial and failure, contraindication, or intolerance of Buphenyl® |  |
|  |  | **Wilson Disease** |  |  |
| Galzin® | NP | * Diagnosis of Wilson’s disease; **AND** * Intolerance to zinc sulfate |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Syprine® | NP |  | 8/day |
| trientine | NP |  | 250mg: 8/day  500mg: 4/day |
|  |  | **WHIM Syndrome** |  |  |
| Xolremdi® | NP |  | 4/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |

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|  |  | **RENAL AND GENITOURINARY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Alpha Blockers for BPH** |  |  |
| alfuzosin | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| tamsulosin | P |  | 2/day |
| Cardura XL | NP |  | 1/day |
| Flomax® | NP |  | 2/day |

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|  | **RENAL AND GENITOURINARY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Androgen Hormone Inhibitors** | |  |  |
| dutasteride | P |  | 1/day | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| finasteride | P |  | 1/day |
| Avodart® | NP |  | 1/day |
| Proscar® | NP |  | 1/day |
| Tezruly® | NP | • Patient is unable to swallow solid dosage forms | 20mL/day |  |
|  | **Agents for BPH** | |  |  |
| Cialis® | NP | * Diagnosis of Benign Prostatic Hypertrophy; **AND** * Patient is NOT concurrently receiving nitrates or guanylate cyclase stimulators; **AND** * Trial and failure, contraindication, or intolerance to at least ONE agent from each of the following classes:   o Alpha blockers for BPHo Androgen Hormone Inhibitors |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| dutasteride/ tamsulosin | NP | Patient has a diagnosis of benign prostatic hyperplasia (BPH) with an enlarged prostate; **AND**  Patient has a contraindication or adverse event to finasteride; **AND** Patient is unable to use the individual components | 1/day |
| Entadfi® | NP | **Criteria (6-month duration):**   * Diagnosis of Benign Prostatic Hyperplasia (BPH) with an enlarged prostate; **AND** * Total length of therapy has not exceeded 26 weeks; **AND** * Trial and failure, contraindication, or intolerance to combination therapy with alpha blocker and androgen • hormone inhibitor; **AND** * Clinically valid reason why the individual components of Entadfi® cannot be used (finasteride and tadalafil); **AND** • Patient is NOT concurrently receiving nitrates or guanylate cyclase stimulators | 1/day;  182/year |
| Jalyn® | NP | See dutasteride/tamsulosin prior authorization criteria | 1/day |
|  | **Phosphorus Depletors** | |  |  |
| sevelamer carbonate tablets | P |  | 9/day |  |
| Renvela® packs | P | Patient is unable to swallow solid dosage forms | 0.8 g packets: 6/day  2.4 g packets: 5/day |  |
| Auryxia® | NP | * Diagnosis of hyperphosphatemia in chronic kidney disease on dialysis; **AND** o Trial and failure, contraindication, or intolerance to TWO preferred agents; **OR** * Diagnosis of iron deficiency anemia in chronic kidney disease NOT on dialysis; **AND**   Trial and failure, contraindication, or intolerance to TWO oral iron products (e.g., ferrous sulfate, ferrous gluconate) |  | [General PA](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf)  [Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Fosrenol® packs | NP | * Trial and failure, contraindication, or intolerance of TWO preferred phosphorus depletors; **AND** * Contraindication to sevelamer powder for suspension; **AND** * Patient is unable to swallow solid dosage forms |  | [General PA Form](https://contenthub-aem.optumrx.com/content/dam/contenthub/rx-assets/en/documents/clients/tenncare/General-TennCare.pdf) |
| Renvela® tablets | NP |  | 9/day |  |
| sevelamer carbonate packs | NP | Patient is unable to swallow solid dosage forms | 0.8 g packets: 6/day  2.4 g packets: 5/day |  |
| Xphozah® | NP | • Patient is 18 years of age or older; **AND** | 2/day | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **RENAL AND GENITOURINARY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | * Diagnosis of chronic kidney disease (CKD); **AND** * Patient is currently on dialysis; **AND** * Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** * Agent will be used as adjunctive therapy to reduce serum phosphorus; **AND** * Patient does not have known or suspected mechanical gastrointestinal obstruction |  | [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Kidney Stone Agents** | |  |  |
