Cigna National Formulary Coverage Policy

Review Date 05/15/2025

Non-Preferred Drug Coverage Review - (Formulary Exception Criteria)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

This policy may be updated on a monthly basis following Pharmacy & Therapeutics (P&T) review of new and/or updated formulary exception criteria.

Cigna National Formulary Medical Necessity

The Cigna National Formulary prescription drug list does not cover certain drugs or biologics unless those products are approved based upon a medical necessity review.

Cigna covers these drugs or biologics as medically necessary when the following criteria are met:

- [see Product-Specific Exception Criteria]

Any other exception is considered not medically necessary.

Approval duration is 12 months unless otherwise noted.

Documentation: When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

Product-Specific Exception Criteria

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Abrilada	adalimumab-afzb subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Absorica LD	isotretinoin capsules low dose	Approve if the patient has tried three of the following: isotretinoin capsules (Absorica [not LD]), Accutane, Amnesteem, Claravis, or Zenatane, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve.
Aciphex Sprinkle and authorized generic [Authorized generic only]	rabeprazole sodium delayed-release capsules	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note:** Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole orally dissolving tablets (Prevacid/Solutabs, generics), omeprazole DR capsules, Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **Note:** The requested agent would NOT count as a trial of an alternative.

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Acuvail	ketorolac tromethamine 0.45% preservative-free solution	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), a bromfenac product (0.09% ophthalmic solution [generics], bromfenac ophthalmic solution 0.07% [Prolensa, generics], or bromfenac 0.075% [BromSite, generics]), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): bromfenac 0.075% (BromSite, generics), diclofenac ophthalmic solution (generics), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **3.** Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]): approve if the patient has tried diclofenac ophthalmic solution (generics), if formulary. If diclofenac ophthalmic solution is non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Adalimumab-fkjp	adalimumab-fkjp subcutaneous injection (unbranded version of Hulio)	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Adlyxin	lixisenatide injection	Type 2 Diabetes Mellitus. **1.** Approve if the patient has tried three formulary alternatives from the following list (or two if two are formulary or one if only one is formulary): Trulicity, Bydureon BCise, a semaglutide product (Ozempic, Rybelsus), Mounjaro, or Victoza **[documentation required]**. If none are formulary, approve. **Note:** A trial of Byetta satisfies the requirement for a trial of Bydureon BCise. Rybelsus and Ozempic would count as one alternative. **2.** Patient with estimated creatinine clearance (CrCl) < 45 mL/min: Approve if the patient has tried two formulary alternatives from the following list (or one if one is formulary): Trulicity, Victoza, Mounjaro, or a semaglutide product (Ozempic, Rybelsus) **[documentation required]**. If none are formulary, approve. **Note:** Rybelsus and Ozempic would count as one alternative

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		3. Patient with a personal or family history of medullary thyroid carcinoma or a patient with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2), approve.
Admelog	insulin lispro vial, SoloStar (prefilled pen)	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, or Lyumjev; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: NovoLog, or Insulin Aspart (authorized generic of NovoLog), or Fiasp; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.
Adthyza	thyroid tablets	**1.** Approve if the patient has tried one levothyroxine product (e.g., levothyroxine, Synthroid, Levoxyl) AND one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). **2.** Patient currently receiving Adthyza: Approve if the patient has tried one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). Note: Some desiccated thyroid products are currently not available, such as Nature thyroid, WP thyroid, Westhroid, and Thyroid tablet, but a previous trial of these would count as a trial of a desiccated thyroid product.
Afrezza	insulin human [rDNA origin] inhalation powder	Approve if the patient meets the following (A, B, C and D): A. Patient has tried Apidra, if formulary; AND B. Patient has tried Fiasp, if formulary; AND C. Patient has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic); AND D. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic), Humalog, or Admelog. **Note:** If no products in A, B, C, or D are formulary, approve. **Note:** The same product with different dosage forms count as one alternative (e.g., Humalog vial and Humalog Kwikpen would count as one alternative).

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Agamree	vamorolone oral suspension	See standard *Muscular Dystrophy – Agamree Prior Authorization Policy* criteria.
AirDuo RespiClick	fluticasone propionate/salmeterol inhalation powder	**1.** Approve if the patient has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (authorized generic of AirDuo RespiClick, AirDuo Digihaler), or budesonide-formoterol aerosol (Symbicort, Breyna, generics). If none are formulary, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick, AirDuo Digihaler), or fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic). If none are formulary, approve. **3.** Patients < 18 years of age: approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick, AirDuo Digihaler), or Dulera. If none are formulary, approve. **4.** Patients < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol inhalation (Advair Diskus, Wixela, generics) or fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick, or AirDuo Digihaler), if one is formulary. If none are formulary, approve.

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		Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick) and AirDuo Digihaler would count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.
Akeega	niraparib and abiraterone acetate tablets	BRCA-mutated Prostate Cancer. **1.** Approve if the patient has tried ONE of the following: 1) Lynparza +/- abiraterone or 2) Talzenna plus Xtandi. Note: If either medication in the regimens above are non-formulary, then that regimen does not need to be tried. Note: If Lynparza is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Akeega.
Akynzeo capsules	netupitant/ palonosetron capsules	Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried two formulary oral or transdermal serotonin 5-HT3 receptor antagonists from the following list (if two are formulary or one if one is formulary): ondansetron oral (generics), granisetron oral (generics), or Sancuso; AND B. Patient has tried one oral formulary Substance P/NK1 antagonists from the following list: aprepitant capsules (Emend, generics) or Varubi tablets, if one is formulary; OR Note: If there are no formulary 5-HT3 receptor antagonists, approve. If there are no Substance P/NK1 antagonists, approve. **2.** Approve if the patient has already started Akynzeo to complete all cycles in the current course of chemotherapy.
Alcortin A	hydrocortisone 2% / iodoquinol 1% / aloe 1% gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five single-entity corticosteroid topical agents AND one prescription topical anti-infective agent. **Note:** Examples of topical corticosteroids include: hydrocortisone cream/lotion/ointment [multiple brand and generic products], betamethasone cream/ointment/lotion [Diprolene, generics], clobetasol cream/gel/lotion [Temovate, Clobex, generics], fluocinolone ointment/cream [Synalar, generics], fluocinonide cream/ointment/gel [generics], mometasone cream/lotion/ointment [Elocon, generics], triamcinolone cream/ointment/lotion [generics]. **Note:** Examples of prescription topical anti-infectives include: mupirocin 2% cream [Bactroban, generics], mupirocin 2%

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		ointment [Bactroban, generics], Centany ointment, Centany AT ointment, Altabax ointment).
Alhemo	concizumab-mtci subcutaneous injection	Patient meets *Hemophilia – Alhemo Prior Authorization Policy* criteria AND For Hemophilia A. **1.** Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. **2.** Approve if, according to the prescriber, there is concern for a drug-drug interaction (e.g., drug interaction with Hemlibra and Feiba). **3.** Approve if the patient has already been started on therapy with Alhemo. For Hemophilia B. Approve.
Alkindi Sprinkle	hydrocortisone oral granules	**1.** Approve if the patient has tried and cannot take hydrocortisone tablets. **2.** Approve if the patient cannot swallow or has difficulty swallowing hydrocortisone tablets. **3.** Approve if the patient's dose cannot be obtained using whole hydrocortisone tablets.
Allopurinol 200 mg tablets (brand)	allopurinol 200 mg tablets	**1.** Direct the patient to allopurinol 100 mg or 300 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the allopurinol 100 mg or 300 mg tablet.
Allzital tablet	butalbital 25 mg, acetaminophen 325 mg tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Alocril	nedocromil sodium 2% ophthalmic solution	Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve.

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alogliptin and metformin tablets	alogliptin and metformin tablets (authorized generic of Kazano)	Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Janumet, Janumet XR, Jentadueto, Jentadueto XR, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), alogliptin (Nesina, authorized generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). **Note:** Janumet and Janumet XR would count as one alternative. Jentadueto and Jentadueto XR would count as one alternative.
Alomide	lodoxamide tromethamine 0.1% ophthalmic solution	**1.** Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve. **2.** For a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, and vernal keratitis, approve if the patient has tried cromolyn sodium 4% solution (generics). If cromolyn sodium 4% solution (generic) is non-formulary, approve.
Alrex	loteprednol etabonate 0.2% ophthalmic suspension	**1.** Approve if the patient has tried three products from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): bepotastine ophthalmic drops (Bepreve, generics), cromolyn ophthalmic drops (generics), epinastine 0.05% solution (generics), Lastacaft, azelastine 0.05% solution (generics), olopatadine ophthalmic solution (generics), Zerviate. If none are formulary, approve. **2.** Patients who require concurrent use of Alrex with an H1 antagonist or an H1 antagonist/mast cell stabilizer (e.g. azelastine [generics], bepotastine, epinastine solution [generics], Lastacaft, olopatadine ophthalmic solution [generics], Zerviate): approve.
Alvaiz	eltrombopag choline tablets	Immune Thrombocytopenia. 1. Approve if the patient has tried one of Promacta or Nplate, if formulary. If neither are formulary, approve. 2. Approve if the patient has already been started on therapy with Alvaiz. Aplastic Anemia; Thrombocytopenia in a Patient with Chronic Hepatitis C; Thrombocytopenia in a Patient with Myelodysplastic

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		Syndrome; Thrombocytopenia in a Patient Post-Allogenic Transplantation. 1. Approve if the patient has tried Promacta, if formulary. If Promacta is non-formulary, approve. 2. Approve if the patient has already been started on therapy with Alvaiz. "
Aplenzin	bupropion hydrobromide extended-release tablets	Approve if the patient has tried one product from the following list: bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics), if formulary. If bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics) are non-formulary, approve.
Altoprev	lovastatin extended-release tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five statins from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five statins from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.

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Alvesco	ciclesonide inhalation aerosol	**1.** Approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex HFA, fluticasone propionate HFA (authorized generic of Flovent HFA), or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.
Amjevita	adalimumab-atto subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Amrix and generic	cyclobenzaprine extended-release 15 mg and 30 mg capsule	Approve if the patient has tried and cannot take cyclobenzaprine 5 mg or 10 mg tablets (generics), if formulary. If cyclobenzaprine 5 mg or 10 mg tablets (generics) are non-formulary, approve.
Android	methyltestosterone 10 mg capsules	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): methyltestosterone capsules (Testred, generics) or Methitest. If none are formulary, approve.
Antara, Lipofen and authorized generics	fenofibrate capsules or tablets	Approve if the patient has tried three other formulary fenofibrate products (e.g., TriCor or generic, Lipofen, Fenoglide or generic, Trilipix or generic, generic fenofibrate capsule/ tablets, Fibricor or generic, generic fenofibric acid tablets) or two if only two are

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		formulary, or one if only one is formulary. If none are formulary approve the requested agent.
Antivert 50 mg tablet and authorized generic meclizine 50 mg	meclizine 50 mg tablet	Patient meets both of the following (i and ii): i. Patient has tried generic 25 mg tablets; AND ii. Patient cannot take generic 25 mg tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.
Anusol-HC suppository	hydrocortisone acetate suppository	Approve if the patient has tried hydrocortisone acetate suppositories. If hydrocortisone acetate suppositories are non-formulary, approve.
Anzemet tablets	dolasetron tablets	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH of the following: 1) granisetron tablets (generics) and 2) ondansetron tablets (generics), if formulary (or only one if one is formulary). If neither are formulary, approve. **2.** Patient < 18 years of age, approve if the patient tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with ondansetron tablets (generics), if formulary. If ondansetron tablets (generics) are non-formulary, approve. **3.** Approve if the patient has already started Anzemet to complete all cycles in the current course of chemotherapy.
Apidra	insulin glulisine vial/Solostar (prefilled pen)	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets both of the following (A and B): A. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; AND Note: If the patient has tried any product from A. regardless of formulary status, criterion A would be satisfied. B. Patient has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic of NovoLog), or Fiasp; OR Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. Note: If no products in A or B are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.
Apokyn	apomorphine injection	See standard *Parkinsons Disease Apokyn Prior Authorization Policy* criteria
ArmonAir Digihaler	fluticasone propionate	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are

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	powder, metered	formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		generic of Flovent HFA]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, fluticasone propionate diskus (authorized generic of Flovent Diskus), or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dosen inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.
Aspruzyo Sprinkle	ranolazine extended-release granules	**1.** Approve if the patient meets one of the following (A or B): A. Patient is unable to or has difficulty swallowing ranolazine extended-release tablets (Ranexa, generics); OR B. Patient requires administration by nasogastric or gastrostomy/gastric tube. **2.** If ranolazine extended-release tablets (Ranexa, generics) are non-formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried two of the following: beta blockers, calcium-channel blockers, or nitrates; OR **Note:** Two products in the same class would satisfy this criterion. B. Patient has difficulty swallowing oral dosage forms and is unable to try a beta-blocker, calcium-channel blocker, or a nitrate; OR C. Patient has already been started on a ranolazine product (e.g., Ranexa, Aspruzyo Sprinkle).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Astagraf XL	tacrolimus extended-release capsules	**1.** Approve if the patient has tried and cannot take tacrolimus immediate-release capsules (Prograf, generics), if formulary. If tacrolimus immediate-release capsules (Prograf, generics) are non-formulary, approve. **2.** If the patient has already started on therapy with Astagraf XL, approve.
Atorvaliq	atorvastatin calcium oral suspension	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.
Atropine sulfate 1% ophthalmic solution (preservative free) [brand]	atropine sulfate 1% ophthalmic solution	**1.** Direct the patient to generic atropine sulfate 1% ophthalmic solution. **2.** Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]), approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Augtyro	repotrectinib capsules	ROS1-positive non-small cell lung cancer. Approve if the patient meets ONE of the following (1, 2, 3, or 4): **1.** Patient has tried Rozlytrek. If Rozlytrek is non-formulary, approve; OR **2.** If Augtyro has not been tried previously, approve if the patient has symptomatic systemic progression (multiple lesions) on Rozlytrek (entrectinib capsules and pellet packet), Xalkori (crizotinib capsules), or Zykadia (ceritinib capsules and tablets); OR **3.** Patient has congestive heart failure or, according to the prescriber, the patient has a risk of QT prolongation; OR **4.** Patient has already been started on therapy with Augtyro. Neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors. Approve if the patient meets ONE of the following (1, 2, 3, or 4): **1.** Patient has tried one of Rozlytrek or Vitrakvi. If neither are formulary, approve; OR **2.** Patient has locally advanced disease; OR **3.** Patient has congestive heart failure or, according to the prescriber, the patient has a risk of QT prolongation, patient has tried Vitrakvi. If Vitrakvi is non-formulary, approve; OR **4.** Patient has already been started on therapy with Augtyro.
Auvelity	dextromethorphan hydrobromide and bupropion hydrochloride extended-release tablets	1. Approve if the patient has tried at least two different antidepressants, one of which must be bupropion and one additional antidepressant **[documentation required]**. Note: Examples of antidepressants include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), mirtazapine, etc. 2. Suicidal ideation: approve. 3. Patient is currently taking or has taken Auvelity at any time in the past: approve **[documentation required]**.
Aveed	testosterone undecanoate for intramuscular use	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone enanthate injection [generics], testosterone cypionate injection [Depo-Testosterone, generics], Azmiro, or Xyosted. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
baclofen 15 mg	baclofen 15 mg tablets	1. Direct the patient to generic baclofen 5mg, 10mg, or 20 mg tablets. 2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic baclofen 5 mg, 10 mg, or 20 mg tablets.
Balcoltra	ethinyl estradiol 0.02 mg; levonorgestrel 0.1 mg; ferrous bisglycinate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. 1. Approve if the patient has tried four other oral contraceptive agents. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. 2. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.
Basaglar	Insulin glargine U-100 KwikPen	Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with one of Rezvoglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. If none of the above are formulary, see, 1, 2, and 3 below. Type 2 Diabetes (Initial user and a patient Currently Receiving Basaglar) [and all others]. **1.** If all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, approve if the patient meets the following (a and b): a. Patient has tried one of Toujeo or Insulin glargine U300, if formulary; AND b. Patient has tried one of Tresiba or Insulin Degludec; if formulary. Note: If the patient has tried any product from a. or b. regardless of formulary status, that criterion would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes (initial user). **2.** If the patient has Type 1 diabetes and all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, approve if the patient meets (a and b): a. Patient has tried one of Toujeo or Insulin glargine U300, if formulary; AND b. Patient has tried one of Tresiba or Insulin Degludec, if formulary. Note: If the patient has tried any product from a. or b. regardless