| Thiola EC® | NP | * Patient has tried/failed an adequate trial of or is intolerant to two preferred agents; **AND** * Clinically valid reason why preferred Thiola cannot be used |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Urinary Tract Antispasmodics** | |  |  |
| fesoterodine | P |  | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Myrbetriq® tabs | P |  | 1/day |
| oxybutynin ER tabs | P |  | 5 mg: 1/day;  10, 15 mg: 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Oxytrol® | P |  | 8 patches/28 days |
| solifenacin | P |  | 1/day |
| tolterodine ER caps | P |  | 1/day |
| tolterodine tabs | P |  | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| darifenacin | NP |  | 1/day |
| Detrol® | NP |  | 2/day |
| Detrol LA® | NP |  | 1/day |
| flavoxate | NP |  | 2 fills/ 60 days |
| Gelnique® | NP |  | 1 pack (1 gr)/day |
| Gemtesa® | NP | Patient is 18 years of age or older: **AND**  Diagnosis of overactive bladder (OAB); **AND**  Trial and failure of one preferred anticholinergic agent (e.g., fesoterodine, oxybutynin, solifenacin, tolterodine); **AND** Trial and failure, or contraindication, or intolerance to Myrbetriq | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| mirabegron tabs | NP | • Clinically valid reason why preferred Myrbetriq® cannot be used | 1/day |
| Myrbetriq® susp | NP | * Clinically valid reason why Myrbetriq tablets cannot be used; **OR** * Diagnosis of neurogenic detrusor overactivity (NDO); **AND** * Trial and failure, contraindication, or intolerance to oxybutynin solution |  | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Toviaz® | NP |  | 1/day |
| trospium | NP |  | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| trospium XR | NP |  | 1/day |
| VESIcare® susp | NP | * Diagnosis of neurogenic detrusor overactivity (NDO); **AND** * Trial and failure, contraindication, or intolerance to oxybutynin solution | 10 mL/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| VESIcare® tabs | NP |  | 1/day |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Anaphylaxis Therapy Agents** | |  |  |
| epinephrine auto injector | P |  | 2/Rx | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Auvi-Q | NP |  | 2/Rx |
| EpiPen® | NP |  | 2/Rx |
| EpiPen-Jr® | NP |  | 2/Rx |
| Neffy® | NP | • Clinically valid reason why the preferred epinephrine auto-injector cannot be used | 2/Rx |
|  | **Anticholinergics, Nasal** | |  |  |
| ipratropium 0.3% | P |  | 2 boxes/30days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| ipratropium 0.6% | P |  | 3 boxes/30days |
|  | **Antihistamines, Nasal** | |  |  |
| Azelastine | P |  | 2 bottles/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Dymista® | P |  | 1 bottle/30 days |
| olopatadine | P |  | 1 bottle/30 days |
| azelastine/ fluticasone | NP | • Trial and failure of preferred Dymista® | 1 bottle/30 days |
| Ryaltris® | NP | * Diagnosis of Seasonal Allergic Rhinitis; **AND** * Patient is 12 years of age or older; **AND** * Trial and failure, contraindication, or intolerance to Dymista; **AND** * Clinically valid reason as to why the patient is unable to take components of Ryaltris individually (**Note:** Patient convenience is not an approvable reason) | 1 bottle/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Antihistamines: Non-Sedating, Oral** (Covered for recipients < 21 years old only) | |  |  |
| cetirizine | P |  | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| cetirizine chewable | P | • Clinically valid reason why the liquid formulation cannot be used | 1/day |
| cetirizine/PSE | P |  | 2/day |
| levocetirizine tablets | P |  | 1/day |
| loratadine tablets | P |  | 1/day |
| loratadine syrup | P |  | 10 mL/day |
| loratadine chewable | P |  | 1/day |
| loratadine RDT | P | • Patient is unable to swallow solid dosage forms | 1/day |
| loratadine/PSE | P |  | 12 Hour: 2/day; 24 Hour (1/day) |
| Allegra® | NP |  | 60mg: 2/day); 180mg (1/day) |
| Allegra D® | NP |  | 12 Hour: 2/day; 24 Hour: 1/day |
| Allegra® ODT | NP | • Patient is unable to swallow solid dosage forms | 2/day |
| Clarinex D® | NP |  | 12 Hour (2/day); 24 Hour (1/day) |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Clarinex RediTabs® | NP | • Patient is unable to swallow solid dosage forms | 1/day |  |
| Clarinex® tabs | NP |  | 1/day |
| Clarinex® syrup | NP |  | 10mg/day |
| Claritin D® | NP |  | 12 Hour: 2/day; 24 Hour: 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Claritin® chewable | NP | • Clinically valid reason why the liquid formulation cannot be used | 1/day |
| Claritin® tabs | NP |  | 1/day |