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		of formulary status, that criterion would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes, Continuation of Therapy with Basaglar. **3.** If all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, the patient has Type 1 diabetes, and the patient is currently taking Basaglar, approve if the patient has tried one of Toujeo or Insulin glargine U300, if formulary. If neither are formulary, approve. Note: If the patient has tried either product above, regardless of formulary status, the criterion would be satisfied.
Basaglar Tempo Pen	Insulin glargine U-100 Tempo Pen	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using Basaglar Tempo Pen with the Tempo Smart Button; AND **2.** Patient has tried a basal insulin pen; AND **3.** Patient was unable to adhere to a regimen using a standard basal insulin pen, according to the prescriber **[documentation required].** **Note:** Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.
Beconase AQ	beclomethasone nasal spray	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone nasal spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, Qnasl, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
Besivance	besifloxacin ophthalmic suspension 0.6%	**1.** Approve if the patient has tried two products from the following list, (if two are formulary, or one if one is formulary): 1) gatifloxacin ophthalmic solution (generics), 2) moxifloxacin ophthalmic solution (Vigamox, Moxeza, generics), or 3) levofloxacin ophthalmic solution (generics). If none are formulary, approve. **2.** Approve if there is laboratory data that the patient has an eye infection due to pathogens resistant to ciprofloxacin and one other ophthalmic quinolone. **3.** For the treatment of currently active eye infections: approve in patients already receiving Besivance therapy to complete the course of therapy."
Besremi	ropeginterferon alfa-2b-njft subcutaneous injection	See *Oncology (Injectable) – Besremi Prior Authorization Policy* criteria.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Betimol	timolol hemihydrates 0.25% and 0.5% ophthalmic solution	Approve if the patient has tried four of the following, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): 1) levobunolol ophthalmic solution, 2) a timolol product (Istalol, Timoptic/XE, generics), 3) a betaxolol ophthalmic solution (generics or Betoptic S), or 4) carteolol ophthalmic solution (generics). If none are formulary, approve. **Note:** If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Bevespi Aerosphere	glycopyrrolate and formoterol fumarate inhalation aerosol	**1.** Approve if the patient has tried three of Anoro Ellipta, Duaklir Pressair, or Stiolto Respimat, if three are formulary, or two if two are formulary, or one if one is formulary. If none are formulary, approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried Stiolto Respimat, if formulary. If Stiolto Respimat is non-formulary, approve.
Bijuva	estradiol 1 mg and progesterone 100 mg capsules	Approve if the patient meets the following (A, B and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey and estradiol-norethindrone); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Premphase or Prempro, if formulary. Note: If none are formulary in A, B and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.
Bimzelx	bimekizumab-bkzx subcutaneous injection	See standard *Inflammatory Conditions (**Bimzelx**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.
Bonjesta	doxylamine succinate and pyridoxine hydrochloride extended-release tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with doxylamine-pyridoxine (Diclegis, generics), if formulary. If doxylamine-pyridoxine (Diclegis, generics) are non-formulary, approve if the patient has tried doxylamine AND pyridoxine (Vitamin B6).
Brenzavvy	bexagliflozin tablets	**1.** Approve if the patient has tried BOTH Farxiga AND Jardiance, if both are formulary (or one if one is formulary). If neither are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. If the patient's estimated glomerular filtration rate is less than 45 mL/minute, approve if the patient has tried Jardiance, if formulary. If Jardiance is non-formulary, approve.
BromSite	bromfenac 0.075% ophthalmic solution	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): Nevanac, Ilevro, diclofenac ophthalmic solution (generics), Acuvail, ketorolac ophthalmic solution (Acular, Acular LS, generics), bromfenac 0.09% ophthalmic solution (generics), or Prolensa. If none of the agents are formulary, then approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): diclofenac ophthalmic solution (generics), Nevanac, Ilevro, Acuvail, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **Note:** If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
budesonide-formoterol (authorized generic of Symbicort)	budesonide-formoterol (inhalation aerosol)	The patient is directed to use Symbicort (brand), if formulary. If Symbicort (brand) is non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Patient has tried Dulera, if formulary. If Dulera is non-formulary, approve; OR **2.** Patient has chronic obstructive pulmonary disease (COPD).
Bupap tablet	butalbital 50 mg, acetaminophen 300 mg tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Cabtreo	clindamycin phosphate, adapalene and benzoyl peroxide topical gel	Acne vulgaris in a patient ≥ 12 years of age. Approve if the patient meets BOTH of the following (A and B): A. Patient has concomitantly tried ALL three of the following products **[documentation required]**: 1) a topical benzoyl peroxide product, 2) a topical tretinoin-containing or adapalene-containing product, and 3) a topical clindamycin-containing product; AND B. According to the prescriber, there is a significant clinical concern such that the patient is unable to continue to use the products in criterion A.
Carac and authorized generic 0.5%	fluorouracil 0.5% cream	Approve if the patient has tried one of the following products, if formulary: Tolak, Fluoroplex, fluorouracil 2% solution, fluorouracil 5% solution, or fluorouracil 5% cream (Efudex, generics). If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
carbinoxamine maleate 4 mg/5 ml oral suspension (brand) [authorized generic of Karbinal ER] and Karbinal ER	carbinoxamine maleate 4 mg/5 ml oral suspension	**1.** Approve if the patient has tried five oral antihistamines (e.g., clemastine, diphenhydramine, chlorpheniramine, carbinoxamine [generic], hydroxyzine, cetirizine, loratadine). Note: OTC products would count toward meeting the requirement. **2.** If the patient is unable to swallow or has difficulty swallowing solid dosage forms, approve if the patient has tried at least two oral liquid antihistamines (e.g., carbinoxamine solution [generic], diphenhydramine solution, hydroxyzine solution or syrup, clemastine syrup, cetirizine solution, or loratadine solution or syrup). Note: OTC products would count toward meeting the requirement.
Carospir	spironolactone oral suspension	**1.** Approve if the patient has tried and cannot take spironolactone tablets (Aldactone, generics), if formulary. If spironolactone tablets (Aldactone, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow spironolactone tablets.
Cetraxal	ciprofloxacin 0.2% otic solution	Approve if the patient has tried one of the following, if one is formulary: ofloxacin otic solution (generics) or ciprofloxacin 0.2% otic solution (generic). If none are formulary, approve.
chorionic gonadotropin	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Pregnyl, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried Pregnyl or Novarel, if formulary. If neither are formulary, approve. **3.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).
Ciloxan ointment	ciprofloxacin ophthalmic ointment 0.3%	**1.** Approve if the patient has tried four products from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): ciprofloxacin ophthalmic solution (Ciloxan, generics), gatifloxacin ophthalmic solution (generics), moxifloxacin ophthalmic solution (Vigamox, Moxeza, generics), levofloxacin ophthalmic solution (generics), or ofloxacin 0.3% ophthalmic solution (Ocuflox, generics). If none are formulary, approve. **2.** If the patient is allergic to benzalkonium chloride, approve if the patient has tried moxifloxacin (Vigamox, Moxeza, generics), if formulary. If moxifloxacin (Vigamox, Moxeza, generics) are non-formulary, approve. **3.** For the treatment of currently active eye infections: approve in patients already receiving Ciloxan ointment to complete the course of therapy.
Cimzia	certolizumab powder for injection	See standard *Inflammatory Conditions (**Cimzia**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies OR FLEX Formulary* policies.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Cipro HC Otic Suspension	ciprofloxacin/ hydrocortisone otic suspension, 0.2%/1%	**1.** Approve if the patient has tried both products from the following list: 1) ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and 2) ciprofloxacin-fluocinolone otic (authorized generic of Otovel) or Otovel otic solution, if formulary. If none are formulary, approve. **2.** Patient has a benzalkonium chloride sensitivity: approve if the patient has tried one of ciprofloxacin-fluocinolone otic (authorized generic of Otovel) or Otovel, if formulary. If neither are formulary, approve.
ciprofloxacin/ fluocinolone otic solution (authorized generic to Otovel)	ciprofloxacin and fluocinolone acetonide otic solution, 0.3%/0.025%	**1.** Direct the patient to Otovel (brand), if formulary. **2.** If Otovel (brand) is non-formulary, approve if the patient has tried both 1) ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and 2) Cipro HC otic suspension (or one if one is formulary). If neither are formulary, approve. **3.** If Otovel (brand) is non-formulary, patients treating acute otitis media through tympanostomy tubes (AOMT), patients with a perforated ear drum (tympanic membrane), or patients < 1 year of age: approve if the patient has tried ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics), if formulary. If ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics) are non-formulary, approve. **4.** If Otovel (brand) is non-formulary, patient has a known hypersensitity to a preservative (e.g., benzalkonium chloride [BAK], benzyl alcohol), approve.
citalopram 30 mg capsules	citalopram capsules	**1.** Direct to citalopram 10 mg or 20 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the citalopram 10 mg and/or 20 mg tablets.
Clenia Plus and authorized generic	sodium sulfacetamide 9%- sulfur 4.25% suspension	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 9.8%-4.8% topical cleanser, generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide/sulfur.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Clenpiq	sodium picosulfate; magnesium oxide; anhydrous citric acid solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient meets one of the following (a or b): a. Patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve; OR b. Patient is < 12 years of age. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, c, or d): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. The patient is less than 18 years of age; OR c. Patients with phenylketonuria; OR d. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient meets one of the following (a or b): a. Patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve; OR b. Patient is < 12 years of age. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, c, or d): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. The patient is less than 18 years of age; OR c. Patients with phenylketonuria; OR d. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Climara Pro	estradiol/ levonorgestrel patch	Approve if the patient has tried CombiPatch, if formulary. If CombiPatch is non-formulary, approve if the patient has tried one oral estrogen/progestin combination product (e.g., estradiol/norethindrone [Activella, generics], Prempro, Premphase, ethinyl estradiol/norethindrone acetate [Femhrt, generics], Prefest, Angeliq).
Cloderm cream	clocortolone pivalate 0.1% cream	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. **Note**: Examples of topical steroid products include: betamethasone, fluocinolone acetonide, hydrocortisone valerate, mometasone, triamcinolone acetonide. **Note**: The five products must be chemically unique (i.e., a trial of betamethasone 0.1% and 0.05% would NOT fulfill the requirement).
colchicine capsules	colchicine capsules	Approve if the patient has tried one product from the following list: colchicine tablets (Colcrys, generics), Mitigare capsules, or Gloperba oral solution, if one is formulary. If none are formulary, approve.
Complera	emtricitabline/rilpivirine/tenofovir disoproxil fumarate (TDF) tablets	**1.** Approve if the patient has tried Odefsey, if formulary. If Odefsey is non-formulary, approve if the patient has tried one of the following products: Biktarvy, Genvoya, Stribild, Triumeq, Symtuza, efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla, generics), efavirenz-lamivudine-tenofovir (Symfi, Symfi Lo, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking single-entity or combination products containing emtricitabine, rilpivirine, and tenofovir disoproxil fumarate and is requesting Complera for a single-table regimen. **3.** Patients already started on therapy with Complera: approve.
Condylox 0.5% topical gel	podofilox 0.5% gel	Approve if the patient has tried two of the following (if two are formulary or one if one is formulary): podofilox 0.5% topical solution, imiquimod cream (Aldara, generics), or Veregen ointment. If none are formulary, approve. **Note:** If the patient has perianal warts, the patient would only need to try one formulary agent.
Conjupri and levamlodipine	levamlodipine tablets	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four formulary products from the following list: amlodipine, felodipine, nifedipine LA, nisoldipine (if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. If the patient is < 18 years of age, approve if the patient has tried amlodipine, if formulary. If amlodipine is non-formulary, approve.
Conzip and tramadol ER capsule	tramadol ER capsule	Approve, if per the prescriber, the patient is unable to use generic tramadol ER tablets.
Corlanor	ivabradine tablets and solution	If requesting brand Corlanor tablets or Corlanor solution, approve if the patient meets ONE of the following (1 or 2): **1.** Patient has tried and cannot take generic ivabradine tablets; OR **2.** Patient cannot swallow or has difficulty swallowing tablets, approve Corlanor solution. If requesting generic ivabradine tablets or generic ivabradine tablets are non-formulary, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Patient has tried, or is currently receiving a beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) OR the patient has a contraindication to beta-blockers; OR **2.** Heart failure due to dilated cardiomyopathy, approve if the patient is < 18 years of age; OR **3.** Patient has already been started on Corlanor or ivabradine.
Cortifoam	hydrocortisone acetate aerosol foam	**1.** Approve if the patient has tried budesonide foam (Uceris foam, generics), if formulary. If budesonide foam (Uceris foam, generics) are non-formulary, approve if the patient has tried one corticosteroid enema from the following list (if one is formulary): Cortenema or hydrocortisone enema. If neither are formulary, approve. **2.** Patients who are unable to retain a corticosteroid enema: approve if the patient has tried budesonide foam (Uceris foam, generics), if formulary. If budesonide foam (Uceris foam, generics) are non-formulary, approve.
Cortrophin Gel (Purified)	repository corticotropin subcutaneous or intramuscular injection	No exceptions are recommended. There is a lack of updated clinical efficacy data and potential safety concerns with long-term use. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There is a lack of updated clinical efficacy data and insufficient information to determine clinically meaningful benefits.)
Cosentyx SC	secukinumab for SC injection	See standard *Inflammatory Conditions (**Cosentyx**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies OR FLEX Formulary* policies.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Coxanto and oxaprozin 300 mg (brand)	oxaprozin capsule	Approve if the patient has tried five prescription-strength, oral NSAIDs. Note: Examples include: oxaprozin (Daypro, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. Note: Five unique NSAIDs should be tried.
Crinone 4% Gel	progesterone gel 4%	Approve if the patient has tried one product from the following list (if one is formulary): medroxyprogesterone [Provera, generics], megestrol acetate, norethindrone tablets, or progesterone capsules (Prometrium, generics). If none are formulary, approve.
Crinone 8% Gel	progesterone gel 8%	**1.** For use as progesterone supplementation/replacement to achieve or maintain pregnancy: approve if the patient has tried Endometrin, if formulary. If Endometrin is non-formulary, approve. **2.** Patients started on a course of therapy with Crinone 8% gel for progesterone supplementation/replacement to achieve or maintain pregnancy: approve to complete the current course of therapy. **3.** Approve if the patient has tried one product from the following list (if one is formulary): medroxyprogesterone [Provera, generics], megestrol acetate, norethindrone tablets, or progesterone capsules (Prometrium, generics). If none are formulary, approve.
Cuvrior	trientine tetrahydrochloride 300 mg tablets	Approve if the patient has tried trientine capsules (Syprine, generics), if formulary. If trientine capsules (Syprine, generics) are non-formulary, approve if the patient meets one of the following: **1.** Approve if the patient has tried one penicillamine product: penicillamine (Cuprimine, generics) or penicillamine (Depen, generics), if one is formulary. If neither are formulary, approve. **2.** Approve if per the prescriber, the patient is intolerant to penicillamine or the patient has clinical features indicating the potential for intolerance to penicillamine (i.e., history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency). **3.** Approve if, per the prescribing physician, the patient has a contraindication to penicillamine.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		4. Approve if the patient has neurological manifestations of Wilson's Disease. **5.** Approve if the patient is pregnant. **6.** Approve if the patient has been started on therapy with Cuvrior.
Cystadrops	cysteamine ophthalmic solution	Cystinosis with Corneal Cysteine Crystal Deposits: Approve, if the patient has tried Cystaran, if formulary. If Cystaran is non-formulary, approve.
dapagliflozin tablets	dapagliflozin tablets (authorized generic of Farxiga)	Direct to Farxiga (brand), if formulary. If Farxiga (brand) is non-formulary: Approve if the patient has tried, according to the prescriber, and experienced inadequate efficacy OR significant intolerance with Jardiance, if formulary. If Jardiance is non-formulary, approve.
dapagliflozin-metformin ER tablets	dapagliflozin-metformin ER tablets	Direct to Xigduo XR (brand), if formulary. If Xigduo XR (brand) is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Synjardy, Synjardy XR, or Segluromet. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND three formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Farxiga, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative. **2.** Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried Synjardy, if formulary. If Synjardy is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary, approve.
Dartisla ODT	glycopyrrolate orally disintegrating tablets	**1.** Direct to glycopyrrolate tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use glycopyrrolate tablets.
Daybue	trofinetide oral solution	See standard *Neurology – Daybue Prior Authorization Policy* criteria. Note: No conditions of approval are recommended in the prior authorization policy.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Delstrigo	doravirine/ lamivudine/ tenofovir disoproxil fumarate tablets	**1.** Approve if the patient has tried one of the following products: Biktarvy, Genvoya, Odefsey, Stribild, Complera, Triumeq, Symtuza, efavirenz-lamivudine-tenofovir (Symfi, Symfi Lo, generics), if formulary. If none are formulary, approve. **2.** Patient < 18 years of age AND weighing ≥ 35 kg (77 pounds), approve if the patient has tried one of Biktarvy, Genvoya, Odefsey, Stribild, Complera, or efavirenz-lamivudine-tenofovir (Symfi Lo, generics), if formulary. If none are formulary, approve. **3.** Approve if the patient is currently taking single-entity or combination products containing doravirine, lamivudine, and tenofovir disoproxil fumarate and is requesting Delstrigo for a single tablet regimen. **4.** Patients already started on therapy with Delstrigo, approve.
Dexilant and authorized generic	dexlansoprazole delayed-release capsules	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note:** Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **Note:** The requested agent would NOT count as a trial of an alternative. **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried four proton pump inhibitors (PPIs) from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): 1) rabeprazole sprinkle; 2) an esomeprazole product (esomeprazole DR capsules [Nexium, generics], esomeprazole packet [Nexium granules for oral suspension, generic]); 3) pantoprazole suspension (granules) [Protonix suspension, generic]; 4) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid Solutab, generics]); 5) an omeprazole product (omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
DexPak 6 day/10 day/13 day and generics	dexamethasone 1.5 mg tablets (6 day, 10 day, and 13 day dose pack)	**1.** Direct to the dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs). Approval duration: 14 days
Dhivy	carbidopa and levodopa immediate-release tablets	Approve if dose prescribed cannot be obtained with carbidopa-levodopa tablets (Sinemet, generics) or half-tablets. **Note:** Dhivy can be split into a ¼ of a tablet (i.e., 6.25 mg of carbidopa and 25 mg of levodopa).
Diabetic Supplies	Blood glucose meters /test strips/ control solutions/ continuous glucose monitoring products	**1.** Approve if the patient has tried one formulary meter/test strip/control solution. If none are formulary, approve. **2.** Patients using an insulin pump/meter system that is not compatible with one of the available formulary alternatives: approve. **3.** If the request is for Freestyle Precision Neo strips for use in a Freestyle Libre reader, approve. **4.** Patients who are blind or significantly visually impaired who are requesting a meter with audio capabilities: approve if the patient has tried one other formulary meter with audio capabilities. If there are no formulary meters with audio capabilities, approve. **Note:** Meters with audio capabilities include Advocate (Redi-Code plus speaking meter), Arkray (Glucocard Expression, Glucocard Shine Express), Foracare (Fora D40D, Fora D40G, For a Gtel, Fora Premium V10 BLE, Fora Test N' Go Advance Voice, Fora Tn'G Voice, Fora V30), Oak Tree Health (EasyMax V, Fortiscare V3), Omnis Health (Embrace Talk), Prodigy (Prodigy Autocode, Prodigy Voice), Relion Premier Voice.
diclofenac epolamine 1.3% topical patch (authorized generic of Flector Patch)	diclofenac epolamine 1.3% topical patch	Direct the patient to use Flector patch (brand), if formulary. If Flector patch (brand) is non-formulary, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Licart 1.3% topical system, diclofenac 2% solution pump (Pennsaid 2.0%, generics), diclofenac sodium 1.5% topical solution (generics), or prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics), if one is formulary. If none are formulary, approve if the patient has tried over-the-counter Voltaren 1% gel.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Dipentum	olsalazine capsule	Approve if the patient has tried two products from the following list (if two are formulary, or one if one is formulary): mesalamine delayed-release tablets (Asacol HD, generics), sulfasalazine (generics), mesalamine delayed-release tablets (Lialda, generics), mesalamine delayed-release capsule (Delzicol, generics), balsalazide (Colazal, generics), mesalamine extended-release capsules (Apriso, generics) or Pentasa. If none are formulary, approve. **Note:** If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Doral and authorized generic	quazepam tablets	Approve if the patient has tried estazolam or lorazepam if formulary. If neither are formulary, approve.
Doryx DR 80 mg and authorized generic	doxycycline hyclate delayed-release tablets	**1.** Direct patient to other doxycycline products. **2.** Approve if, per the prescriber, the 80 mg tablet is required to meet the prescribed dosing requirement.
Doryx MPC	doxycycline hyclate tablet, delayed-release	**1.** Direct patient to other doxycycline products. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic doxycycline product.
Drizalma Sprinkle	duloxetine delayed-release capsules	**1.** Approve if the patient has tried one product from the following list (if one is formulary): duloxetine capsules (Cymbalta, generics), Fetzima, desvenlafaxine succinate extended-release (ER) [Pristiq, generics], venlafaxine ER capsules (Effexor XR, generics), or venlafaxine extended-release tablets. If none are formulary, approve. **Note:** If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the patient is unable to swallow, has difficulty swallowing, or requires administration via a nasogastric tube.
Drysol	aluminum chloride 20% topical solution	Hyperhidrosis in the axillae, palms, or soles. Approve if the patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one over-the-counter aluminum-containing product (such as Certain Dri, Bromi-lotion) **[documentation required].**
Duaklir Pressair	aclidinium bromide and formoterol fumarate inhalation powder	1. Approve if the patient has tried three of Anoro Ellipta, Bevespi Aerosphere, or Stiolto Respimat, if three are formulary, or two if two are formulary or one if one is formulary. 2. If the patient is unable to coordinate breath and actuation with a metered-dose inhaler (MDI), approve if the patient has tried

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Anoro Ellipta, if formulary. If Anoro Ellipta is non-formulary, approve.
Durlaza	aspirin extended-release capsules	Approve if the patient has tried and cannot take two other single-entity oral aspirin products.
Dxevo dose pack	dexamethasone 1.5 mg tablets (11-day pack)	1. Direct to the dexamethasone 1.5 mg tablets (not packed as dose packs). 2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs). Approval duration: 14 days
Dyanavel XR suspension	amphetamine extended-release oral suspension	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), or 2) Adzenys XR ODT tablets, or 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics). If none are formulary, approve. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Adzenys XR ODT tablets, if formulary. If Adzenys XR ODT tablets are non-formulary, approve.
Dyanavel XR tablets	amphetamine extended-release tablets	**1.** Approve if the patient has tried Dyanavel XR oral suspension, if formulary. **2.** If Dyanavel XR oral suspension is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), or 2) Adzenys XR ODT tablets, or 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics). If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Ecoza foam	econazole nitrate topical foam	1. Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. 2. If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. **Note:** Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.
Edarbi	azilsartan	1. Approve if the patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve. 2. Patients recently hospitalized (and discharged within 30 days) for a cardiovascular event (e.g., myocardial infarction [MI], hypertensive emergency) who has already been started and stabilized on Edarbi: approve.
Edarbyclor	azilsartan and chlorthalidone tablets	1. Approve if the patient has tried five of the following formulary angiotensin receptor blocker/diuretic combination products, if five are formulary, or four if four are formulary, or three if three are formlary, or two are formulary, or one if only one is formulary): candesartan-hydrochlorothiazide (Atacand HCT, generics), irbesartan-hydrochlorothiazide (Avalide, generics), losartan-hydrochlorothiazide (Hyzaar, generics), telmisartan-hydrochlorothiazide (Micardis HCT, generics), valsartan-hydrochlorothiazide (Diovan HCT, generics), olmesartan-hydrochlorothiazide (Benicar HCT, generics). 2. Approve if the patient has tried chlorthalidone AND Edarbi, if Edarbi is formulary. If Edarbi is non-formulary, approve if the patient has tried five of the following formulary angiotensin receptor blockers (ARBs), if five are formulary or four if four are formulary or three if three are formulary, or two if only two are formulary; or one if only one is formulary): candesartan

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		(Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve.
Elestrin	estradiol gel 0.06%	Approve if the patient meets BOTH of the following (A <u>and</u> B): A. Patient has tried one formulary non-patch topical estradiol product: Estrogel, estradiol gel (transdermal) [Divigel, generics] Evamist, if one is formulary; AND B. Patient has tried one estradiol patch (e.g., estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics). <u>Note</u>: If no transdermal gels or sprays are formulary, the patient would still need to try an estradiol patch.
Elyxyb	celecoxib oral solution	<u>Acute treatment of migraine.</u> 1. Direct the patient to celecoxib capsules. If celecoxib capsules (Celebrex, generics) are non-formulary, approve. 2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use celecoxib capsules.
Emend oral suspension	aprepitant oral suspension	**1.** Approve if the patient has tried one formulary alternative from the following list: aprepitant capsules (Emend, generics) or Varubi tablets. If none are formulary, approve. **2.** Patients ≥ 12 and <18 years of age: approve if the patient has tried aprepitant capsules (Emend, generics), if formulary. If aprepitant capsules (Emend, generics) are non-formulary, approve. **3.** Patients < 12 years of age: approve. **4.** Patients who cannot swallow or have difficulty swallowing capsules, approve. **5.** Approve if the patient has already started Emend oral suspension to complete all cycles in the current course of chemotherapy.
Emflaza [brand] (tablets and oral suspension)	deflazacort tablets and oral suspension	See standard *Muscular Dystrophy – Deflazacort Preferred Specialty Management Policy* criteria.
Endometrin	progesterone vaginal insert	**1.** Approve if the patient has tried Crinone 8% gel **[documentation required]**, if formulary. If Crinone 8% gel is non-formulary, approve. **2.** A patient already started on a course of therapy with Endometrin for progesterone supplementation/replacement to achieve or maintain pregnancy: approve to complete the current course of

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		therapy. Note: Approve for 9 months or to complete the course of therapy.
Entadfi	finasteride 5 mg and tadalafil 5 mg capsules	Benign Prostatic Hyperplasia (BPH). Approve if, according to the prescriber, the patient has a clinical reason they cannot take finasteride 5 mg and tadalafil 5 mg as separate agents.
Entyvio SC	vedolizumab for subcutabeous injection	See standard *Inflammatory Conditions (**Entyvio SC**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.
Envarsus XR	tacrolimus extended-release tablets	**1.** Approve if the patient has tried and cannot take tacrolimus immediate-release capsules (Prograf, generics), if formulary. If tacrolimus immediate-release capsules (Prograf, generics) are non-formulary, approve. **2.** Approve if the patient has the CYP3A5*1 allele. **Note:** The CYP3A5*1 allele is a gene variant determined by testing that may confer faster metabolism of certain medications. **3.** If the patient has already started on therapy with Envarsus XR, approve.
Eohilia	budesonide oral suspension	Patient meets *Gastroenterology – Eohilia Prior Authorization Policy* AND Patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). **2.** Approve if the patient has already been started on a 12-week course of therapy with Eohilia (to allow for completion of up to a 12-week course of therapy).
epinephrine auto-injector	epinephrine 0.15 mg, 0.3 mg auto-injector authorized generic (Amneal Pharmace, Avkare, A-S Medication)	Approve if the patient has tried one product from the following list, if one is formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Eprontia	topiramate oral solution	Approve if the patient has tried and cannot take topiramate sprinkle capsules (Topamax Sprinkle capsules, generics). If topiramate sprinkle capsules (Topamax Sprinkle capsules, generics) are non-formulary, approve.
Ertaczo	sertaconazole nitrate 2% cream	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. **Note:** Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ecoza foam, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.
Esgic capsule	butalbital 50 mg, acetaminophen 325 mg, caffeine 40 mg capsule or tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
esomeprazole strontium	esomeprazole strontium 49.3 mg capsules	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Estring	estradiol 2 mg vaginal ring	1. Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Femring vaginal ring, Premarin Cream, estradiol 0.01% cream (Estrace Cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. 2. If according to the prescriber, the patient requires a low-dose vaginal product, approve if the patient has tried one of Imvexxy vaginal insert or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve.
Estrogel	estradiol gel 0.06%	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried one formulary non-patch topical estradiol product: Elestrin, Evamist, estradiol gel (transdermal) [Divigel, generics] if one is formulary; AND B. Patient has tried one estradiol patch (e.g., estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics). Note: If no transdermal gels or sprays are formulary, the patient would still need to try an estradiol patch.
Evamist	estradiol transdermal spray	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried one formulary non-patch topical estradiol product: Elestrin, estradiol gel (transdermal) [Divigel, generics], Estrogel, if one is formulary; AND B. Patient has tried one estradiol patch (e.g., estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics). Note: If no transdermal gels or sprays are formulary, the patient would still need to try an estradiol patch.
Exelderm and authorized generic (sulconazole nitrate 1%)	sulconazole nitrate 1% (cream and solution)	1. Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. 2. If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. **Note:** Example of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, ciclopirox 0.77% cream or gel (generics), Luzu 1% cream, Mentax 1% cream, Xolegel 2% gel.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Extavia	interferon beta-1b injection	Relapsing form of multiple sclerosis. **Note:** Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets one of the following: (A or B) A. Patient has tried three formulary products from the following list: Betaseron, Rebif, Avonex, or Plegridy **[documentation required]**, if three are formulary (or two if two are formulary or one if one is formulary); OR B. If no beta-interferon products (above) are formulary, patient meets BOTH of the following (i and ii): i. Patient has tried one oral fumarate product: Bafiertam, Vumerity, or dimethyl fumarate (Tecfidera, generics), if formulary; AND **Note:** If no oral fumarate products are formulary, approve. ii. Patient has tried one other agent for multiple sclerosis. **Note:** Examples of other agents for multiple sclerosis include Mayzent, Ponvory, Zeposia, fingolimod (Gilenya, generics), Tascenso ODT, teriflunomide (Aubagio, generics), glatiramer, Glatopa (Copaxone, generics). **2.** Patient has been established on Extavia for greater than or equal to 120 days, direct to Betaseron. If Betaseron is non-formulary, approve.
Ezallor Sprinkle	rosuvastatin capsules	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.
Fabior and authorized generic	tazarotene 0.1% foam	Other diagnoses (e.g., acne vulgaris). Approve if the patient meets the following (A and B): A. Patient has tried and cannot take one of tazarotene cream (Tazorac cream, generics) or tazarotene gel (Tazorac gel, generics), if one is formulary. If none are formulary, approve; AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with one topical tretinoin-containing product. Note: Examples of topical retinoid products include tretinoin cream (Retin-A cream, generics), tretinoin gel (Retin-A gel, generics). Psoriasis. Approve if the patient has tried and cannot take one of tazarotene cream (Tazorac cream, generics) or tazarotene gel (Tazorac gel, generics), if one is formulary. If none are formulary, approve.
Fanapt	iloperidone tablets and titration pack	**1.** Approve if the patient has tried two oral antipsychotics (e.g., risperidone tablets/orally disintegrating tablets [ODT]{Risperdal, generics}, olanzapine tablets/ODT [Zyprexa/Zydis, generics], quetiapine tablets [Seroquel, generics], quetiapine extended-release tablets [Seroquel XR, generics], aripiprazole tablets [Abilify, generics], paliperidone ER tablets [Invega, generics], ziprasidone capsules [Geodon, generics], Latuda tablets, Rexulti tablets, Vraylar

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		capsules, asenapine sublingual tablets [Saphris, generics], Caplyta). **2.** Approve if the patient is currently taking Fanapt. **3.** Approve if the patient has taken Fanapt at any time in the past.
Femlyv	norethindrone acetate and ethinyl estradiol orally disintegrating tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Charlotte 24 Fe, Finzala, Kaitlib Fe, Layolis Fe, Mibelas 24 Fe, norethindrone-ethinyl estradiol, Wymzya Fe. **2.** If the patient is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried one oral chewable birth control product (e.g., Finzala, Mibelas, Charlotte, Wymzya, Kaitlib, Layolis). OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Charlotte 24 Fe, Finzala, Kaitlib Fe, Layolis Fe, Mibelas 24 Fe, norethindrone-ethinyl estradiol, Wymzya Fe. **2.** If the patient is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried one oral chewable birth control product (e.g., Finzala, Mibelas, Charlotte, Wymzya, Kaitlib, Layolis). **3.** The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.
Femring	estradiol vaginal ring (0.05 mg and 0.10 mg)	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Premarin cream, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), estradiol patch (Climara, generics), estradiol patch (Vivelle Dot, generics), Menostar patch, estradiol tablets (Estrace, generics), Menest tablets, or Premarin tablets. If none are formulary, approve.
Fenoprofen capsules [brand]	fenoprofen capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note:** For example: fenoprofen (tablets/generic), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
Fentora and authorized generic	fentanyl buccal tablet	See *Opioids Transmucosal – Fentora FE*
Fexmid	cyclobenzaprine tablet	Approve if the patient has tried and cannot take cyclobenzaprine tablets (generics), if formulary. If cyclobenzaprine tablets (generics) are non-formulary, approve.
Fiasp	insulin aspart injection vial, pen, cartridge, PumpCart	Approve if the patient meets one of the following (1 or 2): A. Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; AND **Note:** If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic of NovoLog); OR **Note:** If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. **Note:** If no products in A, B, or C are formulary, approve. B. Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.
Filspari	sparsentan tablets	See standard *Nephrology – Filspari Prior Authorization Policy* criteria.
Fintepla	fenfluramine oral solutionf	See standard *Antiepileptics – Fintepla Prior Authorization Policy criteria.*
Fioricet capsule	butalbital 50 mg,	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g.,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
	acetaminophen 300 mg, caffeine 40 mg capsule or tablet	butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Fiorinal capsule	butalbital 50 mg, aspirin 325 mg, caffeine 40 mg capsule	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.
Firazyr	icatibant injection for subcutaneous use	**1.** See standard *Hereditary Angioedema – Icatibant Preferred Specialty Management Policy* criteria.
Firvanq and authorized generic vancomycin oral solution	vancomycin oral solution	**1.** Approve if the patient has tried vancomycin capsules (Vancocin oral capsule, generics) or vancomycin oral solution (Vancocin oral solution, generics), if formulary. If neither are formulary, approve. **2.** If the patient is unable to swallow or has difficulty swallowing capsules, approve if the patient has tried vancomycin oral solution (Vancocin oral solution, generics), if formulary. If vancomycin oral solution is non-formulary, approve.
Flarex	fluorometholone acetate ophthalmic suspension 0.1%	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; FML Forte), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild), if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a fluorometholone product (FML Liquifilm, generics; FML Forte), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. **Note:** If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Fleqsuvy	baclofen oral suspension, concentrated formulation	**1.** Direct to oral baclofen tablets. **2.** Patient is unable to or has difficulty swallowing oral tablets, approve if the patient has tried baclofen 25 mg/5ml oral suspension (generic of Fleqsuvy), if formulary. If baclofen 25 mg/5ml oral suspension (generic of Fleqsuvy) is non-formulary, approve if the patient has tried one of 1) Ozobax solution or 2) Lyvispah oral gransules, if formulary. If neither are formulary, approve.
Flowtuss	hydrocodone bitartrate/ guaifenesin oral solution	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine/guaifenesin oral solution (generics), Guaifenesin AC syrup, guaifenesin with codeine syrup (generics), Mar-Cof CG liquid, M-Clear WC liquid, Ninjacof XG liquid, Virtussin AC liquid, Obredon solution. If none are formulary, approve if the patient has tried two other prescription or over-the-counter (OTC) cough and cold products.
Flovent Diskus (brand and authorized generic	fluticasone inhalation powder	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipa), or Qvar RediHaler, if formulary. If none are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, fluticasone propionate HFA [authorized generic of Flovent HFA]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if one is formulary): ArmonAir Digihaler, Asmanex Twisthaler or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.
Flovent HFA (brand)	fluticasone inhalation aerosol HFA	Direct the patient to fluticasone propionate HFA, if formulary. If fluticasone propionate HFA is non-formulary: **1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		i. If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is only formulary): Asmanex HFA AND Qvar RediHaler. If neither are formulary, approve. **ii.** If the patient is < 12 years of age and is unable to use BOTH a DPI AND a breath-actuated metered-dose inhaler (MDI) [i.e., Qvar Redihaler], approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): Qvar RediHaler AND Asmanex HFA. If none are formulary, approve. **ii.** If the patient is < 6 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. **c.** If the patient is 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is 4 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried Qvar RediHaler, if formulary. If Qvar RediHaler is non-formulary, approve. **ii.** If the patient is 4 year of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve. **d.** If the patient is < 4 years of age: approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, or Qvar RediHaler. If none are formulary, approve. **3.** Patients with eosinophilic esophagitis: approve, if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, and fluticasone propionate diskus (authorized generic of Flovent Diskus) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.
Fluticasone propionate HFA (authorized generic of Flovent HFA)	fluticasone propionate HFA	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. a. If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. i. If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is only formulary): Asmanex HFA AND Qvar RediHaler. If neither are formulary, approve. ii. If the patient is < 12 years of age and is unable to use BOTH a DPI AND a breath-actuated metered-dose inhaler (MDI) [i.e., Qvar Redihaler], approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. b. If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. i. If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): Qvar RediHaler AND Asmanex HFA. If none are formulary, approve. ii. If the patient is < 6 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve if the patient has tried Asmanex HFA, if formulary. If

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Asmanex HFA is non-formulary, approve. c. If the patient is 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. i. If the patient is 4 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried Qvar RediHaler, if formulary. If Qvar RediHaler is non-formulary, approve. ii. If the patient is 4 year of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve. d. If the patient is < 4 years of age: approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, or Qvar RediHaler. If none are formulary, approve. **3.** Patients with eosinophilic esophagitis: approve if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, and fluticasone propionate diskus (authorized generic of Flovent Diskus) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.
fluticasone propionate/salmeterol HFA	fluticasone propionate/salmeterol HFA	Direct to Advair HFA (brand), if formulary. If Advair HFA (brand) is non-formulary: **1.** Approve if the patient has tried four of the following, if (four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, AirDuo Digihaler), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. **2.** Patients < 18 years of age: approve if the patient has tried three of the following, if three are formulary (if three are formulary, or

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, AirDuo Digihaler), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. **3.** Patients with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the patient has tried both 1) budesonide-formoterol (Symbicort, Breyna, generics) and 2) Dulera (if both are formulary or one if only one is formulary). If neither are formulary, approve. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler, AirDuo RespiClick, and AirDuo Digihaler count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.
fluticasone propionate/salmeterol multidose dry powder inhaler	fluticasone propionate/ salmeterol inhalation powder (authorized generic to AirDuo RespiClick)	**1.** Approve if the patient has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, AirDuo Digihaler, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), Dulera or budesonide-formoterol (Symbicort, Breyna, generics). If none are formulary, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, AirDuo Digihaler, or fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic). If none are formulary, approve. **3.** Patients < 18 years of age: approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol, (Symbicort, Breyna, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, AirDuo Digihaler, or Dulera. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		4. Patients < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, or AirDuo Digihaler, if formulary. If neither are formulary, approve. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. AirDuo RespiClick and AirDuo Digihaler count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.
Fluticasone-vilanterol	fluticasone furoate and vilanterol inhalation powder	Direct the patient to Breo Ellipta (brand), if formulary. If Breo Ellipta (brand) is non-formulary: **1.** Approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, AirDuo Digihaler), budesonide-formoterol aerosol (Symbicort, Breyna, generics), or Dulera. If none are formulary, approve. **2.** Patients < 12 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), Dulera, or budesonide-formoterol aerosol (Symbicort, Breyna, generics). If none are formulary, approve. **3.** Patients ≤ 5 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) or Dulera. If neither are formulary, approve. **4.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, or AirDuo Digihaler), if one is formulary. If neither are formulary, approve. **a.** Patient < 12 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): Approve if the patient has tried fluticasone propionate/salmeterol inhalation powder (Advair Diskus,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Wixela, generics). If fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. **5.** Patients with COPD: Approve if the patient has tried both 1) fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) and 2) budesonide-formoterol aerosol (Symbicort, Breyna, generics) [if both are formulary or one if only one is formulary]. If none are formulary, approve. **6.** Patients with COPD who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) if formulary. If fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler, AirDuo RespiClick, and AirDuo Digihaler count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.
FML Forte	fluorometholone 0.25% ophthalmic suspension	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; Flarex), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 5) prednisolone (Pred Forte, Omnipred, generics; Pred Mild), if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 2) a fluorometholone product (FML Liquifilm, generics; Flarex), or 3) difluprednate (Durezol, generics). If none are formulary, approve. **Note:** If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Follistim AQ	follitropin beta	**1.** Approve if the patient has tried one product from the following list: Gonal-F/Gonal-F RFF, if formulary. If Gonal-F/Gonal-F RFF is non-formulary, approve. **2.** Patient has been started on a current cycle of therapy with Follistim AQ: approve to complete the current cycle.
Forfivo XL and authorized generic	bupropion hydrochloride extended-release tablets	**1.** Patient is directed to bupropion hydrochloride XL 150 mg and/or 300 mg tablets (Wellbutrin XL, generics). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the buproprion hydrochloride XL 150 mg and/or 300 mg tablets (Wellbutrin XL, generics).
Forteo	teriparatide injection	Approve if the patient has tried generic teriparatide (generic Forteo), if formulary. If generic teriparatide (generic Forteo) is non-formulary or if generic teriparatide (generic Forteo) is being requested, approve if the patient meets one of the following (1, 2, or 3): **1.** Approve if the patient has tried brand teriparatide, if formulary. If brand teriparatide is non-formulary, approve if patient has tried Tymlos, if formulary. If Tymlos is non-formulary, approve. **2.** Approve if the patient has tried brand teriparatide, if formulary. If brand teriparatide is non-formulary, patients with glucocorticoid-induced osteoporosis (GIO): approve. Note: For approvals above under criteria (1 and 2): Use of teriparatide (Forteo [generics] or teriparatide) exceeding 2 years during a patient's lifetime, approve if the patient is at high risk for fracture as determined by the prescriber. **3.** Approve if the patient has tried brand teriparatide, if formulary. If brand teriparatide is non-formulary, approve if the patient has a diagnosis of chronic hypoparathyroidism
Fosrenol oral powder	lanthanum carbonate oral powder	**1.** Approve if the patient has tried two formulary alternatives from the following list (if two are formulary or one if one is formulary): sevelamer hydrochloride tablets, lanthanum carbonate chewable tablets (Fosrenol, generics), Velphoro chewable tablets, Auryxia tablets, or sevelamer carbonate tablets/powder for oral suspension (Renvela, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who are unable to chew and swallow tablets: approve if the patient has tried sevelamer carbonate powder for oral suspension (Renvela powder, generics), if formulary. If sevelamer carbonate powder for oral suspension (Renvela powder, generics) is non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Fotivda	tivozanib capsules	Renal Cell Carcinoma. Approve if the patient meets one of the following (1, 2, or 3): **1.** Patient has tried one of Inlyta, Lenvima, or Cabometyx. If none are formulary, approve; OR **2.** If there are toxicity concerns with a trial of Lenvima (and other concomitantly given medications), according to the prescriber, approve if the patient has tried Inlyta or Cabometyx. If neither are formulary, approve; OR **3.** Patient has already been started on therapy with Fotivda.
Fulvicin P/G	griseofulvin ultramicrosize 165 mg tablets	**1**. Approve if the patient has tried griseofulvin ultra 125 mg or 250 mg tablets, if formulary. If neither are formulary, approve. **2**. Approve if the prescribed dose cannot be obtained with whole tablets of the griseofulvin ultramicrosize 125 mg or 250 mg strengths. **3**. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use griseofulvin ultra 125 mg or 250 mg tablets. **4.** Approve if the patient has been started on a course of therapy with Fulvicin P/G (to allow for completion of a course of therapy).
Furoscix	furosemide subcutaneous injection by on-body infusor	For the treatment of edema in a patient ≥ 18 years of age with chronic heart failure or chronic kidney disease, including the nephrotic syndrome. Approve if the patient has tried at least one loop diuretic **[documentation required]** or the patient is currently taking a loop diuretic. Note: Examples of loop diuretics include furosemide, bumetanide, torsemide.
Fylnetra	pegfilgrastim-pbbk subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if there are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Udenyca, Ziextenzo, Nyvepria, or Stimufend **[documentation required]**; AND **Note:** If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Gilenya 0.25 mg	fingolimod capsule	Patient meets all of the following (A, B, C and D): A. Patient with relapsing form of multiple sclerosis; AND **Note:** Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		B. Patients ≥ 10 years of age; AND C. Patient weighs less than or equal to 40 kg **[documentation required]**; AND D. Patient has tried Tascenso 0.25 mg orally disintegrating tablets (ODT), if formulary. If Tascenso 0.25 ODT are non-formulary, approve.
Gimoti	metoclopramide nasal spray	No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Gimoti. (**NOTE**: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)
Glipizide 2.5 mg	glipizide 2.5 mg	Approve if the patient's prescribed dose cannot be obtained with glipizide 5 mg. Note: The patient is NOT required to split the 5 mg tablets in half.
GlucaGen/ GlucaGen HypoKit	glucagon, human recombinant for injection	**1.** Approve if the patient has tried TWO products from the following list: Baqsimi intranasal, Gvoke, or Zegalogue, if formulary (or only one if one is formulary). If none are formulary, approve. **2.** Patient is ≥ 2 years of age but < 6 years of age, approve if the patient has tried one of Baqsimi or Gvoke, if formulary. If neither are formulary, approve. **3.** Patient is < 2 years of age and ≥ 1 year of age, approve if the patient has tried Baqsimi, if formulary. If Baqsimi is non-formulary, approve. **4.** If the patient is < 1 year of age, approve.
Glucagon/Glucagon Emergency Kit	glucagon/glucagon Emergency Kit	**1.** Approve if the patient has tried TWO products from the following list: Baqsimi intranasal, Gvoke, or Zegalogue, if formulary (or only one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 2 years of age but < 6 years of age, approve if the patient has tried one of Baqsimi or Gvoke, if formulary. If neither are formulary, approve. **3.** If the patient is < 2 years of age and ≥ 1 year of age, approve if the patient has tried Baqsimi, if formulary. If Baqsimi is non-formulary, approve. **4.** If the patient is < 1 year of age, approve.
Other continuous glucose monitoring systems (receiver/reader, transmitter, sensor) [That are NOT Dexcom 6 or	Other continuous glucose monitoring systems (receiver/reader, transmitter, sensor) [That are NOT Dexcom 6 or	Patient meets the following *Diabetes – Continuous Glucose Monitoring Systems Prior Authorization Policy* criteria AND Patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried BOTH of the following systems, if formulary: 1) Freestyle Libre 2 or Freestyle Libre 3 AND 2) Dexcom G6 or Dexcom G7. If none are formulary, approve. Note: If only a Freestyle Libre product is formulary and the patient has tried a different Freestyle Libre product (e.g., Freestyle Libre 10- or 14 day- product), approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Freestyle Libre 2 or Freestyle Libre 3], this includes Bigfoot Unity Program Kit	Freestyle Libre 2 or Freestyle Libre 3]	Note: If only a Dexcom product is formulary and the patient has tried a different Dexcom product (e.g., Dexcom G4 or G5), approve. **2.** If the patient is using an insulin pump system that is not compatible with one of the formulary alternatives: approve.
Glumetza	metformin extended-release tablets	Approve if the patient has tried BOTH one metformin immediate-release tablet product AND two other formulary metformin extended-release products (if two are formulary or one if one is formulary): metformin extended-release tablets, or Fortamet (brand or generic). **Note:** A trial of Glumetza would NOT count toward this requirement.
Gocovri ER	amantadine extended-release capsules	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND meets one of the following (A or B): A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber; **[documentation required]**; OR B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber **[documentation required]**.
Hadlima	adalimumab-bwwd subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Hemady	dexamethasone 20 mg tablets	Approve if the patient has tried generic dexamethasone tablets, if formulary. If dexamethasone tablets are non-formulary, approve.
Hemangeol	propranolol hydrochloride 4.28 mg/mL oral solution	Proliferating infantile hemangioma. Approve if the patient has tried propranolol hydrochloride oral solution (20 mg/5mL) [NOT Hemangeol].
Hulio	adalimumab-fkjp subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary policies.*
Humalog	insulin lispro syringe, cartridge/Kwikpen/vial 100 units/mL, and Kwikpen 200 units/mL	**1.** If the patient is requesting Humalog vial 100 units/mL or Humalog Kwikpen 100 units/mL, direct the patient to Insulin Lispro (authorized generic of Humalog), if formulary. If Insulin Lispro (authorized generic of Humalog) is non-formulary, then approve if the patient meets one of the following (A or B): A. Patient meets all of the following (i, ii, and iii): i. Patient has tried Apidra, if formulary; AND