| Claritin RediTabs® | NP | • Patient is unable to swallow solid dosage forms | 1/day |
| desloratadine | NP |  | 1/day |
| desloratadine ODT | NP | • Patient is unable to swallow solid dosage forms | 1/day |
| fexofenadine | NP |  | 60 mg: 2/day);  180 mg (1/day) |
| fexofenadine/PSE | NP |  | 12 Hour: 2/day; 24 Hour: 1/day |
| levocetirizine solution | NP |  | 10 mL/day |
| Semprex®-D | NP |  | 4/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Xyzal® | NP |  | 5 mg/day |
| Zyrtec® chewable | NP | • Clinically valid reason why the liquid formulation cannot be used | 1/day |
| Zyrtec® tabs | NP |  | 1/day |
| Zyrtec® ODT | NP | • Patient is unable to swallow solid dosage forms | 1/day |
| Zyrtec D® | NP |  | 1/day |
|  | **Antitussives, Non-Narcotic** | |  |  |
| benzonatate | P | * Patient is > 10 years of age; **OR** * Patient is < 10 years of age and prescriber is aware that, if chewed, benzonatate may cause numbness of the mouth, tongue, throat, and esophagus, increasing the risk of choking | 3/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Cystic Fibrosis Agents, Inhaled/Injectable** | |  |  |
| Bethkis® | P | • Diagnosis of Cystic Fibrosis or *Pseudomonas* infection | 224 mL/56 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Kitabis Pak® | P | • Diagnosis of Cystic Fibrosis or *Pseudomonas* infection | 280 mL/56 days |
| Pulmozyme® | P | • Diagnosis of Cystic Fibrosis or *Pseudomonas* infection | 5 mL/day |
| tobramycin solution 300 mg/5 mL | P | • Diagnosis of Cystic Fibrosis or *Pseudomonas* infection | 280 mL/56 days |
| tobramycin vial (excluding 1.2 g vials) | P | • Claims exceeding $200 will only be approved for diagnoses of Cystic Fibrosis or *Pseudomonas* infection |  |
| Bronchitol | NP | * Diagnosis of Cystic Fibrosis; **AND** * Patient must not have an episode of hemoptysis (>60 mL) in the last 3 months; **AND** * Must be 18 years of age or older; **AND** * Patient must have baseline FEV1 >40% to <90%; **AND** | 20/day |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | * Patient has passed the Bronchitol Tolerance Test; **AND** * Must be used concomitantly with a short-acting bronchodilator; **AND** * Prescriber attests that the patient has been instructed to administer the agent 5-15 minutes after a short-acting bronchodilator |  |  |
| Cayston® | NP | * Diagnosis of Cystic Fibrosis or Pseudomonas Infection; **AND** * Trial and failure, contraindication, intolerance, or resistance to preferred inhaled tobramycin product | 84 mL/56 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| tobramycin solution 300 mg/4 mL  (generic for Bethkis) | NP | * Diagnosis of Cystic Fibrosis or *Pseudomonas* infection; **AND** * Clinically valid reason why preferred Bethkis® cannot be used | 224 mL/56 days |
| TOBI® Podhaler and inhalation solution | NP | * Diagnosis of Cystic Fibrosis or Pseudomonas Infection; **AND** * Provider must provide peer-reviewed medical literaturedocumentingwhy the requested drug for the requested indication is the only appropriate choice versus the preferred agents | Podhaler:  224 caps/56 days; Solution:  280 mL/56 days |
|  | **Cystic Fibrosis Agents, Oral** | | |  |
| Alyftrek® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of cystic fibrosis (CF); **AND** * Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND** * Age ≥ 6 years old; **AND** * Lab documentation confirming ONE of the following:   + Patient has at least one copy of the F508del mutation in the CFTR gene   + Patient has a mutation in the CFTR gene that is responsive based on in vitro data; **AND** * For patients 6- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement, or stabilization of lung function) | 4-20-50 mg: 3/day  10-50-125 mg: 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Kalydeco® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of cystic fibrosis (CF); **AND** * Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND** * Lab documentation confirming patient has one mutation in the CFTR gene that is responsive to Kalydeco®; **AND** * For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment **Renewal Criteria:** * Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement, or stabilization of lung function)   **Note**: will NOT be approved for homozygous F508del mutation in the CFTR gene | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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| **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Orkambi® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of cystic fibrosis (CF); **AND** * Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND** • Age ≥ 1 years old; **AND** * Lab documentation confirming patient has homozygous F508del mutation in the CFTR gene * For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment **Renewal Criteria:**   Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement, or stabilization of lung function) | Tablets: 4/day Granules: 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Symdeko® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of cystic fibrosis (CF); **AND** * Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND** * Age ≥ 6 years old; **AND** * Lab documentation confirming ONE of the following:   + Patient is homozygous for the F508del mutation in the CFTR gene   + Patient has >1 mutation in the CFTR gene that is responsive based on in vitro data; **AND** * For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment **Renewal Criteria:** * Patient had not received a lung transplant; **AND** o Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement or stabilization of lung function); **OR** * Patient has received a lung transplant; **AND**   Prescriber attests that the patient continues to experience nonpulmonary CF related symptoms (e.g., sinus, gastrointestinal, diabetes, pancreatic) | 2/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Trikafta® | NP | **Initial Criteria (6-month duration):**   * Diagnosis of cystic fibrosis (CF); **AND** * Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND** * Patient is ≥ 2 years of age; **AND** * Lab documentation confirming ONE of the following:   + Patient is homozygous for the F508del mutation in the CFTR gene   + Patient has >1 mutation in the CFTR gene that is responsive based on in vitro data; **AND** * For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment **Renewal Criteria:** * Patient had not received a lung transplant; **AND** o Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement or stabilization of lung function); **OR** * Patient has received a lung transplant; **AND**   Prescriber attests that the patient continues to experience nonpulmonary CF related symptoms (e.g., sinus, gastrointestinal, diabetes, pancreatic) | 3/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Inhaled: Anticholinergics and Anticholinergic Combinations** | |  |  |
| Anoro Ellipta® | P |  | 2 blisters/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| albuterol/ ipratropium | P |  | 18 mL/day |
| Atrovent HFA® | P |  | 2 inhalers/month |
| ipratropium solution | P |  | 10 mL/day |
| Spiriva HandiHaler ® | P |  | 1 capsule/day |
| Spiriva Respimat® | P | * Diagnosis of Asthma; **AND** o Patient age ≥ 6 years; **AND**   + Diagnosis of step 4 or higher asthma; **AND**   + Optimal doses of inhaled steroids and long-acting beta-agonists are being used and breakthrough symptoms require frequent use of inhaled short-acting bronchodilators; **OR** * Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** o Must be used as maintenance therapy only; **AND**   + Trial and failure, contraindication, or intolerance to Spiriva HandiHaler® | 1 inhaler/month |
| Trelegy Ellipta® | P | **Initial Criteria:**   * Diagnosis of chronic obstructive pulmonary disease (COPD); **AND** o Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment with a longacting beta-agonist + long-acting antimuscarinic; **AND**   + Must be used as maintenance therapy only; **OR** * A diagnosis of asthma in patients 12 years of age or older; **AND** o Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment with 2 dual combination inhaled corticosteroid + long-acting beta-agonist therapies; **AND**   + Must be used as maintenance therapy only; **AND** o Patient does not have known hypersensitivity to milk proteins **Renewal Criteria:** * Documentation of continued efficacy via prescriber’s medical opinion on patient evaluation; **AND** * Patient has not experienced any intolerable adverse effects (e.g., hypersensitivity, bronchospasm, worsening of intraocular pressure, increased severe infections) | 2 blisters/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Bevespi  Aerosphere® | NP | Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD)**; AND**  Must be used as maintenance therapy only; **AND**  Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents | 1 inhaler/ month |