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		ii. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Fiasp; AND Note: If the patient has tried any product from ii. regardless of formulary status, criterion ii would be satisfied. iii. Patient has tried one of Admelog or Lyumjev, if formulary; OR Note: If the patient has tried any product from iii. regardless of formulary status, criterion iii would be satisfied. Note: If no products in i, ii, or iii are formulary, approve. B. Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve. **2.** If the patient is requesting Humalog cartridge, Humalog KwikPen U-200, or Tempo Pen, approve if the patient has tried Insulin Lispro (authorized generic of Humalog), if formulary. If Insulin Lispro (authorized generic of Humalog) is non-formulary, then approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Fiasp; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of Admelog or Lyumjev, if formulary. Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve.
Humalog Tempo Pen	insulin lispro 100 units/ml Tempo Pen	**1.** Approve if the patient meets the following (1, 2, and 3): Patient will use or is using Humalog Tempo Pen with the Tempo Smart Button; AND **2.** Patient has tried a rapid-acting insulin pen; AND **3.** Patient was unable to adhere to a regimen using a standard rapid-acting pen device, according to the prescriber **[documentation required]**. **Note:** Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.
Humatrope	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton. **[documentation required]**; AND Note: If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.
Humira	adalimumab injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Hycofenix	hydrocodone/ pseudophedrine/ guaifenesin oral solution	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): Tusnel C syrup, Virtussin DAC liquid. If none are formulary, approve if the patient has tried two other prescription or over-the-counter (OTC) cough and cold products.
Hydrocortisone - pramoxine suppository	hydrocortisone-pramoxine suppository 25-18 mg	Approve if the patient has tried one of 1) hydrocortisone acetate suppositories or 2) a rectal topical product containing hydrocortisone and pramoxine (e.g., topical foam, topical cream).
Hympavzi	marstacimab-hncq subcutaneous injection	Patient meets *Hemophilia – Hympavzi Prior Authorization Policy* criteria AND For Hemophilia A. **1.** Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Hympavzi. For Hemophilia B. Approve.
Hyrimoz	adalimumab-adaz subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary policies.*
Ibsrela	tenapanor tablets	Patient ≥ 18 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list: Linzess AND Trulance, if two are formulary or one if one is formulary. If neither are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Idacio and adalimumab-aacf	adalimumab-aacf subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Ilumya	tildrakizumab SC injection	See standard *Inflammatory Conditions (**Ilumya**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies OR FLEX Formulary* policies.
Impeklo	clobetasol propionate lotion, 0.05%	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. **Note:** Examples of topical steroid products include: desoximetasone, triamcinolone, desonide, betamethasone, clobetasol, fluocinonide, halobetasol, mometasone, halcinonide, diflorasone. **Note:** The five products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).
Impoyz	clobetasol propionate cream, 0.025%	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. **Note:** Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide, diflorasone. **Note:** The products must be chemically unique.
Imvexxy	estradiol vaginal insert	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Premarin vaginal cream, Femring vaginal ring, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** If according to the prescriber, the patient requires a low-dose vaginal product, approve if the patient has tried one of Estring or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve.
Inderal XL	propranolol hydrochloride capsule, extended release	**1.** Direct the patient to propranolol extended-release capsules. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic propranolol extended-release capsules.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Indocin Suppositories	indomethacin suppositories	No exceptions are recommended. There are multiple therapeutic alternatives available. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There are multiple therapeutic alternatives available.)
Indocin Suspension	indomethacin oral suspension	Approve if the patient has tried one of ibuprofen suspension (e.g., Motrin, generics) or naproxen suspension (e.g., Naprosyn, generics), if formulary. If neither are formulary, approve. **Note:** Over-the-counter ibuprofen suspension would count as an alternative, regardless of formulary status.
Innopran XL	propranolol hydrochloride capsule, extended release	**1.** Direct the patient to propranolol extended-release capsules. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic propranolol extended-release capsules.
Inpefa	sotagliflozin tablets	Patients with one of the following: 1) Heart Failure OR 2) Type 2 diabetes, Chronic Kidney Disease (CKD), and Other cardiovascular (CV) risk factors. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH Farxiga and Jardiance, if formulary (or one if one is formulary). If neither are formulary, approve.
Inqovi	decitabine and cedazuridine tablets	Chronic Myelomonocytic Leukemia; Myelodysplastic Syndrome/Myeloproliferative Neoplasm Overlap Syndrome; Myelodysplastic Syndromes (Note: Examples of myelodysplastic syndromes include: refractory anemia, refractory anemia with ringed sideroblasts, and refractory anemia with excess blasts.). **1.** Approve if the patient has tried decitabine injection (Dacogen, generics), if formulary. If decitabine injection (Dacogen, generics) is non-formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** Approve if the patient has already started therapy with Inqovi.
Inrebic	febratinib capsules	Myelofibrosis. Note: Myelofibrosis includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. **1.** Approve if the patient has tried Jakafi. If Jakafi is non-formulary, approve. **2.** Approve if the patient has already been started on Inrebic.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Accelerated or Blast Phase Myeloproliferative Neoplasm: approve. Myeloid/Lymphoid Neoplasms: approve.
Insulin Degludec	insulin degludec vial and FlexTouch pen U-100 and U-200	Patient is directed to use Tresiba (brand), if formulary. If Tresiba (brand) is non-formulary, approve if the patient meets 1, 2, 3, or 4 below: All patients < 6 years (Type 1, Type 2, all others). **1.** Patients < 6 years of age: approve. Type 2 Diabetes (Initial user and a Patient Currently Receiving Tresiba) [and all others]. **2**. Approve if the patient has tried one of Rezvoglar, Toujeo, Insulin glargine U300, Basaglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product above regardless of formulary status, this criterion would be satisfied. Note: If there are no formulary products in this criterion, approve. Type 1 Diabetes (Initial user). **3.** Patients with Type 1 diabetes- approve if the patient has tried one formulary product from the following list: Rezvoglar, Basaglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN), Toujeo, or Insulin glargine U300. If none are formulary, approve. Note: If the patient has tried any product from 3. regardless of formulary status, criterion 3 would be satisfied. Type 1 Diabetes, Continuation of therapy with Insulin Degludec or Tresiba. **4.** If the patient has Type 1 diabetes and is currently taking Tresiba or Insulin Degludec, approve.
Insulin glargine U300	insulin glargine U-300 SoloStar pen	Direct to Toujeo (brand), if formulary. If Toujeo (brand) is non-formulary, approve if the patient meets (1, 2, 3 or 4): Type 2 Diabetes, (initial user) OR taking Toujeo/Insulin glargine U300 < 100 Units/injection (all others taking < 100 units/injection). **1.** Approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a. would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Type 2 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300 ≥ 100 units per injection (and all others taking ≥ 100 units/injection). **2.** Patients currently taking Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection, approve if the patient has tried one of Tresiba U-200 or Insulin Degludec U-200, if formulary. If neither are formulary, approve. Note: If the patient has tried either product listed in 2. regardless of formulary status, criterion 2 would be satisfied. Note: A patient who has previously tried Tresiba U-100 is not required to try Tresiba U-200. Type 1 Diabetes (initial user). **3.** Patients with Type 1 diabetes- approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300. **4.** Patients with Type 1 diabetes currently taking Toujeo or Insulin glargine U300- approve if the patient meets the following (a or b): a. Patient has tried one of Rezvoglar, Basaglar, Semglee (YFGN), Insulin Glargine (YFGN), or Lantus, if formulary. If none are formulary, approve; OR Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient is currently receiving a Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection.
Insulin Lispro JR	Insulin lispro JR	Direct the patient to Humalog JR (brand). If Humalog JR (brand) is non-formulary, approve if the patient meets the following (A or B): A. Patient meets the following (i, ii, and iii): i. Patient has tried Apidra, if formulary; AND ii. Patient has tried one of the following, if formulary: Novolog, Insulin Aspart (authorized generic of Novolog), or Fiasp; AND iii. Patient has tried Admelog, if formulary; OR B. Patient requires ½ unit dosing.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: If no products in A i, ii, or iii are formulary, approve. **Note:** The same product with different dosage forms count as one alternative (e.g., Fiasp vial, Fiasp Flextouch, Fiasp penfil would all count as one alternative).
Insulin Lispro Mix 75/25	75% Insulin lispro protamine/ 25% insulin lispro Kwikpen	Direct the patient to Humalog 75/25 (brand), if formulary. If Humalog 75/25 (brand) is non-formulary, approve if the patient has tried one of Novolog 70/30 or Insulin Aspart Protamine-Insulin Aspart Mix if formulary. If neither are formulary, approve.
Intrarosa	prasterone vaginal inserts	**1.** Approve if the patient has tried one formulary alternative from the following list: Imvexxy, Femring vaginal ring, Premarin Cream, Estring vaginal ring, estradiol 0.01% cream (Estrace cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** Approve if, according to the prescriber, the patient is at an increased risk of endometrial cancer, stroke, or deep vein thrombosis (DVT).
Invega Hafyera	paliperidone palmitate extended-release injectable suspension	**1.** Approve if the patient has been established on therapy with Invega Sustenna for ≥ 4 months OR Invega Trinza for ≥ one 3-month cycle AND the prescriber attests the patient requires an extended dosing interval due to a demonstrated significant concern for non-adherence with a 4-week or 3-month dosing interval. **Note**: Invega Sustenna/Invega Trinza Formulary Exception Criteria will apply. **2.** Approve if the patient has already been started on therapy with Invega Hafyera.
Invokamet	canagliflozin and metformin tablets	**1.** Approve if the patient has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet XR, Synjardy, Synjardy XR, Segluromet, or Xigduo XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if only one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative. **2.** Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried BOTH of 1) Synjardy and 2) one of dapagliflozin-metformin ER tablets (authorized generic of Xigduo XR), or Xigduo XR (brand), if formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1)

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary, approve.
Invokamet XR	canagliflozin and metformin extended-release tablets	**1.** Approve if the patient has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet (not XR), Synjardy, Synjardy XR, Xigduo XR, or Segluromet. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative. **2.** Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried BOTH of 1) Synjardy and 2) one of dapagliflozin-metformin ER tablets (authorized generic of Xigduo XR), or Xigduo XR (brand), if formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary, approve.
Invokana	canagliflozin tablets	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list (or one if only one is formulary): Farxiga and Jardiance. If neither are formulary, approve. **2.** If Invokana is being used for glycemic control and the patient's estimated glomerular filtration rate is less than 45 mL/minute, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with Jardiance, if formulary. If Jardiance is non-formulary, approve.
Iqirvo	elafibranor tablets	Primary Biliary Cholangitis. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Livdelzi, if formulary. If Livdelzi is non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Isturisa	osilodrostat tablets	Cushing's Disease in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. Patient has tried, or is currently taking, one of Signifor or Signifor LAR. If neither are formulary, approve; OR B. Patient has already been started on Isturisa. Endogenous Cushing's Syndrome in a patient ≥ 18 years of age. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. Approve if the patient meets one of the following (A or B): A. Patient has tried, or is currently taking, one of Signifor, Signifor LAR, ketoconazole, Metopirone (metyrapone capsules), Recorlev, or mifepristone (Korlym, generics). If none are formulary, approve; OR B. Patient has already been started on Isturisa. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product.
Iyuzeh	latanoprost ophthalmic solution, 0.005%; preservative-free	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of 1) latanoprost ophthalmic solution (Xalatan, generics) or 2) Xelpros, if formulary. If none are formulary, approve. **2.** If according to the prescriber, the patient has a significant benzalkonium chloride allergy/sensitivity: approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Xelpros, if formulary. If Xelpros is non-formulary, approve. **3.** If, according to the prescriber, the patient has a significant allergy/sensitivity to other preservatives (OTHER than benzalkonium chloride), approve.
Izervay	avacincaptad pegol intravitreal injection	See standard *Ophthalmology – Izervay Prior Authorization Policy* criteria.
Jaypirca	pirtobrutinib tablets	Mantle cell lymphoma. **1.** Approve if the patient has tried one of Brukinsa or Calquence. If neither are formulary, approve. **2.** Patient has already been started on Jaypirca therapy, approve. Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		1. Approve if the meets BOTH of the following (A and B): A. Patient has tried one of Brukinsa or Calquence; AND Note: If the patient had tried Imbruvia, this would also satisfy criterion A. Note: If neither Brukinsa nor Calquence are formulary, would still need to meet criterion B. B. Patient meets one of the following (i or ii): i. Patient has tried Venclexta; OR Note: If Venclexta is non-formulary, would still need to meet criterion A. ii. Patient is not a candidate for rituximab or Gazyva (obinutuzumab). **2.** Patient has already been started on Jaypirca therapy, approve. Richter's Transformation to Diffuse Large B-Cell Lymphoma; Marginal Zone Lymphoma: Approve. Note: Marginal zone lymphoma includes gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma.
Jentadueto	linagliptin and metformin tablets	**1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto XR, alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, saxagliptin tablets (Onglyza, generics), or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). **Note:** Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried ONE of Jentadueto XR, Janumet or Janumet XR, if one is formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). **Note:** A brand product and its generic or authorized generic would count as one alternative.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Jentadueto XR	linagliptin and metformin extended-release tablets	**1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list: (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto (NOT XR), alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, saxagliptin tablets (Onglyza, generics), or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). **Note:** Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure or renal impairment: approve if the patient has tried one of Jentadueto (NOT XR), Janumet or Janumet XR, if formulary**.** If **n**one are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). **Note:** A brand product and its generic or authorized generic would count as one alternative.
Jesduvroq	daprodustat tablets	Treatment of anemia due to chronic kidney disease in a patient ≥ 18 years of age. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has been receiving dialysis for at least 4 months; AND **2.** Patient meets ONE of the following (A or B): A. If Vafseo is formulary, patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Vafseo; OR B. If Vafseo is non-formulary, patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of the following: an epoetin alfa product or Aranesp or Mircera. Note: Examples of epoetin alfa products are Procrit, Epogen, and Retacrit.
Jylamvo	methotrexate 2 mg/mL oral solution	Approve if the patient has tried Xatmep, if formulary. If Xatmep is non-formulary, approve if the patient meets one of the following (1 or 2):

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		1. Patient cannot swallow or has difficulty swallowing oral methotrexate tablets; OR **2.** The dose prescribed cannot be obtained using whole methotrexate tablets.
Kapspargo Sprinkle	metoprolol succinate extended-release capsules	**1.** Approve if the patient has tried metoprolol succinate extended-release tablets, if formulary. If non-formulary, approve. **2.** If the patient requires a dosage form which can be opened and sprinkled for alternative administration (e.g., for patients unable to swallow capsules, for nasogastric tube administration), approve.
Katerzia	amlodipine oral suspension	**1.** Direct the patient to amlodipine tablets. **2.** If the patient is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the patient has tried Norliqva oral solution, if formulary. If Norliqva oral solution is non-formulary, approve.
Kazano	alogliptin and metformin tablets	Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto, Jentadueto XR, Janumet, Janumet XR, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), alogliptin tablets (Nesina, authorized generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). **Note:** Jentadeuto and Jentadueto XR would count as one alternative. Janumet and Janumet XR would count as one alternative. A brand product and its generic or authorized generic would count as one alternative.
Keveyis and generics (including dichlorphenamide tablets, Ormalvi)	dichlorphenamide tablets	Approve if the patient has tried one of dichlorphenamide tablets or Ormalvi, if formulary. If BOTH dichlorphenamide tablets and Ormalvi are non-formulary, or generic dichlorphenamide or Ormalvi is being requested, approve if the patient meets one of the following (1 or 2): **1.** For the treatment of primary hyperkalemic periodic paralysis (HyperPP), primary hypokalemic periodic paralysis (HypoPP), and related variants: approve if the patient has tried one of acetazolamide tablets (generics) or acetazolamide ER capsules, if one is formulary. If neither are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. For the treatment of primary hyperkalemic periodic paralysis (HyperPP), primary hypokalemic periodic paralysis (HypoPP), and related variants: approve if the patient has been started on therapy with Keveyis, Ormalvi or dichlorphenamide.
Kevzara	sarilumab subcutaneous injection	See standard *Inflammatory Conditions (**Kevzara**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.
Kineret	anakinra SC injection	See standard *Inflammatory Conditions (**Kineret**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.
Kisqali	ribociclib tablets	See standard *Oncology – Kisqali and Kisqali Femara Co-Pack Prior Authorization Policy* criteria.
Kisqali-Femara Co-Pack	ribociclib tablets and letrozole tablets	See standard Oncology – Kisqali and Kisqali Femara Co-Pack Prior Authorization Policy criteria.
Klisyri	tirbanibulin ointment 1%	Approve if the patient has tried two of the following products: diclofenac 3% gel, a fluorouracil-containing product (e.g., fluorouracil cream, Carac, fluorouracil topical solution), or an imiquimod-containing product (e.g., imiquimod 5% cream, Zyclara).
Kombiglyze XR	saxagliptin plus metformin extended-release tablets	If requesting brand Kombiglyze XR: Approve if the patient has tried generic Kombiglyze XR tablets (saxagliptin plus metformin ER tablets), if formulary. If requesting brand Kombiglyze XR and generic Kombiglyze XR tablets (saxagliptin plus metformin ER tablets) are non-formulary (or if requesting generic Kombiglyze), approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, Janumet, or Janumet XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin tablets (Onglyza, generic), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). **Note:** Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		one alternative. Janumet and Janumet XR would count as one alternative. A brand product and its generic or authorized generic would count as one alternative.
Konvomep	omeprazole and sodium bicarbonate oral suspension	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). Note: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, dexlansoprazole DR capsules (Dexilant DR capsules, generics), esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole orally disintegrating tablets (Prevacid SoluTab, generics), omeprazole DR capsules, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried four proton pump inhibitors (PPIs) from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): 1) rabeprazole sprinkle; 2) an esomeprazole product (esomeprazole DR capsules [Nexium, generics], esomeprazole packet [Nexium granules for oral suspension, generic]); 3) pantoprazole suspension (granules) [Protonix suspension, generic]; 4) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid Solutab, generics]); 5) an omeprazole product (omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.
Korlym	mifepristone 300 mg tablets	Endogenous Cushing's Syndrome in a patient ≥ 18 years of age. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. Approve in patients who meet the following criteria (A and B): A. Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance; AND B. The patient meets ONE of the following (1 or 2): 1. Patient has tried, or is currently taking one product from the following list : ketoconazole tablets, Recorlev, Isturisa, Metopirone capsules, or Signifor/Signifor LAR injection. If none are formulary, approve; OR Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. 2. The patient has already been started on Korlym therapy.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Krazati	adagrasib tablets	Non-Small Cell Lung Cancer - KRAS G12C-mutated. **1.** Approve if the patient has tried Lumakras. If Lumakras is non-formulary, approve. **2.** Patient with brain metastases, approve. **3.** Approve if the patient has already been started on therapy with Krazati. Colon or Rectal Cancer - KRAS G12C-mutated. **1.** Approve if the patient has tried Lumakras. If Lumakras is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Krazati OR has already been started on therapy with Erbitux. Ampullary Adenocarcinoma - KRAS G12C-mutated; Biliary Tract Cancer - KRAS G12C-mutated; Pancreatic Adenocarcinoma - KRAS G12C-mutated; Small Bowel Adenocarcinoma - KRAS G12C-mutated: Approve.
Kyzatrex and Undecatrex	testosterone undecanoate capsules	Approve if the patient has tried both of Jatenzo and Tlando capsules, if formulary (or one if one is formulary). If neither are formulary, approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).
labetalol 400 mg tablets	labetalol 400 mg tablets	**1.** Direct the patient to labetalol 100 mg, 200 mg, or 300 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the labetalol 100 mg, 200 mg, or 300 mg tablets.
Lampit	nifurtimox tablets	1. Approve if the patient has tried benznidazole, if formulary. If benznidazole is non-formulary, approve. 2. Approve if the patient is less than 2 years of age. 3. Approve if the patient has already started on therapy with Lampit.
Lantus and Insulin glargine (by Winthrop, A-S Medication)	insulin glargine U-100 vial and SoloStar device	**1.** Patient is directed to use Semglee (YFGN) or Insulin glargine (YFGN) [authorized generic of Semglee {YFGN}], if formulary. If neither are formulary, approve. **2.** Approve if the patient has tried and cannot use Semglee (YFGN) or Insulin glargine (YFGN) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **Note:** If the patient had a trial of Insulin glargine (YFGN) and cannot use due to a formulation difference, an additional trial of Semglee (YFGN) would not be required and vice-versa, regardless of the formulary status of these products.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
ledipasvir / sofosbuvir tablets 90 mg/400 mg (Authorized generic for Harvoni)	ledipasvir/ sofosbuvir tablets 90 mg/400 mg	Patient is directed to use Harvoni 90 mg/400 mg. If Harvoni 90 mg/400 mg is non-formulary, approve.
Leqvio	inclisiran subcutaneous injection	Established Cardiovascular Disease; Heterozygous Familial Hypercholesterolemia; Primary Hyperlipidemia (all diagnoses in a patient ≥ 18 years of age). Approve if the patient has tried Repatha or Praluent, if formulary. If neither are formulary, approve.
Levemir	insulin detemir U-100 vial and FlexTouch pen	Type 2 Diabetes (Initial user and a patient Currently Receiving Levemir); AND Type 1 Diabetes (Initial user) [and all others]. **1.** Approve if the patient meets the following (a and b): **a.** Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a. would be satisfied. **b.** Patient has tried one of Rezvoglar, Toujeo, Basaglar, Lantus, Insulin Glargine (YFGN), or Semglee (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b. would be satisfied. Note: If there are no formulary products in a or b, approve. **2.** Patients < 6 years of age: approve if the patient has tried one of Tresiba or Insulin Degludec, if formulary. If neither are formulary, approve. Note: If the patient has tried either product listed in 2. regardless of formulary status, criterion 2. would be satisfied. **3.** Pregnant patients: approve. Type 1 Diabetes, Continuation of Therapy with Levemir. **4.** If the patient has Type 1 diabetes and is currently taking Levemir, approve.
Lexette and halobetasol propionate 0.05% topical foam	halobetasol propionate topical foam 0.05%	Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. **Note:** Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. **Note:** The products must be chemically unique.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Librax	chlordiazepoxide/ clidinium bromide capsules	Approve if the patient has tried clidinium-chlordiazepoxide capsules. If clidinium-chlordiazepoxide capsules are non-formulary, approve.
Likmez	metronidazole oral suspension	**1.** Direct the patient to metronidazole tablets. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.
Liqrev	sildenafil oral suspension 10 mg/mL	Pulmonary arterial hypertension World Health Organization Group 1. **1.** Direct the patient to sildenafil powder for oral suspension 10 mg/mL (Revatio oral suspension, generics), if formulary. **2.** Approve if, according to the prescriber, there is a significant clinical concern (e.g., a significant allergy or serious adverse reaction due to inactive ingredients) such that the patient is unable to use sildenafil powder for oral suspension 10 mg/mL (Revatio oral suspension, generics). **3.** If sildenafil powder for oral suspension (10 mg/mL) is non-formulary, approve if the patient meets one of the following (A or B): A. Patient has tried Tadliq, if formulary. If Tadliq is non-formulary, approve; OR **Note:** This criterion would also be satisfied if the patient tried any other tadalafil product. B. Patient has already been started on a sildenafil product (e.g., sildenafil tablets or suspension, Revatio, or Liqrev).
Lispro (authorized generic to Humalog)	Insulin lispro vial/ Kwikpen	Direct the patient to brand Humalog, if formulary. If brand Humalog is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): 1. Patient has tried Apidra, if formulary; AND 2. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Fiasp; AND **Note:** If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. 3. Patient has tried one of Admelog or Lyumjev, if formulary; OR **Note:** If the patient has tried any product from C. regardless of formulary status, criterion C would be