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| **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | | |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Breztri Aerosphere® | NP | **Initial Criteria:**   * Diagnosis of chronic obstructive pulmonary disease (COPD); **AND** * Must be used as maintenance therapy only; **AND** * Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment with a long-acting beta-agonist + long-acting antimuscarinic; **AND** * Trial and failure, contraindication, or intolerance to the preferred product Trelegy Ellipta **Renewal Criteria:**   Documentation of continued efficacy via prescriber’s medical opinion on patient evaluation; **AND**  Patient has not experienced any intolerable adverse effects (e.g., hypersensitivity, bronchospasm, worsening of intraocular pressure, increased severe infections) | 1 inhaler/month |  |
| Combivent Respimat® | NP | Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND**  Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents | 2 inhalers/month | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Duaklir Pressair® | NP | Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** Must be used as maintenance therapy only; **AND**  Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents | 1 inhaler/month |
| Incruse Ellipta® | NP | Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** Must be used as maintenance therapy only; **AND**  Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents  Patient must not have severe hypersensitivity to milk proteins | 1 blister/day |
| Stiolto Respimat® | NP | See Duaklir Pressair prior authorization criteria | 1 inhaler/month |
| tiotropium inhalation capsules | NP | • Clinically valid reason why the patient cannot use the preferred brand Spiriva HandiHaler | 1 capsule/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Tudorza® | NP | See Incruse Ellipta® prior authorization criteria | 1 inhaler/month |
| Yupelri® | NP | **Initial Criteria:**   * Patient must be ≥ 18 years of age; **AND** * Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** * Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents; **AND** * Must be used as maintenance therapy only**; AND** * Patient is unable to master proper inhaler technique, as attested by prescriber; **AND** * Patient is not prescribed other inhaled long-acting anticholinergic agents.   **Renewal Criteria:**   * Patient continues to meet initial criteria; **AND** * Patient symptoms are clinically improving, as documented by provider; **AND** * Patient demonstrates continued compliance, based on fill history (not using PRN); **AND** * Prescriber documents that nebulized therapy continues to be required. | 3 mL/day |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  | **Inhaled: Beta Agonists-Corticosteroid Combination Products** | | |  |
| Advair HFA® | P |  | 1 inhaler/month | [Beta](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Beta%20Agonist%20Combos%20PA%20Form.pdf)  [Agonist](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Beta%20Agonist%20Combos%20PA%20Form.pdf)  [Combos](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Beta%20Agonist%20Combos%20PA%20Form.pdf) |
| Advair Diskus® | P |  | 2 blisters/day |
| Dulera® | P |  | 2 inhalers/month |
| fluticasone/ salmeterol aerosol | P |  | 1 inhaler/month |
| Symbicort® | P |  | 2 inhalers/month |
| AirDuo RespiClick® | NP | * Agent will be used for the treatment of asthma in patients 12 years of age or older; **AND** * Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** * Patient must not have severe hypersensitivity to milk proteins | 1 inhaler/month |
| Airsupra® | NP | * Agent will be used for the treatment of asthma in patients 18 years of age and older; **AND** * Trial and failure, contraindication, or intolerance to preferred agents Symbicort and Dulera | 2 inhalers/month |
| Breo Ellipta® | NP | * Agent will be used for the treatment of asthma in patients 18 years of age or older; **OR** * Agent will be used for the treatment of COPD where optimal doses of a long-acting beta agonist and/or long-acting muscarinic antagonists are being used and symptoms are still uncontrolled (100/25 mcg strength only); **AND** * Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** * Patient must not have severe hypersensitivity to milk proteins | 2/day |
| Breyna® | NP | * Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** * Clinically valid reason why the patient cannot use the preferred brand Symbicort® | 2 inhalers/month |