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		satisfied. **Note:** If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.
Lo Loestrin FE	ethinyl estradiol 0.01 mg; norethindrone acetate 1 mg; ferrous fumarate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried two other oral contraceptive agents. Note: Examples include, but may not be limited to, Hailey Fe, Junel Fe, Larin Fe, Mibelas 24 Fe, Microgestin Fe, norethindrone-ethinyl estradiol-iron. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried two other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Hailey Fe, Junel Fe, Larin Fe, Mibelas 24 Fe, Microgestin Fe, norethindrone-ethinyl estradiol-iron. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.
Lodoco	colchicine 0.5 mg tablets	Atherosclerotic Disease. Approve if the patient meets ALL of the following (1, 2, 3, and 4): **1.** Patient is ≥ 18 years of age; AND **2.** Lodoco is being added onto a background regimen(s) of other atherosclerotic disease medication(s) **[documentation required]**; AND Note: Examples of medications recommended in guideline-directed therapy for patients with atherosclerotic disease can include aspirin, antiplatelet agents (e.g., clopidogrel, Brilinta [ticagrelor tablets]), anticoagulants, lipid-lowering agents (e.g., statins such as atorvastatin and rosuvastatin), beta blockers, angiotensin-converting enzyme inhibitors, and/or angiotensin receptor blockers. **3.** Patient has a creatinine clearance ≥ 50 mL/min; AND **4.** Patient has tried colchicine 0.6 mg tablets or capsules **[documentation required]**.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Lofena and authorized generic diclofenac potassium [Authorized generic only]	diclofenac potassium tablets	**1.** Approve if the patient has tried five prescription-strength, oral NSAIDS. **Note:** Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note:** Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note:** Five unique NSAIDs should be tried.
Loreev XR	lorazepam extended-release capsules	**1.** Direct the patient to use lorazepam tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use lorazepam immediate-release tablets.
Lorzone	chlorzoxazone tablets	Approve if the patient has tried and cannot take generic chlorzoxazone tablets, if formulary. If generic chlorzoxazone tablets are non-formulary, approve.
Lucemyra	lofexidine tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with clonidine.
Lumigan	bimatoprost 0.01% ophthalmic solution	Approve if the patient has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): latanoprost ophthalmic solution (Xalatan, generics), bimatoprost 0.03% ophthalmic solution (generics), travoprost ophthalmic solution (Travatan Z, generics), Vyzulta, or tafluprost ophthalmic solution (Zioptan, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Lupkynis	voclosporin capsules	Lupus nephritis: **1.** Approve if the medication is being used concurrently with an immunosuppressive regimen; OR **Note:** For example, mycophenolate mofetil or azathioprine with a systemic corticosteroid. **2.** Approve if the patient has already been started on Lupkynis.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Luzu and authorized generic (luliconazole 1% cream) [Authorized generic only]	luliconazole 1% cream	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. **Note:** Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.
Lybalvi	olanzapine and samidorphan tablets	**1.** Approve if the patient has tried two oral antipsychotics (e.g., olanzapine tablets, aripiprazole tablets [Abilify, generics], Fanapt tablets, ziprasidone capsules [Geodon, generics], paliperidone ER tablets [Invega, generics], risperidone tablets/orally disintegrating tablets [ODT] {Risperdal, generics}, asenapine sublingual tablets [Saphris, generics], quetiapine tablets [Seroquel, generics], quetiapine extended-release tablets [Seroquel XR, generics], Rexulti tablets, Vraylar capsules, olanzapine tablets/ODT [Zyprexa/Zydis, generics], Caplyta, Latuda). **2.** Approve if the patient is currently taking Lybalvi. **3.** Approve if the patient has taken Lybalvi at any time in the past.
Lyumjev Tempo Pen	insulin lispro-aabc 100 units/ml Tempo Pen	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using Lyumjev Tempo Pen with the Tempo Smart Button; AND **2.** Patient has tried a rapid-acting insulin pen; AND **3.** Patient was unable to adhere to a regimen using a standard rapid-acting pen device, according to the prescriber **[documentation required]**. **Note:** Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.
Lyvispah	baclofen oral granules	**1.** Direct the patient to oral baclofen tablets. **2.** If Lvyispah will be administered via a feeding tube, approve. **3.** Patient is unable to or has difficulty swallowing oral tablets, approve if the patient has tried one of 1) Ozobax solution or 2) baclofen 25mg/5ml oral suspension (Fleqsuvy suspension, generics), if formulary. If neither are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Mavyret	glecaprevir/ pibrentasvir tablets	See *Hepatitis C Virus Direct Acting Antivirals Preferred Specialty Management (PSM) for National Preferred Formulary and Basic Formulary (Mavyret Criteria)*
Maxidex	dexamethasone 0.1% ophthalmic suspension	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary or one if one is formulary): 1) dexamethasone (generics), 2) difluprednate (Durezol, generics), 3) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 4) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), or 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild). If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): 1) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Meloxicam suspension	meloxicam suspension	Approve if the patient has tried one of ibuprofen suspension (e.g., Motrin, generics) or naproxen suspension (e.g., Naprosyn, generics), if formulary. If neither are formulary, approve. **Note**: Over-the-counter ibuprofen suspension would count as an alternative, regardless of formulary status.
Menest	esterified estrogens tablets	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: estradiol tablets (Estrace, generics) and Premarin tablets. If neither are formulary, approve.
metaxalone 640 mg tablet	metaxalone 640 mg tablet	**1.** Approve if the patient has tried and cannot take one of metaxolone 400 mg or 800 mg tablets. **2.** According to the prescriber, there is a significant clinical concern such that the patient is unable to use metaxolone 400 mg or 800 mg tablets.
metformin immediate release 625 mg	metformin immediate-	Approve if the patient had inadequate efficacy OR significant intolerance with metformin 500 mg, 850 mg, or 1000 mg immediate-release tablets.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
	release tablet 625 mg	
Methocarbamol 1,000 mg tablets (brand)	methocarbamol 1,000 mg tablets	**1.** Direct the patient to methocarbamol 500 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the methocarbamol 500 mg tablets.
Minolira and authorized generic	minocycline ER tablet	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve.
Motegrity	prucalopride tablets	Patient ≥ 18 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list: Linzess AND Trulance **[documentation required]**, if two are formulary or one if one is formulary. If neither are formulary, approve.
Motpoly XR	lacosamide extended-release capsules	Approve if the patient is unable to use lacosamide immediate-release tablets (Vimpat tablets, generics), if formulary. If lacosamide immediate-release tablets (Vimpat tablets, generics) are non-formulary, approve.
Mulpleta	lusutrombopag tablets	Mulpleta is being used pre-procedure and the patient has thrombocytopenia and chronic liver disease. **1.** Approve if the patient has tried Doptelet, if formulary. If Doptelet is non-formulary, approve. **2.** Approve if the patient has already started a course of therapy with Mulpleta in order to finish the course.
Mytesi	crofelemer delayed-release tablets	For the symptomatic relief of non-infectious diarrhea in adult patients with Human immunodeficiency virus (HIV) or Acquired immunodeficiency syndrome (AIDS): Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both diphenoxylate-atropine tablets AND loperamide.
Natal PNV	ascorbic acid, cholecalciferol, thiamine hydrochloride, riboflavin,pyridoxal phosphate,levomefolate glucosamine, folic acid, methylcobalamin, calcium	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
	carbonate, ferrous gluconate, potassium iodide tablet, film coated	
Natazia	dienogest; estradiol valerate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.
Natesto	testosterone nasal gel	Approve if the patient has tried three other topical testosterone products (e.g., Androgel 1% or generics, Axiron [generics only], Androgel 1.62% or generics, Fortesta or generics, Testim or generics, Vogelxo or generics.)
Nesina and authorized generic	alogliptin tablets	Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): saxagliptin (Onglyza, generics), Tradjenta, or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Saxagliptin and Onglyza count as one alternative. Januvia and Zituvio would count as one alternative.
Neulasta	pegfilgrastim injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Fulphila, Udenyca, Ziextenzo, Nyvepria, Fylnetra, or Stimufend **[documentation required]**; AND **Note:** If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Nevanac	nepafenac ophthalmic suspension 0.1%	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), ketorolac ophthalmic solution (Acular, Acular LS, generics), Acuvail, Ilevro, or a bromfenac product (0.09% ophthalmic solution [generics], bromfenac ophthalmic solution 0.07% [Prolensa, generics], or bromfenac 0.075% [BromSite, generics]). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): bromfenac 0.075% (BromSite, generics), diclofenac ophthalmic solution (generics), Ilevro, ketorolac ophthalmic solution (Acular, Acular LS, generics), or Acuvail. If none are formulary, approve. **3.** Patients < 18 years of age: approve if the patient has tried ketorolac ophthalmic solution (Acular, Acular LS, generics) or Ilevro, if one is formulary. If neither are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Nexiclon XR and authorized generic	clonidine ER tablet and authorized generic	Approve if the patient tried and is unable to use both clonidine immediate-release tablets AND clonidine transdermal patches.
Nexium packet (granules for oral suspension) 5 mg and 2.5 mg packets	esomeprazole delayed-release granules for oral suspension (packet)	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules, Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		3. Patients < 1 year of age: approve if the patient has tried Prilosec DR suspension, if formulary. If Prilosec DR suspension is non-formulary, approve. **Note**: The requested agent would NOT count as a trial of an alternative.
Nextstellis	estetrol and drospirenone tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.
Nitrofurantoin 50 mg/5 ml suspension (brand)	nitrofurantoin 50 mg/5 ml suspension	**1.** Direct to nitrofurantoin 25 mg/5 ml oral suspension. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the nitrofurantoin 25 mg/5 ml oral suspension.
Noctiva	desmopressin acetate nasal spray for intranasal use	See standard *Desmopressin Products – Noctiva Prior Authorization with Step Therapy Policy* criteria.
Norditropin Flexpro	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.
Noritate	metronidazole cream 1%	**1.** Direct the patient to a topical metronidazole product. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical metronidazole agent. **Note:** Examples of topical metronidazole products include metronidazole 0.75% cream (MetroCream, generics), metronidazole 0.75% or 1% gel (Metrogel, generics), metronidazole 0.75% lotion (MetroLotion, generics).
Norliqva	amlodipine oral solution	**1.** Direct the patient to amlodipine tablets. **2.** If the patient is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the patient has tried Katerzia oral suspension, if formulary. If Katerzia oral suspension is non-formulary, approve.
Norpace and disopyramide capsules	disopyramide phosphate capsules	**1.** Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol). **2.** Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.
Norpace CR	disopyramide extended-release capsule	**1.** Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol). **2.** Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.
Northera and generic droxidopa capsules	droxydopa capsules	Neurogenic Orthostatic Hypotension. Approve if the patient has tried two of the following products: 1) midodrine tablets, 2) fludrocortisone tablets, 3) dihydroergotamine injection/nasal spray, 4) indomethacin capsules/injection, 5) pyridostigmine tablets, or 6) atomoxetine.
Novacort gel	hydrocortisone 2%/ pramoxine 1%/ aloe 1% gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Epifoam, hydrocortisone-pramoxine cream, Pramosone cream, Pramosone lotion, or Pramosone ointment. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Novolin 70/30 Flexpen and Relion Novolin 70/30 Flexpen	insulin, 70/30 pen	**1.** Approve if the patient has tried Humulin 70/30 Kwikpens or Humulin 70/30 vials, if formulary. If both Humulin 70/30 Kwikpens and Humulin 70/30 vials are non-formulary, approve. **2.** If only Humulin 70/30 vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.
Novolin 70/30 vials and Relion Novolin 70/30 vials	insulin, 70/30 vials	Approve if the patient has tried Humulin 70/30 vials or Humulin 70/30 Kwikpens, if formulary. If both Humulin 70/30 vials and Humulin 70/30 Kwikpens are non-formulary, approve.
Novolin N Flexpen and Relion Novolin N Flexpen	insulin, NPH pen	**1.** Approve if the patient has tried Humulin N Kwikpens or Humulin N vials, if formulary. If both Humulin N Kwikpens and Humulin N vials are non-formulary, approve. **2.** If only Humulin N vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.
Novolin N vials and Relion Novolin N vials	insulin, NPH vials	Approve if the patient has tried Humulin N vials or Humulin N Kwikpens, if formulary. If both Humulin N vials and Humulin N Kwikpens are non-formulary, approve.
Novolin R Flexpen and Relion Novolin R U-100 Flexpen	insulin, regular pen	**1.** Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve. **2.** Approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disable), or have coordination issues.
Novolin R U-100 vials and Relion Novolin R vials	insulin, regular vials	Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve.
NovoLog 70/30 and authorized generic (insulin aspart protamine-	insulin aspart protamine/ insulin aspart, Flexpen	Approve if the patient has tried Humalog 75/25, if formulary. If Humalog 75/25 is non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
insulin aspart) and Relion Novolog 70/30	(prefilled syringe)/ vial	
NovoLog and authorized generic (insulin aspart) and Relion Novolog	insulin aspart syringe, cartridge/ Flexpen (prefilled syringe)/ vial	Approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried Fiasp, if formulary; AND C. Patient has tried one of following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.
Nucynta	tapentadol immediate-release tablets	**1.** Approve if the patient has tried three other oral immediate-release (NOT long-acting) centrally acting/opioid analgesics. Examples of oral immediate-release (NOT long-acting) centrally acting/opioid analgesics include, but are not limited to: hydromorphone (Dilaudid, generics), oxycodone hydrochloride tablets (Roxicodone, generics), oxymorphone (generics), morphine (generics), hydrocodone/acetaminophen (Vicodin, Vicodin ES, Norco, Lortab, Lorcet, multiple generics), oxycodone/acetaminophen (Percocet, Endocet, Roxicet, multiple generics), tramadol (Ultram, generics), tramadol/acetaminophen (Ultracet, generics). **Note:** A trial of the requested product does not count toward this requirement. **2.** Patients ≥ 6 years of age to < 18 years of age, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried one of morphine sulfate immediate-release tablets or morphine sulfate immediate-release oral solution. If neither are formulary, approve; OR B. Patient has renal insufficiency; OR C. Patient is intolerant or allergic to morphine.
Nucynta ER	tapentadol extended-release tablets	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], OxyContin, oxycodone ER tablets [generics], Xtampza ER, hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release tablets, or hydrocodone ER (Zohydro ER, Hysingla ER, generics).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, Xtampza ER, or oxycodone ER tablets (generics). If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, Xtampza ER, or oxycodone ER tablets (generics). If none are formulary, approve.
Nutropin AQ Nuspin	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Omnitrope, Saizen, or Zomacton. **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.
Nypozi	filgrastim-txid subcutaneous or intravenous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (A and B): A. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Neupogen, Releuko, Zarxio, Nivestym, or Granix **[documentation required]**; AND Note: If none are formulary, approve. B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets the following (A and B): A. Patient has tried one of Neupogen, Releuko, Zarxio, or Nivestym **[documentation required]**, if formulary; AND Note: If none are formulary, approve. B. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Nyvepria	pegfilgrastim-apgf	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Udenyca, Ziextenzo, Fylnetra, or Stimufend **[documentation required]**; AND **Note:** If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Obredon	hydrocodone/ guaifenesin oral solution	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine/guaifenesin oral solution (generics), Guaifenesin AC syrup, guaifenesin with codeine syrup (generics), Mar-Cof CG liquid, M-Clear WC liquid, Ninjacof XG liquid, Virtussin AC liquid. If none are formulary, approve if the patient has tried two other prescription or over-the-counter (OTC) cough and cold products.
Ojjaara	momelotinib tablets	Myelofibrosis. Note: This includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. **1.** Approve if the patient has tried Jakafi. If Jakafi is non-formulary, approve. Note: If the patient has tried Vonjo, this would satisfy requirement for approval. **2.** If the patient has myelofibrosis anemia, approve. **3.** Approve if the patient has already started on therapy with Ojjaara. Accelerated or Blast Phase Myeloproliferative Neoplasm: approve.
Olumiant	baricitinib tablets	See standard *Inflammatory Conditions (**Olumiant**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.
ondansetron ODT 16 mg (brand)	ondansetron ODT 16 mg	Approve if the patient has tried ondansetron ODT 4 mg or ondansetron ODT 8 mg AND is unable to continue to use these products. If both ondansetron ODT 4 mg and ondansetron ODT 8 mg are non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Omnaris	ciclesonide nasal spray	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Qnasl, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
Ongentys	opicapone capsules	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with entacapone tablets (Comtan, generics). If entacapone tablets (Comtan, generics) are non-formulary, approve. **2.** If the patient has been on Ongentys for more than one month, approve.
Onglyza	anagliptin tablets	If requesting brand Onglyza: Approve if the patient has tried saxagliptin tablets (generic for Onglyza), if formulary. If requesting brand Onglyza and generic saxagliptin tablets are non-formulary (or if requesting generic Onglyza), approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Alogliptin and Nesina count as one alternative. Januvia and Zituvio count as one alternative.
Onureg	azacitadine tablets	Acute Myeloid Leukemia: Approve if the patient meets ONE of the following (1 OR 2): 1. Patient is ≥ 18 years of age and using the medication for post-remission maintenance; OR 2. The patient has been started on therapy with Onureg. Peripheral T-Cell Lymphoma: Approve.
Onzetra Xsail	sumatriptan nasal powder	Approve if the patient meets both of the following (a and b): a. Patient has tried one of sumatriptan nasal spray (Imitrex Nasal Spray, generics) or Tosymra, if formulary; AND b. Patient has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary. **Note:** If no products from a. or b. are formulary, approve.
Opipza	aripiprazole oral film	Approve if the patient has tried and cannot take ONE of aripiprazole ODT or aripiprazole oral solution. If neither are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Oracea	doxycycline capsules 40 mg	Inflammatory Rosacea. Approve if the patient meets both of the following (A and B): A. Patient has tried two of the following: 1) a topical metronidazole-containing product, 2) a topical azelaic acid-containing product or 3) topical ivermectin; AND B. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, has experienced inadequate efficacy with one other generic, oral doxycycline product after a 4 week duration with the product; OR ii. Patient has tried, and according to the prescriber, has experienced a significant intolerance with one other generic, oral doxycycline product.
Orencia IV	abatacept injection for intravenous use	Juvenile Idiopathic Arthritis; Psoriatic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: a tocilizumab product (e.g., Actemra intravenous [IV] or subcutaneous), a sarilumab product (Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab IV product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya), or a ustekizumab product (e.g., Stelara SC). If none are formulary, approve. **2.** According to the prescriber, the patient previously experienced a serious infection: Approve. **3.** Patient is currently taking Orencia intravenous or subcutaneous: Approve if the patient has been established on Orencia intravenous or subcutaneous for ≥ 3 months. **4.** Patient has been started on Orencia intravenous or subcutaneous for < 3 months: Refer to the appropriate criteria above. Graft-Versus-Host Disease – Prevention: Approve.
Orencia for SC use	abatacept injection for subcutaneous use	See standard *Inflammatory Conditions (**Orencia SC**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies OR FLEX Formulary* policies.
Oseni and authorized generic	alogliptin and pioglitazone tablets	Approve if the patient has tried pioglitazone (Actos, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin (Onglyza, generics), alogliptin (Nesina, authorized generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried pioglitazone (Actos, generics). **Note:** A trial of Oseni or its authorized generic would not count toward this requirement.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Osphena	ospemifene tablets	Approve if the patient has tried one vaginal estrogen product from the following list (if one is formulary): estradiol cream (Estrace cream, generics), Femring vaginal ring, Premarin vaginal cream, Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), or Imvexxy If none are formulary, approve.
Otulfi IV	ustekinumab-aauz for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, or Yesintek IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Stelara IV, 2) Steqeyma IV, 3) Wezlana IV, 4) Pyzchiva IV or ustekinumab-ttwe IV, 5) Yesintek IV, and 6) Selarsdi IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Yesintek IV, approve if the patient meets ONE of the following (1 or 2): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve.
Otrexup	methotrexate injection for subcutaneous use; 10mg, 12.5 mg, 15 mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg	Approve if the patient has tried Rasuvo, if formulary. If Rasuvo is non-formulary, approve if, according to the prescriber, the patient and caregiver are unable to administer methotrexate injection (NOT including Otrexup or Rasuvo).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Oxistat lotion	oxiconazole nitrate lotion	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. **Note:** Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.
Oxybutynin 2.5 mg tablet (brand)	oxybutynin 2.5 mg tablet	Approve if the patient has tried oxybutynin oral solution or syrup, if formulary. If neither oxybutynin oral solution nor syrup is formulary approve if the patient meets one of the following (A or B): A. Patient has tried other strengths of oxybutynin tablets; OR B. Patient's dose requires a 2.5 mg increment.
oxycodone ER	oxycodone extended-release tablets	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, or Xtampza ER. **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **4.** Patients ≥ 11 years and < 18 years of age: approve if the patient has tried OxyContin, if formulary. If Oxycontin is non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
oxycodone-acetaminophen 10-300 tablets (includes Primlev, Prolate)	oxycodone-acetaminophen 10-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 10-325 mg tablets.
oxycodone-acetaminophen 5-300 tablets (includes Primlev, Prolate)	oxycodone-acetaminophen 5-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 5-325 mg tablets.
oxycodone-acetaminophen 7.5-300 tablets (includes Primlev and Prolate)	oxycocodne-acetaminophen 7.5-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 7.5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 7.5-325 mg tablets.
Ozobax, Ozobax DS and authorized generic	baclofen oral solution	**1.** Direct to oral baclofen tablets. **2.** Patient is unable to or has difficulty swallowing oral tablets, approve if the patient has tried one of 1) baclofen 25 mg/5ml oral suspension (Fleqsuvy suspension, generics) or 2) Lyvispah oral granules, if formulary. If neither are formulary, approve.
Palforzia	peanut [Arachis hypogaea] allergen powder-dnfp for oral administration	See standard *Allergen Immunotherapy – Palforzia Prior Authorization Policy* criteria.
Pen needles by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other diabetic pen needles that are not BD	Pen needles by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other diabetic pen needles that are not BD	**1.** Approve if the patient has tried one formulary pen needle. If none are formulary, approve. **2.** Approve if the prescriber states the patient requires a needle of the requested length and/or gauge which is not available as a formulary product. **Note:** NPF prefers BD products.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Pertzye	pancrelipase delayed-release capsules	Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Creon, Pancreaze, or Zenpep. If none are formulary, approve.
Phexxi	L-lactic acid, citric acid, and potassium bitartrate vaginal gel	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried or is unable to tolerate THREE other barrier methods of contraception, such as diaphragms, condoms, spermicides (over-the-counter), or sponges. Note: Examples include, but may not be limited to, Caya contoured diaphragm, condom, FC2 Female Condom, FemCap, Gynol II contraceptive gel, VCF contraceptive gel. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following (i or ii): i. Patient has tried or is unable to tolerate THREE other barrier methods of contraception, such as diaphragms, condoms, spermicides (over-the-counter), or sponges; OR Note: Examples include, but may not be limited to, Caya contoured diaphragm, condom, FC2 Female Condom, FemCap, Gynol II contraceptive gel, VCF contraceptive gel. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other barrier methods of contraception would not be as medically appropriate for the patient as the requested non-formulary drug.
Pifeltro	doravirine tablets	**1.** Approve if the patient has tried one non-nucleoside reverse transcriptase inhibitor (NNRTI) or a NNRTI-containing product (e.g., Sustiva, Edurant, Delstrigo, Complera, Odefsey, Atripla, Symfi, Smyfi Lo). **2.** Patients already started on therapy with Pifeltro, approve.
Piqray	alpelisib tablets	**1.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the patient has a known PIK3CA mutation, Piqray is used in combination with fulvestrant, and the patient has tried one of the following agents: a Cyclin-Dependent Kinase 4/6 Inhibitor (e.g., Ibrance [palbociclib], Kisqali [ribociclib], Kisqali Co-Pack [ribociclib, letrozole], Verzenio [abemaciclib]), an aromatase inhibitor (e.g., letrozole, anastrozole,exemestane), tamoxifen, or fulvestrant. **2.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the patient has a known PIK3CA mutation and the patient has already been started on Piqray.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Pirfenidone 534 mg tablet	pirfenidone 534 mg tablet	Idiopathic pulmonary fibrosis. Patient meets both of the following (i and ii): i. Patient has tried generic pirfenidone tablets; AND **Note:** True generic tablets are available in 267 mg tablets. ii. Patient cannot continue to use generic pirfenidone tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent product which, per the prescriber, would result in a significant allergy or serious adverse reaction.
Plenvu	polyethylene glycol; electrolytes; ascorbic acid powder for solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR ii. Patients with phenylketonuria. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i, ii, or iii): i. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR ii. Patients with phenylketonuria; OR iii. Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.
Pliaglis and lidocaine 7% and tetracaine 7% cream (brand)	lidocaine 7% and tetracaine 7% cream	Approve if the patient has tried and cannot use two of the following, if two are formulary (or one if only one is formulary): lidocaine and prilocaine cream (generics), lidocaine cream (generics, multiple strengths), Livixil Pak, DermacinRx Prizopak. If none are formulary, approve.
Pokonza	potassium chloride powder, for solution	Approve if the patient has tried one other oral potassium chloride product (e.g., potassium chloride powder for oral solution, potassium chloride oral solution).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Pradaxa	dabigatran etexilate mesylate capsules	**1.** Approve if the patient has tried one of dabigatran capsules, Eliquis, Savaysa, or Xarelto, if one is formulary **[documentation required]**. If none are formulary, approve. **2.** Patient is less than (<) 18 years of age: approve if the patient has tried Xarelto (tablets or oral suspension) **[documentation required]**, if formulary. If neither are formulary, approve. **3.** Patients currently receiving Pradaxa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]), approve. **4.** Patients currently receiving Pradaxa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip or knee replacement surgery), approve.
Pradaxa oral pellets	dabigatran oral pellets	**1.** Regardless of the patient's age, approve if the patient is currently receiving Pradaxa (oral pellets or tablets) for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]). **2.** Patient is ≥ 8 years of age and < 12 years of age, approve if the patient meets one of the following (A or B): A. Patient has tried dabigatran capsules (Pradaxa, generics) **[documentation required]**, if formulary. If dabigatran capsules (Pradaxa, generics) are non-formulary, approve; OR B. Patient is not able to swallow capsules, approve if the patient has tried Xarelto (tablets or oral suspension) **[documentation required]**, if formulary. If neither are formulary, approve. **3.** Patient is < 8 years of age, approve if the patient has tried Xarelto (tablets or oral suspension) **[documentation required]**, if formulary. If neither are formulary, approve.
Praluent	alirocumab injection for subcutaneous use	See *Proprotein Convertase Subtilisin Kexin Type 9 Related Products Care Value Policy* criteria **For Praluent only**
Pred Mild	prednisolone acetate 0.12% ophthalmic suspension	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary; or one if one is formulary): 1) dexamethasone (generics or Maxidex), 2) difluprednate (Durezol, generics), 3) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), or 3) a prednisolone

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		product (Pred Forte, Omnipred, generics). If none are fomualry, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): 1) a fluorometholone product (FML Liquifilm, generics; Flarex; FML Forte), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. **Note:** If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Pregenna	beta carotene, ascorbic acid, cholecalciferol, .alpha.-tocopherol acetate, pyridoxine hydrochloride, biotin, folic acid, levomefolate calcium, cyanocobalamin, calcium carbonate, magnesium oxide, ferrous bisglycinate, and potassium iodide tablet	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.
Pregnyl	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): chorionic gonadotropin, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried chorionic gonadotropin or Novarel, if formulary. If neither are formulary, approve. **3.** Patients with a latex allergy: approve if the patient has tried Novarel, if formulary. If Novarel is non-formulary, approve. **4.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Premarin	conjugated estrogens tablets	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: estradiol tablets (Estrace, generics) and Menest tablets. If neither are formulary, approve.
Premphase	conjugated estrogens/ medroxy progesterone tablets	Approve if the patient meets the following (A, B, and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey and estradiol-norethindrone); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.
Prempro	conjugated estrogens/ medroxy progesterone tablets	Approve if the patient meets the following (A, B, and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey and estradiol-norethindrone); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.
Prezcobix	darunavir and cobicistat tablets	**1.** Approve if the patient has tried one protease inhibitor (PI) or a PI-containing product (e.g., Aptivus, atazanavir [Reyataz, generics], Viracept, ritonavir [Norvir, generics], fosamprenavir, Prezista, Evotaz, lopinavir-ritonavir [Kaletra, generics]). **2.** Approve if, according to the prescriber, the patient meets BOTH of the following (A and B): A. Patient has a history of Apretude (cabotegravir extended-release injectable suspension) for pre-exposure prophylaxis (PrEP); AND B. Patient meets ONE of the following (i or ii): i. Results of resistance testing are not available; OR ii. Patient has integrase strand-transfer inhibitor (INSTI)

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		resistance. **3.** If the patient, according to the prescriber, needs to begin antiretroviral therapy urgently, approve. **4.** Approve if the patient has already been started on therapy with Prezcobix.
Prilosec oral suspension	omeprazole delayed-release oral suspension	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole orally disintegrating tablets (Prevacid SoluTab, generics), omeprazole DR capsules, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **3.** Patients < 1 year of age: approve if the patient has tried Nexium DR packet (granules for oral suspension), if formulary. If Nexium DR packet (granules for oral suspension), is non-formulary, approve. **Note**: The requested agent would NOT count as a trial of an alternative.
Primidone 125 mg (brand)	primidone 125 mg tablet	Approve if the patient's prescribed dose cannot be obtained with primidone 50 mg or 250 mg tablets. **Note:** The patient is NOT required to split the 250 mg tablets in half.
ProAir Digihaler	albuterol sulfate inhalation powder	**1.** Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried ProAir Respiclick, if formulary. If ProAir Respiclick is non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
ProAir Respiclick	albuterol sulfate inhalation powder	**1.** Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried ProAir Digihaler, if formulary. If ProAir Digihaler is non-formulary, approve.
Proctofoam-HC	pramoxine hydrochloride hydrocortisone acetate aerosol, foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with pramoxine-hydrocortisone cream.
Procysbi	cysteamine bitartrate delayed-release capsules and granule packets	Approve if the patient meets the following criteria (A, B, C, and D): A. Patients with nephropathic cystinosis; AND B. According to the prescriber, the diagnosis was confirmed by one of the following (i or ii): i. Genetic testing confirmed a mutation of the CTNS gene; OR ii. White blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory; AND C. The patient will not be using Cystagon and Procysbi concurrently; AND D. The patient has tried Cystagon **[documentation required]**, if formulary. If Cystagon is non-formulary, approve.
Prolate solution	oxycodone and acetaminophen 10-300 mg/5 oral solution	**1.** Approve if the patient has tried and cannot take oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if the patient is unable to swallow or has difficulty swallowing tablets.
Prolia	denosumab injection for subcutaneous use	**1**. Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2**. Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4**. Patients who have had an osteoporotic fracture or a fragility

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		fracture: approve. **5**. Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6**. Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy): approve. Note: Examples of androgen deprivation therapy are: Lupron Depot [leuprolide for depot suspension], Eligard [leuprolide acetate for injectable suspension], Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7**. Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Lupron Depot [leuprolide for depot suspension], Eligard [leuprolide acetate for injectable suspension], Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8**. Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9**. Treatment to increase bone mineral density in patients with breast cancer: approve.
Pulmicort Flexhaler	budesonide inhalation powder	**1.** Approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.
Pylera	bismuth subcitrate potassium, metronidazole plus tetracycline capsules	If requesting brand Pylera: Approve if the patient has tried generic Pylera (bismuth-metronidazole-tetracycline 140-125-125), if formulary. If requesting brand Pylera and generic Pylera (bismuth-metronidazole-tetracycline 140-125-125), is non-formulary (or if requesting generic Pylera), approve if the patient meets ONE of the following (A or B): A. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with TWO different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth-containing product + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]; Voquezna + amoxicillin +/- clarithromycin); OR B. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with any TWO pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole [Prevpac, generics], Omeclamox-Pak, Voquezna Pak, or Talicia).

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Pyzchiva IV	ustekinumab-ttwe for IV infusion	Direct to ustekinumab-ttwe IV, if formulary. If ustekinumab-ttwe IV is non-formulary, If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Wezlana IV, Yesintek IV, Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Stelara IV, 2) Steqeyma IV, 3) Wezlana IV, 4) Yesintek IV, 5) Otulfi IV, and 6) Selarsdi IV, if formulary; AND B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Wezlana IV, Yesintek IV, Otulfi IV, approve if the patient meets ONE of the following (1 or 2): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve.
Qbrelis	lisinopril oral solution	**1.** Approve if the patients has tried lisinopril tablets (Prinivl, Zestril, generics), if formulary. If lisinopril tablets (Prinivil, Zestril, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.
Qbrexza	glycopyrronium cloth 2.4%, for topical use	Hyperhidrosis, Primary Axillary in a patient ≥ 9 years of age. Note: Qbrexza is not intended for application to areas other than the axillae. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient meets ONE of the following (A or B): A. Patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one of Drysol, Xerac AC, or Bromi-lotion **[documentation required]**; OR B. According to the prescriber, the patient has experienced a significant intolerance with one of these products **[documentation required]**. **2.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Sofdra, if formulary. Note: If Sofdra is non-formulary, criterion 2 is met.
Qdolo and authorized generic	tramadol hydrochloride oral solution	Approve if the patient is unable to swallow or has difficulty swallowing tramadol tablets.
Qinlock	ripretinib tablets	Gastrointestinal stromal tumor. **1.** Approve if the patient has been previously treated with at least two other kinase inhibitors. Note: Examples of kinase inhibitors are an imatinib product (Gleevec, generics, Imkeldi), sunitinib (Sutent), Stivarga, sorafenib (Nexavar), pazopanib (Votrient), Tasigna, dasatinib (Sprycel), Ayvakit. **2.** Approve if the patient has already been started on therapy with Qinlock. Melanoma, Cutaneous. **1.** Approve if the patient meets all of the following (A, B and C): A. Patient has metastatic or unresectable disease; AND B. Patient has an activating KIT mutation; AND C. Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules) + Mekinist (trametinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets). **2.** Approve if the patient has already been started on therapy with Qinlock.
Qlosi	pilocarpine hydrochloride ophthalmic solution, 0.4%	No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: Formulary coverage is not provided for this medication.)
Qnasl	beclomethasone dipropionate nasal aerosol	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
Qtern	dapagliflozin/ saxagliptin tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both Glyxambi and Steglujan, if formulary. If one if formulary, try

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		one, if neither are formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary). SGLT-2 inhibitors: Brenzavvy, Farxiga, Invokana, Jardiance, Steglatro. DPP-4 inhibitors: Januvia, Nesina (alogliptin), Onglyza (saxagliptin), Tradjenta. **Note:** If the patient has tried a combination product containing a DPP-4 inhibitor or an SGLT-2 inhibitor, this would count as a trial of the respective product. A trial of the request agent would NOT count toward this requirement.
Quetiapine 150 mg tablets	quetiapine 150 mg tablet	**1.** Direct to quetiapine 50 mg and/or quetiapine 100 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the quetiapine 50 mg and/or 100 mg tablet.
QuilliChew ER	methylphenidate HCl extended-release chewable tablets	Approve if the patient has tried Quillivant XR suspension, if formulary. If Quillivant XR suspension is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, 4) Azstarys.
Quillivant XR	methylphenidate hydrochloride for extended-release oral suspension	**1.** Approve if the patient has tried QuilliChew ER tablets, if formulary. If QuilliChew ER tablets are non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, 4) Azstarys. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Ravicti	glycerol phenylbutyrate oral liquid	Patient meets the following: *Metabolic Disorders – Phenylbutyrate Products Prior Authorization Policy* criteria AND Patient meets one of the following (1, 2, 3, or 4): **1.** Approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): Olpruva and Pheburane **[documentation required]**. If neither are formulary, approve; OR **2.** Patient has a feeding tube: Approve if the patient has tried sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) **[documentation required]**, if formulary. If sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) is non-formulary, approve; OR **3.** Patient is < 20 kg: approve if the patient meets one of the following (a or b): a. Patient has tried Pheburane **[documentation required]**, if formulary. If Pheburane is non-formulary, approve; OR b. Patient is NOT eating solid food AND does NOT have a feeding tube (e.g., young infant): Approve; OR **4.** Patient is on a sodium-restricted diet OR, according to the prescriber, a high sodium diet is contraindicated **[documentation required]**: Approve.
Rayos	prednisone delayed-release tablets	Approve if the patient has tried prednisone immediate-release tablets AND had inadequate efficacy with the product, according to the prescriber, OR experienced adverse events severe enough to warrant discontinuation of the product.
Rebyota Rectal Suspension	fecal microbiota, live – jslm suspension, for rectal use	For the prevention of recurrent Clostridioides difficile infection in a patient ≥ 18 years of age. Approve if the patient has tried Vowst, if formulary. If Vowst is non-formulary, approve.
Recorlev	levoketoconazole tablets	Endogenous Cushing's Syndrome in a patient ≥ 18 years of age. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. 1. Approve if the patient meets the following (A and B): A. Patient has tried ketoconazole; AND B. Patient has tried, or is currently taking, two of Isturisa or Metopirone (metyrapone). If neither Isturisa nor Metopirone are formulary, approve if the patient has tried ketoconazole. If both or one of Isturisa or Metopirone (metyrapone) are formulary, then one of those agents AND ketoconazole would need to be tried. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. 2. If the patient has already been started on Recorlev, approve if the patient has tried ketoconazole.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Relafen DS	nabumetone 1,000 mg tablets	Approve if the patient has tried five prescription-strength oral NSAIDs. **Note**: For example: nabumetone (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.
Relexxii and authorized generic	methylphenidate ER tablet	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five products (or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, or 4) Azstarys or 5) QuilliChew ER tablets or Quillivant XR suspension. **Note:** QuilliChew ER tablets and Quillivant XR suspension count as one alternative.
Relistor	methylnaltrexone bromide tablets	Approve if the patient has tried two products from the following list **[documentation required]**: Movantik, Symproic, or Amitiza (lubiprostone), if two are formulary or one if one is formulary. If none are formulary, approve if the patient has tried two laxative agents (e.g., bisacodyl-containing products, senna-containing products, milk of magnesia, lactulose).
Reltone	ursodiol capsules 200 mg, 400 mg	**1.** Approve if the patient has tried generic ursodiol capsules or tablets. **2.** Approve, if according to the prescriber, the patient is unable to achieve the appropriate dosage requirement with ursodiol capsules.
Relyvrio	sodium phenylbutyrate and taurursodiol powder for oral suspension	No exceptions are recommended. There is unclear clinical benefit with Relyvrio and a lack of clinical efficacy data.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Rezlidhia	olutasidenib capsules	Acute myeloid leukemia with isocitrate dehydrogenase-1 (IDH1) mutation positive disease in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Tibsovo. If Tibsovo is non-formulary, approve. **2.** Approve if the patient has QTc prolongation OR is or will be taking medications that can prolong the QTc interval. **3.** Patients with Guillain-Barre, approve. **4.** Approve if the patient has already been started on Rezlidhia therapy.
Rezvoglar	insulin glargine-aglr 100 units/mL Kwikpen	**1.** Patient is directed to use Semglee (YFGN) or Insulin glargine (YFGN) [authorized generic of Semglee {YFGN}], if formulary. If neither are formulary, approve. **2.** Approve if the patient has tried and cannot use Semglee (YFGN) or Insulin glargine (YFGN) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **Note:** If the patient had a trial of Insulin glargine (YFGN) and cannot use due to a formulation difference, an additional trial of Semglee (YFGN) would not be required and vice-versa, regardless of the formulary status of these products.
Rivfloza	nedosiran subcutaneous injection	Primary Hyperoxaluria Type 1 in a patient ≥ 2 years of age. **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Oxlumo, if formulary. If Oxlumo is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Rivfloza.
Roszet and authorized generic	rosuvastatin and ezetimibe	Approve if the patient meets the following criteria (A and B): A. Patient has tried ezetimibe; AND B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with atorvastatin (Lipitor, generics) or rosuvastatin (Crestor, generics). If neither of atorvastatin (Lipitor, generics) nor rosuvastatin (Crestor, generics) are formulary, approve.
Roxybond	oxycodone hydrochloride tablet, coated	Approve if the patient has tried and cannot take one of the following formulary products: oxycodone hydrochloride tablets (Roxicodone, generics). If oxycodone hydrochloride tablets (Roxicodone, generics) are non-formulary, approve.
Rukobia	fostemsavir extended-release tablets	Human Immunodeficiency Virus (HIV) infection, multi-drug treatment-resistant. **1.** Approve if the patient has tried Sunlenca or is concomitantly receiving Sunlenca, if formulary. If Sunlenca is non-formulary,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		approve. **2.** Approve if the patient has exhausted at least FOUR of the following antiretroviral classes defined as elimination of all antiretrovirals within a given class due to demonstrated or projected resistance to the agent(s) in that class OR due to significant intolerance (FOUR of a, b, c, d, e, or f): a) Nucleoside reverse transcriptase inhibitor; OR Note: Examples of nucleoside reverse transcriptase inhibitors include abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine. b) Non-nucleoside reverse transcriptase inhibitor; OR Note: Examples of non-nucleoside reverse transcriptase inhibitor include delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine. c) Protease inhibitor; OR Note: Examples of protease inhibitors include atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir. d) Fusion inhibitor; OR Note: Examples of fusion inhibitors include Fuzeon (enfuviritide for injection). e) Integrase strand transfer inhibitor; OR Note: Examples of integrase strand transfer inhibitors include raltegravir, dolutegravir, elvitegravir. f) CCR5 antagonist. Note: Examples of CCR5 antagonists include Selzentry (maraviroc tablets). **3.** Approve if the patient has already been started on Rukobia therapy.
Saizen/ SaizenPrep	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Zomacton. **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Savaysa	edoxaban tablets	**1.** Approve if the patient has tried one of the following, if one is formulary: dabigatran (Pradaxa, generics), Xarelto, or Eliquis **[documentation required]**. If none are formulary, approve. **2.** Patients currently receiving Savaysa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]), approve. **3.** Patients using Savaysa for treatment of DVT or PE associated with cancer: approve if the patient has tried Eliquis **[documentation required]**, if formulary. If Eliquis is non-formulary, approve. **4.** Patients currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery), approve.
Saxenda	liraglutide [rDNA] injeciton	Weight loss in a patient ≥ 18 years of age. Approve if the patient meets the following (A and B): A. At baseline, the patient has or had a body mass index (BMI) ≥ 30 kg/m2; or a BMI ≥ 27 kg/m2 and at least one of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound). B. Patient has tried one of Wegovy or Zepbound, if formulary. If neither are formulary, approve. Weight loss in a patient is ≥ 12 years of age and < 18 years of age. Approve if the patient meets the following (A and B): A. At baseline, the patient has or had a BMI ≥ 95th percentile for age and sex; AND Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound). B. Patient has tried Wegovy, if formulary. If Wegovy is non-formulary, approve.
Scemblix	asciminib tablets	Chronic Myeloid Leukemia (Philadelphia chromosome-positive). **1.** Approve if the patient is T315I-positive. **2.** Approve if the patient has tried two other tyrosine kinase inhibitors.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Examples of other tyrosine kinase inhibitors include: imatinib tablets (Gleevec, generics), Sprycel, Tasigna, Bosulif, Iclusig. **3.** Approve if the patient has been started on Scemblix. <u>Myeloid/Lymphoid Neoplasms with Eosinophilia.</u> A. Approve if the tumor has an ABL1 rearrangement.
Seglentis	celecoxib and tramadol hydrochloride tablets	**1.** Direct the patient to tramadol tablets and celecoxib capsules as separate agents. If celecoxib capsules (Celebrex, generics) are non-formulary, approve. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use tramadol and celecoxib as separate agents.
Segluromet	ertugliflozine and metformin tablets	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Synjardy, Synjardy XR, or Xigduo XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND three formulary alternatives from the following list, if formulary (or two if two are formulary or one if one is formulary: Farxiga, Steglatro, or Jardiance. <u>Note</u>: Synjardy and Synjardy XR would count as one alternative.
Semglee (non YFGN)	insulin glargine U-100 vial and pen	**1.** Patient is directed to use Semglee (YFGN) [brand] or Insulin glargine-YFGN, if formulary. **2.** If neither are formulary, approve if the patient has tried one of Rezvoglar, Lantus, or Basaglar, if formulary. If Rezvoglar, Lantus, and Basaglar are non-formulary, approve. **<u>Note</u>:** If the patient has tried any product from 2. regardless of formulary status, criterion 2 would be satisfied.
Serevent Diskus	salmeterol xinafoate inhalation powder	**1.** Approve if the patient has tried Striverdi Respimat, if formulary. If Striverdi is non-formulary, approve. **2.** Patient who is unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve. **3.** Patient with asthma: Approve if the patient is using Serevent Diskus concomitantly with an inhaled corticosteroid or an inhaled corticosteroid-containing product. **4.** Patient with exercise induced bronchospasm <u>without</u> asthma: approve. <u>Note</u>: A patient with exercise-induced bronchospasm and asthma should be referred to criterion #3.
Sernivo spray	betamethasone dipropionate spray 0.05%	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. **<u>Note</u>:** Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		fluocinonide, mometasone, halcinonide. **Note:** The five products must be chemically unique.
Siklos	hydroxyurea tablets	**1.** Approve is the patient has tried Droxia, if formulary. If Droxia is non-formulary, approve. **2.** If the patient requires Siklos 100 mg or 1,000 mg tablets to achieve a dosage that cannot be achieved with the available strengths of Droxia, approve. **3.** If the patient cannot swallow or has difficulty swallowing Droxia capsules, approve.
Siliq	brodalumab for subcutaneous injection	See standard *Inflammatory Conditions (**Siliq**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies OR FLEX Formulary* policies.
Simponi SC	golimumab subcutaneous injection	See standard *Inflammatory Conditions (**Simponi SC**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies OR FLEX Formulary* policies.
sitagliptin and metformin hydrochloride tablets and Zituvimet	sitagliptin and metformin hydrochloride tablets 50-1000; 50-500	Approve if the patient has tried Janumet, if formulary. If Janumet is non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two or formulary or one if one is formulary): alogliptin and metformin tablets, Janumet XR, Jentadueto, Jentadueto XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), Januvia, Tradjenta, or alogliptin (Nesina, authorized generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried Janumet XR. If Janumet XR is non-formulary, approve if the patient has tried metformin (Glucopage, Glucophage ER, generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Sitavig	acyclovir buccal tablets	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), penciclovir 1% cream (Denavir, generics), Xerese 5%/1% cream, acyclovir 5% cream (Zovirax 5% cream, generics), or over-the-counter (OTC) Abreva 10% cream.
Sivextro	tedizolid phosphate tablets	**1.** Approve if the patient has tried linezolid tablets or oral suspension (Zyvox, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking a medication that interacts with linezolid (Zyvox, generics) [e.g., monoamine oxidase inhibitors {MAOIs} or selective serotonin reuptake inhibitors {SSRIs}]. **3.** Approve if the patient is being treated for an organism that is resistant to linezolid (Zyvox, generics), but sensitive to Sivextro. **4.** Approve if the patient has been started on a course of therapy with Sivextro (to allow for completion of a course of therapy).
Skyclarys	omaveloxolone capsules	See standard *Neurology – Skyclarys Prior Authorization Policy* criteria.
Skytrofa	lonapegsomatropin-tcgd subcutaneous injection	**1.** Growth hormone deficiency in a patient ≥ 2.5 years of age to < 3 years of age, approve if the patient has tried Sogroya for 6 months OR experienced an intolerance with Sogroya if formulary. If Sogroya is non-formulary, approve if the patient meets criteria #3. **2.** Growth hormone deficiency in patients ≥ 3 years of age to < 18 years of age, approve if the patient has tried one of Sogroya or Ngenla for 6 months OR experienced an intolerance with the respective agent if one is formulary. **3.** If neither Sogroya nor Ngenla are formulary (in patients ≥ 2.5 years of age to < 18 years of age) OR the patient is ≥ 1 year of age and < 2.5 years of age, approve if the patient meets ONE of the following (A or B): A. Patient has been able to adhere to somatropin product(s) administered daily AND has experienced inadequate efficacy (i.e., patient has tried for 12 months and has a growth rate of less than 2 cm per year) **[documentation required]** with ONE product from the following list: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND ii. Patient cannot continue to use each of the TWO products due to a formulation difference in the

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **Note:** Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. **Note:** If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE.
Slynd	drospirenone tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried one progesterone-only contraceptive containing norethindrone. Note: Examples of progesterone-only contraceptives containing norethindrone include Camila, Deblitane, Emzahh, Errin, Nora-BE, norethindrone, Heather, Jencycla, Lyza, Sharobel, Tulana, Lyleq, Incassia. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): **i.** Patient has tried one progesterone-only contraceptive containing norethindrone; OR Note: Examples of progesterone-only contraceptives containing norethindrone include Camila, Deblitane, Emzahh, Errin, Nora-BE, norethindrone, Heather, Jencycla, Lyza, Sharobel, Tulana, Lyleq, Incassia. **ii.** The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other progesterone-only contraceptives containing norethindrone would not be as medically appropriate for the patient as the requested non-formulary drug.
Soaanz	torsemide tablets	Approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): torsemide tablets, bumetanide (Bumex, generics), furosemide (Lasix, generics). If none are formulary, approve.
Sodium oxybate oral solution (AG to	sodium oxybate oral solution	Cataplexy Treatment in Patients with Narcolepsy: Direct the patient to one of 1) Xyrem (brand) OR 2) sodium oxybate oral solution (by Hikma), if formulary. If neither are formulary, approve if the patient meets (1 or 2):

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Xyrem) by AMNEAL		**1.** Patients ≥ 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve. **2.** Patients ≥ 7 years of age and < 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Lumryz or Xywav, if formulary. If neither are formulary, approve. Excessive Daytime Sleepiness in Patients with Narcolepsy: Direct the patient to one of 1) Xyrem (brand) OR 2) sodium oxybate oral solution (by Hikma), if formulary. If neither are formulary, approve if the patient (≥ 7 years of age) has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve.
Sofdra	sofpironium topical gel, 12.45%	Hyperhidrosis, Primary Axillary in a patient ≥ 9 years of age. Note: Sofdra is not intended for application to areas other than the axillae. Approve if the patient meets BOTH of the following (1 and 2): **1.** Approve if the patient meets ONE of the following (A or B): A. Patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one of Drysol, Xerac AC, or Bromi-lotion **[documentation required]**; OR B. According to the prescriber, the patient has experienced a significant intolerance with one of these products **[documentation required]**; AND **2.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Qbrexza, if formulary. Note: If Qbrexa is non-formulary, criterion 2 is met.
sofosbuvir/ velpatasvir (Authorized generic for Epclusa) 400 mg/ 100 mg tablets	sofosbuvir/ velpatasvir tablets 400 mg/ 100 mg tablets	Patient is directed to use Epclusa. If Epclusa is non-formulary, approve.
Sogroya	somapacitan-beco subcutaneous injection	**1.** Growth hormone deficiency in patients ≥ 2.5 years of age to < 3 years of age, approve if the patient has tried Skytrofa for 6 months OR experienced an intolerance with Skytrofa, if formulary. If Skytrofa is non-formulary, approve if the patient meets criteria #3. **2.** Growth hormone deficiency in patients ≥ 3 years of age to < 18 years of age, approve if the patient has tried one of Skytrofa or