| budesonide/ formoterol | NP | * Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** * Clinically valid reason why the patient cannot use the preferred brand Symbicort® | 2 inhalers/month |
| fluticasone/ salmeterol powder | NP | * Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** * Clinically valid reason why the patient cannot use the preferred Advair HFA® or Advair Diskus® cannot be used. | 55, 113, 232, -14mcg:  1 inhaler/month  100, 250, 500 -50mcg: 2 blisters/day |
| fluticasone/ vilanterol | NP | See Breo Ellipta® prior authorization criteria; **AND**  • Clinically valid reason why the patient cannot use the brand Breo Ellipta® | 2/day |
| Wixela® | NP | * Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** * Clinically valid reason why the patient cannot use the preferred Advair HFA® or Advair Diskus® | 2 blisters/day |
|  | **Inhaled: Beta Agonists, Long Acting** | | |  |
| Serevent Diskus® | P |  | 2 blisters/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Striverdi Respimat® | NP | * Diagnosis of COPD; **AND** * Trial and failure, contraindication, or intolerance of the preferred agent (Serevent Diskus) | 1/day |
|  | **Inhaled: Beta Agonists, Short Acting** | | |  |
| albuterol HFA | P |  | 2 inhalers/month |  |
| Proventil® HFA | P |  | 2 inhalers/month |  |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Ventolin® HFA | P |  | 2 inhalers/month |  |
| Xopenex® HFA | P | • Patients has experienced intolerable side effects to albuterol (e.g., tachycardia, etc.) | 2 canisters/month |  |
| levalbuterol HFA | NP | * Patients has experienced intolerable side effects to albuterol (e.g., tachycardia, etc.); **AND** * Clinically valid rationale for why patient cannot use brand Xopenex HFA® | 2 canisters /month |  |
| ProAir RespiClick® | NP |  | 2 inhalers/month |  |
|  | **Inhaled: Nebulizers, Beta Agonists** | |  |  |
| albuterol nebulizer solution | P |  | 125 nebs/month (3 bottles/month | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| arformoterol | P |  | 60 nebs/month |
| Brovana® | NP | * Diagnosis of COPD; **AND** * Difficulty using a dry powder inhaler (DPI); **AND** * Trial and failure, contraindication, or intolerance of the preferred agent (arformoterol nebulizer) | 60 nebs/month (120 mL/month) |
| formoterol | NP | See Brovana® prior authorization criteria | 60 nebs/month |
| levalbuterol | NP | • Patients has experienced intolerable side effects to albuterol (e.g., tachycardia) | 96 nebs/month |
| Perforomist® | NP | See Brovana® prior authorization criteria | 60 nebs/month |
|  | **Inhaled: Nebulizers, Mast Cell Stabilizers** | |  |  |
| cromolyn solution | P | • Diagnosis of asthma | 120 vials/month | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **Inhaled: Steroids** | |  |  |
| Alvesco® | P | * Diagnosis of asthma; **AND** * Patient is 12 years of age or older | 2/30 days | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Arnuity Ellipta® | P |  | 1 blister/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Asmanex HFA® | P |  | 1/30 days |
| Asmanex Twisthaler® | P |  | 1/30 days |
| budesonide suspension | P | * ONE of the following:   o Diagnosis of asthma; **AND**  ­ Patient is < 8 years old; **OR** o Diagnosis of Eosinophilic esophagitis (EoE); **AND**  ­ Prescribed by, or in consultation with, a gastroenterologist, allergist, or immunologist; **AND** ­ Prescriber attest to both of the following:   * Esophageal biopsy consists of ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) following treatment course of a proton pump inhibitor; **AND** * Patient is experiencing symptoms of esophageal dysfunction (e.g., feeding difficulties, vomiting, dysphagia)   **Note**: PA not required for patients < 8 years of age | 0.25, 0.5 mg:  2 vials/day;  1 mg: 1 vial/day |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Flovent Diskus® | P |  | 50 mcg: 2/day;  100 mcg: 4/day;  250 mcg: 8/day |  |
| Flovent HFA® | P |  | 2/30 days |
| fluticasone HFA | P |  | 2/30 days |
| Pulmicort Flexhaler® | P | • Diagnosis of asthma; **AND** • Patient is 6 years of age or older | 2/30 days |
| Pulmicort Respules® | P | * Diagnosis of asthma; **AND** * Patient is < 8 years old | 0.25, 0.5 mg:  2 vials/day;  1 mg: 1 vial/day |
| QVAR RediHaler® | P |  | 2/30 days |
|  | **Intranasal: Steroids** | |  |  |
| budesonide nasal [(OTC)](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | P |  | 2/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| fluticasone propionate | P |  | 1/30 days |
| Nasacort® ([OTC)](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | P |  | 2/30 days |
| budesonide nasal (Rx only) | P |  | 2/30 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| flunisolide | NP |  | 2/30 days |
| mometasone furoate | NP |  | 1/30 days |
| Nasonex® | NP |  | 1/30 days |
| Omnaris® | NP |  | 1/30 days |
| Qnasl® | NP |  | 1/30 days |
| triamcinolone acetonide | NP |  | 1/30 days |
| Xhance® | NP | * Patient has a trial/failure, contraindication, or intolerance to at least 2 preferred nasal corticosteroid agents; **AND** * Patient has a clinically valid reason as to why preferred fluticasone propionate products cannot be used | 2/30 days |
|  | **Leukotriene Modifiers** | |  |  |
| montelukast tabs and chewables | P |  | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Accolate® | NP | * Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables); **AND** * Patient is 5 years of age or older and has a diagnosis of asthma | 2/day |

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|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| montelukast granules | NP | * One of the following:    + Diagnosis of asthma in patients 12 months of age or older; **OR**   + Diagnosis of exercise-induced bronchoconstriction (EIB) documented with concomitant use of at least one other asthma medication in patients 6 years of age or older; **OR**   + For treatment of seasonal allergic rhinitis in patients 2 years of age or older OR perennial allergic rhinitis in patients 6months of age or older, patient must have failed trial of an intranasal corticosteroid OR a non-sedating antihistamine;   **AND**   * Will be approved ONLY for patients who have clinically valid reason not to use chewable tablets **Note**: For patients less than 3 years of age, no prior authorization is required | 1/day |  |
| Singulair® tabs and chewables | NP | * One of the following:    + Diagnosis of asthma in patients 12 months of age or older; **OR**   + Diagnosis of exercise-induced bronchoconstriction (EIB) documented with concomitant use of at least one other asthma medication in patients 6 years of age or older; **OR**   + For treatment of seasonal allergic rhinitis in patients 2 years of age or older OR perennial allergic rhinitis in patients 6months of age or older, patient must have failed trial of an intranasal corticosteroid OR a non-sedating antihistamine;   **AND**   * Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables) | 1/day |
| Singulair® granules | NP | See montelukast granules prior authorization criteria; **AND**  • Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables) | 1/day |
| zafirlukast | NP | See Accolate® prior authorization criteria | 2/day |
| zileuton CR | NP | • Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables); **AND** • Patient is 12 years of age or older and has a diagnosis of asthma | 4/day |
| Zyflo® | NP | See zileuton CR prior authorization criteria | 4/day |
|  | **Miscellaneous**[**: OTC Products**](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | |  |  |
| Peak Flow Meters |  |  | 4 per 365 days | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Spacers |  |  | 4 per 365 days |
|  | **Phosphodiesterase 4 (PDE-4) Inhibitors** | |  |  |
| roflumilast | P | **Initial Criteria (6-month duration):**   * Diagnosis of COPD associated with chronic bronchitis, **AND** * Patient has forced expiratory volume in 1 second [FEV1] < 50%; **AND** * Patient is currently receiving standard of care COPD treatments, unless contraindicated (short acting β agonists OR short acting anticholinergics PLUS long acting β agonists OR long-acting anticholinergics), **AND** * Patient has a history of continued COPD exacerbations on their current COPD treatment regimen   **Renewal Criteria**   * Positive clinical response to treatment (e.g., improvement in FEV1 from baseline, reduction in COPD exacerbations); **AND** * Patient is currently receiving standard of care COPD treatments, unless contraindicated (short acting β agonists OR short acting anticholinergics PLUS long acting β agonists OR long-acting anticholinergics) | 250 mcg: 28/year 500 mcg: 1/day |  |
|  | **RESPIRATORY**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Daliresp® | NP | See roflumilast prior authorization criteria; **AND**  • Clinically valid reason why the patient cannot use the preferred generic roflumilast | 250 mcg: 28/year 500 mcg: 1/day |  |
| Ohtuvayre® | NP | * Patient is ≥ 18 years of age; **AND** * Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** * Submission of medical records (e.g. chart notes) that patient meets ALL the following:   + Bronchodilator FEV1/FVC ratio of <0.7 o FEV1 % predicted of ≤ 79%   + Modified medical research council (mMRC) dyspnea scale score of ≥ 2; **AND** * Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment concomitantly with ONE of the following: o A long-acting beta-agonist (LABA) + long-acting antimuscarinic (LAMA) + inhaled corticosteroid; **OR** o A long-acting beta-agonist (LABA) and long-acting antimuscarinic (LAMA); **AND** • Medication must be used as maintenance therapy only | 2 ampules/day |  |

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| **SMOKING CESSATION AGENTS**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | | | |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| **Smoking Cessation Agents** | | | |  |
| apo-varenicline | P |  | 2/day;  24 weeks/yr\* |  |
| bupropion sustained release | P |  | 2/day;  24 weeks/yr\* | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| Chantix® | P |  | 2/day;  24 weeks/yr\* |
| nicotine polacrilex gum | P |  | 24 weeks/yr\* |
| nicotine polacrilex lozenge | P |  | 24 weeks/yr\* |
| nicotine transdermal patch | P |  | 24 weeks/yr\* |
| Varenicline | P |  | 2/day;  24 weeks/yr\* |
| Nicotrol® inhaler | NP |  | 24 weeks/yr\* |
| Nicotrol® nasal spray | NP |  | 24 weeks/yr\* |
| Zyban® | NP |  | 2/day;  24 weeks/yr\* |
| ***\* For children, larger quantities may be approved as medically necessary.*** | | | |  |

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|  |  | **VITAMINS/ELECTROLYTES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
|  |  | **Folic Acid Preparations** |  |  |
| L-methylfolate | NP | • Patient has documented methylenetetrahydrofolate reductase (MTHFR) mutation/deficiency |  |  |
|  |  | **Potassium Depletors** |  |  |
| Lokelma® | NP | **Initial Criteria:**   * Patient must be ≥ 18 years of age; **AND** * Patient has a diagnosis of chronic hyperkalemia; **AND** * One of the following:   o Trial and failure, contraindication, or intolerance to a loop or thiazide diuretic; **OR** o Trial and failure, contraindication, or intolerance to a preferred potassium deplete agent  **Renewal Criteria:**   * Patient has a positive clinical response to therapy [e.g., decreased serum potassium levels, levels within normal limits) | 1/day | [General PA Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
|  | **VITAMINS/ELECTROLYTES**  ***Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*** | |  |  |
| **Medication** | **PDL** | **Prior Authorization Criteria** | **Qty. Limits** | **PA Form** |
| Veltassa® | NP | **Initial Criteria:**   * Patient must be ≥ 12 years of age; **AND** * Patient has a diagnosis of chronic hyperkalemia; **AND** * One of the following:   o Trial and failure, contraindication, or intolerance to a loop or thiazide diuretic; **OR** o Trial and failure, contraindication, or intolerance to a preferred potassium deplete agent  **Renewal Criteria:**   * Patient has a positive clinical response to therapy [e.g., decreased serum potassium levels, levels within normal limits) | 1 packet/day |  |
|  | **Vitamin B Products** | |  |  |
| cyanocobalamin injection | P | * Diagnosis of Pernicious Anemia; **AND** * Product is being administered by the patient, patient’s caregiver, or in a long-term care facility   **NOTE:** If the medication is being administered in the prescriber’s office **OR** by a Home Health Nurse, coverage must be obtained through the patient’s MCO. |  | [General PA](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf)  [Form](https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/General%20PA%20Form.pdf) |
| cyanocobalamin nasal spray | P | • Diagnosis of one of the following:  o Pernicious Anemia o B12 deficiency; **AND**  ­ Provider must submit lab documentation confirming deficiency |  |
| hydroxocobalamin injection | P | See cyanocobalamin injection prior authorization criteria |  |
| cyanocobalamin[, OTC](https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Covered-OTC-List.pdf) | P | Will be approved for patients who meet the following criteria:   * Diagnosis of Pernicious Anemia o Patient must be **UNDER** 21 years old (not a covered benefit for adults) * Diagnosis of B12 deficiency o Patient must be **UNDER** 21 years old (not a covered benefit for adults) o Provider must submit lab documentation confirming deficiency |  |
| Nascobal® nasal spray | NP |  |  |
|  | **Vitamin K Products** | |  |  |
| phytonadione | P |  | 5/Rx |  |