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

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. **Note:** If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE.
Sorilux and authorized generic	calcipotriene foam	**1.** Approve if the patient has tried calcipotriene solution, if formulary. If calcipotriene solution is non-formulary, approve. **2.** Approve if the patient has tried calcipotriene cream or ointment. **3.** If the patient is using the requested medication for plaque psoriasis and is between the ages ≥ 4 and < 18 years of age, approve.
Sovaldi 200 mg tablets and oral pellets	sofosbuvir tablets and oral pellets	If Epclusa (brand) is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start: Sovaldi is not approved. Offer to review for Epclusa (brand only) using the standard Hepatitis C – Epclusa PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi: Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If Epclusa (brand) is non-formulary and sofosbuvir/velpatasvir is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start. Approve for the duration specified in the standard Hepatitis C – Sovaldi PA Policy criteria if the patient has met the standard Hepatitis Sovaldi PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi. Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If neither Epclusa (brand) nor sofosbuvir/velpatasvir are formulary, approve.
Sovaldi 400 mg tablets	sofosbuvir tablets	If Epclusa (brand) is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start: Sovaldi is not approved. Offer to review for Epclusa (brand only) using the standard Hepatitis C – Epclusa PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi: Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If Epclusa (brand) is non-formulary and sofosbuvir/velpatasvir is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start. Sovaldi is not approved. Offer to review for sofosbuvir/velpatasvir 400

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		mg/100 mg tablets (generic only) using the standard Hepatitis C – Epclusa PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi. Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If neither Epclusa (brand) nor sofosbuvir/velpatasvir are formulary, approve.
Sovuna	hydroxychloroquine sulfate 200 mg, 300 mg	**1.** Direct to generic hydroxychloroquine tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic hydroxychloroquine tablets.
Spravato	esketamine nasal spray	**1. For the diagnosis of Treatment-Resistant Depression:** approve if the patient meets the following criteria (A, B, C, D, and E): A. Patient is ≥ 18 years of age; AND B. Patient meets both of the following (i and ii): i. Patient has demonstrated nonresponse (≤ 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic class, according to the prescriber; AND Note: Different pharmacologic classes of antidepressants include selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, bupropion, mirtazapine, etc. ii. Each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber; AND C. Patient has one of the following (i or ii): i. No history of psychosis; OR ii. History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks; AND D. The patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program, according to the prescriber; AND E. The medication is prescribed by a psychiatrist. **2. Major Depressive Disorder with Acute Suicidal Ideation or Behavior:** approve if the patient meets the following criteria (A, B, C, D, and E): A. Patient is ≥ 18 years of age; AND B. Patient has major depressive disorder that is considered to be severe, according to the prescriber; AND C. Patient is concomitantly receiving at least one oral antidepressant; AND Note: Antidepressants may include, but are not limited to, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, mirtazapine, and bupropion. D. Patient has one of the following (i or ii):

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		i. No history of psychosis; OR ii. History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks; AND E. The medication is prescribed by a psychiatrist. **3. For the diagnosis of Treatment-Resistant Depression OR Major Depressive Disorder with acute suicidal ideation or behavior:** approve if the patient has already started therapy with Spravato.
Sprix and authorized generic	ketorolac tromethamine nasal spray	**1.** Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried. **2.** Approve for patients with difficulty swallowing or for patients who cannot swallow.
Steglatro	ertugliflozin tablets	Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list (or one if only one is formulary): Farxiga and Jardiance. If neither are formulary, approve.
Steglujan	ertugliflozin/ sitagliptin tablets	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both Qtern and Glyxambi, if formulary **[documentation required]**. If one is formulary, try one, if neither are formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) **[documentation required]** AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary) **[documentation required]**. **2.** Patient with a history of heart failure or renal impairment: Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Glyxambi, if formulary **[documentation required]**. If Glyxambi is not formulary, approve if the patient has tried and, according to the

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Farxiga or Jardiance, if formulary **[documentation required]**, AND one of Tradjenta or Januvia, if formulary **[documentation required]**. If Farxiga and Jardiance are both non-formulary, approve. If Tradjenta and Januvia are both non-formulary, approve. Note: SGLT-2 inhibitors: Brenzavvy, Farxiga, Invokana, Jardiance, Steglatro. DPP-4 inhibitors: Januvia, Nesina (alogliptin), Onglyza (saxagliptin), Tradjenta. Note: If the patient has tried a combination product containing the DPP-4 inhibitor or the SGLT-2 inhibitor, this would count as a trial of the respective product. A trial of the request agent would NOT count toward this requirement.
Steqeyma IV	ustekinumab-stba for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Wezlana IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Stelara IV, 2) Wezlana IV, 3) Yesintek IV, 4) Pyzchiva IV or ustekinumab-ttwe IV, 5) Otulfi IV, and 6) Selarsdi IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Wezlana IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, Otulfi IV, approve if the patient meets ONE of the following (1 or 2): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Stimufend	pegfilgrastim-fpgk	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Nyvepria, Fulphila, Udenyca, Ziextenzo, or Fylnetra **[documentation required]**; AND **Note:** If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Stribild	elvitegravir/ cobicistat/ emtricitabine/ tenofovir tablets	**1.** Approve if the patient has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve. **2.** Approve if the patient has tried one integrase strand transfer inhibitor (INSTI) or an INSTI-containing product (e.g., Genvoya, Tivicay, Triumeq, Juluca, Isentress or Intress-HD). **3.** Patients already started on therapy with Stribild: approve.
Striverdi Respimat	olodaterol inhalation spray	**1.** Approve if the patient has tried Serevent Diskus, if formulary. If Serevent Diskus is non-formulary, approve. **2.** Patients who have a low inspiratory flow rate and are unable to use a dry-powder inhaler (DPI): approve.
Suflave	polyethylene glycol 3350, sodium sulfate, potassium chloride, magnesium sulfate, and sodium chloride for oral solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		1. Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.
sulfacetamide-sulfur 8-4% cleanser	sulfacetamide-sulfur 8-4% cleanser	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide-sulfur.
Sutab	sodium sulfate, magnesium sulfate, and potassium chloride tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep,

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.
Syringes by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other syringes that are not BD	Syringes by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other syringes that are not BD	**1.** Approve if the patient has tried one formulary syringe. If none are formulary, approve. **2.** Approve if the prescriber states the patient requires a needle of the requested length and/or gauge which is not available as a formulary product. **Note:** NPF prefers BD products
Tadliq	tadalafil oral suspension	Pulmonary arterial hypertension World Health Organization Group 1. **1.** Approve if the patient is unable to swallow or has difficulty swallowing tadalafil tablets (Adcirca tablets, Alyq tablets, generics), if formulary. **2.** If tadalafil tablets (Adcirca tablets, Alyq tablets, generics) are non-formulary, approve if the patient meets one of the following (A or B): A. Patient has tried sildenafil powder for oral suspension (Revatio oral suspension, generics), if formulary. If sildenafil powder for oral suspension (Revatio oral suspension, generics) is non-formulary approve; OR

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: This criterion would also be satisfied if the patient tried any other sildenafil product. B. Patient has already been started on a tadalafil product (e.g., tadalafil tablets, Adcirca tablets, Alyq, Tadliq).
Taperdex	dexamethasone 1.5 mg tablets (6 day and 12 day dose packs)	**1.** Direct to dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs).
Tascenso ODT 0.25 mg	fingolimod orally disintegrating tablets	Approve if the patient meets the following 1 AND 2: **1.** Patient meets all of the following (A, B, and C): A. Patient with relapsing form of multiple sclerosis; AND **Note:** Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. B. Patients ≥ 10 years of age; AND C. Patient weighs less than or equal to 40 kg **[documentation required]**; AND **2.** Patients meets one of the following (A, B, OR C): A. Patient is unable to swallow or has difficulty swallowing Gilenya **[documentation required]**; OR B. Patient is unable to obtain Gilenya 0.25 mg capsules from the manufacturer; OR C. Gilenya 0.25 mg is non-formulary.
Tascenso ODT 0.5 mg	fingolimod orally disintegrating tablets	Patient with relapsing form of multiple sclerosis. **Note:** Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. 1. Approve if the patient is unable to swallow or has difficulty swallowing fingolimod 0.5 mg capsules or Gilenya 0.5 mg capsules **[documentation required]**. 2. Approve if neither fingolimod 0.5 mg capsule nor Gilenya 0.5 mg capsules are formulary.
Tazorac 0.05% cream and tazarotene cream 0.05%	tazarotene cream 0.05%	If requesting brand Tazorac 0.05% cream: Approve if the patient has tried generic tazarotene 0.05% cream, if formulary. If generic tazarotene 0.05% cream is non-formulary or generic tazarotene is being requested, approve if the patient has tried one of 1) tazarotene 0.1% cream (Tazorac 0.1% cream, generics) or 2) tazarotene gel (Tazorac gel, generics), if one is formulary. If neither are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Tecfidera	dimethyl fumarate delayed-release capsules	See standard *Multiple Sclerosis (Tecfidera) Preferred Specialty Management Policy* criteria.
Tempo Refill Kit	Tempo Lancets, strips, and Pen needles	Approve if the patient meets the following (1, 2, and 3): 1. Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND 2. Patient has tried standard insulin products; AND 3. Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. **Note:** Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.
Tempo Smart Button	Tempo Smart Button	Approve if the patient meets the following (1, 2, and 3): 1. Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND 2. Patient has tried standard insulin products; AND 3. Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. **Note:** Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.
Tempo Welcome Kit	Tempo Smart Button; Tempo Blood Glucose Monitoring System, Lancets, Strips, and Pen needles	Approve if the patient meets the following (1, 2, and 3): 1. Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND 2. Patient has tried standard insulin products; AND 3. Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. **Note:** Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.
Tepmetko	tepotinib tablets	Non-Small Cell Lung Cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations or high-level MET amplification: 1. Approve if the patient has tried Tabrecta. If Tabrecta is non-formulary, approve. 2. Approve if the patient has already been started on Tepmetko.
Testred	methyltestosterone 10 mg capsules	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): methyltestosterone capsules (generics), Android, or Methitest. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Thalitone 15 mg	chlorthalidone 15 mg tablets	1. Direct the patient to chlorthalidone tablets. Available as 25 mg, 50 mg. 2. Approve if the patient's prescribed dose cannot be obtained with the 25 mg and/or 50 mg strength tablets.
Thyquidity	levothyroxine sodium oral solution	1. Approve if the patient has tried five formulary levothyroxine products from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint capsules **[documentation required]**. If none are formulary, approve. 2. If the patient cannot swallow or has difficulty swallowing tablets or capsules **[documentation required]**, approve if the patient has tried both Tirosint oral solution and Ermeza oral solution, if formulary (or one if one is formulary). If neither are formulary, approve.
Timoptic in Ocudose	timolol maleate 0.25% and 0.5% ophthalmic solution	1. Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list: 1) a timolol product (Istalol, Timoptic/XE, generics), 2) levobunolol ophthalmic solution (generics), 3) betaxolol ophthalmic solution (generics or Betoptic S), or 4) carteolol opthalmic solution (generics), if four are formulary (or three if three are formulary or two if two are formulary or one if one is formulary). If none are formulary, approve. **Note:** If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. 2. Approve if the patient has a known sensitivity to a preservative or when use of a preservative-free topical medication is advisable.
Tirosint and authorized generic	levothyroxine capsules	Approve if the patient has tried five formulary levothyroxine products from the following list (if five are formulary or four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint oral solution **[documentation required]**. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Tirosint-SOL	levothyroxine oral solution	**1.** Approve if the patient has tried five formulary levothyroxine products from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint capsules **[documentation required]**. If none are formulary, approve. **2.** If the patient cannot swallow or has difficulty swallowing tablets or capsules **[documentation required]**, approve if the patient has tried both Thyquidity oral solution and Ermeza oral solution, if formulary (or one if one is formulary). If neither are formulary, approve.
Tivorbex and authorized generic	indomethacin, submicronized capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: indomethacin (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.
Tlando	testosterone undecanoate oral capsules	**1**. Approve if the patient meets BOTH of the following, if formulary (or one if one is formulary) [a and b]: a. Patient has tried Jatenzo, if formulary; AND b. Patient has tried one of Kyzatrex or Undecatrex, if formulary. Note: Kyzatrex and Undecatrex count as one alternative. **2**. If neither are formulary, approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).
TobraDex ST	tobramycin 0.3% / dexamethasone 0.05% ophthalmic suspension	**1.** Approve if the patient has tried tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics), if formulary. If tobramycin-dexamthasone ophthalmic suspension (Tobradex, generics) are non-formulary, approve. **2.** For the treatment of currently active eye infections: approve in patients already receiving TobraDex ST to complete the course of therapy.
Tolsura	itraconazole capsules	**1.** Approve if the patient has tried one of itraconazole capsules (Sporanox, generics) or itraconazole oral solution (Sporanox liquid, generics). **Note:** A trial of either the conventional intraconazole capsules or intraconazole solution would count toward meeting criteria regardless of the formulary status of the product.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. Patient has been started on a current course of therapy with Tolsura (for a non-oncychomycosis diagnosis): approve to complete the current course. **3.** Deny: If the patient is requesting Tolsura for a diagnosis of onychomycosis. **Note:** If the patient is requesting Tolsura for a diagnosis of onychomycosis, the request should be denied regardless of what the patient has tried for the current condition or if the patient has already been started on the product.
Tradjenta	linagliptin tablets	**1.** Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin (Onglyza, generics), or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Alogliptin and Nesina count as one alternative. Saxagliptin and Onglyza count as one alternative. Januvia and Zituvio count as one alternative. **2.** Patients with a history of heart failure or a history of renal impairment: Approve if the patient has tried a sitagliptin product (Januvia or Zituvio), if formulary. If neither Januvia nor Zituvio is formulary, approve.
tramadol 25 mg tablets (brand)	tramadol 25 mg tablets	Approve if the prescribed dose cannot be obtained with tramadol 50 mg. Note: The patient is NOT required to split the 50 mg tablets in half.
tramadol 100 mg tablets (brand)	tramadol 100 mg tablets	Approve, if per the prescriber, the patient is unable to use generic tramadol 50 mg tablets.
Treximet	sumatriptan/ naproxen sodium tablets	Approve if the patient has tried naproxen AND sumatriptan tablets (Imitrex, generics), if formulary. If sumatriptan tablets (Imitrex, generics) are non-formulary, approve. **Note:** A trial of the requested agent would NOT count toward meeting this requirement.
Trientine 500 mg capsules	trientine 500 mg capsules	Approve if the patient has tried generic trientine 250 mg capsules, if formulary. If generic trientine 250 mg capsules are non-formulary, approve if the patient meets one of the following: **1.** Approve if the patient has tried one penicillamine product: penicillamine (Cuprimine, generics) or penicillamine (Depen, generics), if one is formulary. If neither are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		2. Approve if per the prescriber, the patient is intolerant to penicillamine or the patient has clinical features indicating the potential for intolerance to penicillamine (i.e., history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency). **3.** Approve if, per the prescriber, the patient has a contraindication to penicillamine. **4.** Approve if the patient has neurological manifestations of Wilson's Disease. **5.** Approve if the patient is pregnant. **6.** Approve if the patient has been started on therapy with a trientine product.
Tri-luma cream	fluocinolone acetonide 0.01%/ hydroquinone 4%/ tretinoin 0.05% cream	Direct the patient to the separate entities: fluocinolone 0.01% cream- hydroquinone 4% cream- tretinoin 0.05% cream.
Trinaz	ascorbic acid, cholecalciferol, thiamine hydrochloride, riboflavin, pyridoxal phosphate anhydrous, folic acid, methylcobalamin, calcium carbonate, ferrous gluconate, and potassium iodide tablet, film coated	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.
Trudhesa	dihydroergotamine mesylate nasal spray	Approve if the patient has tried dihydroergotamine nasal spray (Migranal, generics), if formulary. If dihydroergotamine nasal spray (Migranal, generics) are non-formulary, approve if the patient meets one of the following (A or B): A. Patient meets one of the following (i or ii): i. Patient has tried one of sumatriptan nasal spray (Imitrex Nasal Spray, generics), Tosymra, or Onzetra Xsail, if formulary; OR

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		ii. Patient has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary: OR Note: If no products from i. or ii. are formulary, approve. B. Patient has already experienced inadequate efficacy or a contraindication with a triptan product.
Truseltiq	nfigratinib capsules	Cholangiocarcinoma with fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. Approve if the patient has already been started on therapy with Truseltiq.
Tryvio	aprocitentan tablets	Approve if the patient has tried, or is currently receiving, at least three other antihypertensive agents for the treatment of hypertension from at least three of the following pharmacological classes **[documentation required]** (i, ii, iii, iv, v, vi, vii, viii, ix, x). Note: A combination product from two or more different classes would count as an alternative from each class. i. Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB); Note: Examples of ACE inhibitors include benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, ramipril, and trandolapril. Examples of ARBs include azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, and valsartan. ii. Non-dihydropyridine calcium channel blocker; Note: Examples include diltiazem and verapamil. iii. Dihydropyridine calcium channel blocker; Note: Examples include amlodipine, felodipine, isradipine, nicardipine, nifedipine, and nisoldipine. iv. Diuretic; Note: Examples of thiazide diuretics include chlorthalidone, chlorothiazide, hydrochlorothiazide, indapamide, and metolazone. Examples of potassium-sparing diuretics are amiloride and triamterene. v. Mineralocorticoid receptor antagonist; Note: Examples of mineralocorticoid receptor antagonists include eplerenone and spironolactone. vi. Beta-blocker; Note: Examples of beta blockers include acebutolol, atenolol, betaxolol, bispoprolol, carvedilol, metoprolol, nadolol, nebivolol, pindolol, propranolol, and timolol. vii. Alpha-adrenergic blocker; Note: Examples of alpha-adrenergic blockers are doxazosin, prazosin, and terazosin. viii. Central alpha-adrenergic agonist; Note: Examples of central alpha-adrenergic agonists are clonidine, guanfacine, and methyldopa. ix. Direct vasodilator; Note: Examples of direct vasodilators are hydralazine and minoxidil.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		x. Direct renin inhibitor. Note: An example of a direct renin inhibitor is aliskiren.
Tudorza Pressair	aclidinium bromide inhalation powder	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) a tiotropium inhaler (tiotropium cap-inhaler [Spiriva HandiHaler, generics], or Spiriva Respimat). If neither are formulary, approve.
Tussicaps	hydrocodone/ chlorpheniramine capsules	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine and promethazine syrup (Promethazine VC codeine syrup, generics), hydrocodone polistirex/chlorpheniramine polystirex pennkinetic suspension, Tuzistra XR oral suspension. If none are formulary, approve if the patient has tried two other prescription or over-the-counter (OTC) cough and cold products.
Tuzistra XR	codeine/ chlorpheniramine extended-release oral suspension	Approve if the patient has tried and cannot take two of the following, if two are formulary (or one if only one is formulary): codeine and promethazine syrup (Promethazine VC codeine syrup, generics), hydrocodone polistirex/chlorpheniramine polystirex pennkinetic suspension. If none are formulary, approve if the patient has tried two other prescription or over-the-counter (OTC) cough and cold products.
Twirla	levonorgestrel and ethinyl estradiol transdermal system	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried five other contraceptive agents (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]). Note: Examples include, but may not be limited to, Blisovi Fe, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Hailey Fe, Junel Fe, Larin Fe, Xulane. Note: A trial of five different oral contraceptive agents would meet the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following (i or ii): i. The patient has tried five other contraceptive agents (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]); OR Note: Examples include, but may not be limited to, Blisovi Fe, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Hailey Fe, Junel Fe, Larin Fe, Xulane.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: A trial of five different oral contraceptive agents would meet the requirement. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy AND other contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.
Tyblume	levonorgestrel 0.1 mg and ethinyl estradiol 0.02 mg tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. Note: Examples include, but may not be limited to, Altavera, Aviane, Falmina, Lessina, levonorgestrel-ethinyl estradiol, Portia, Vienva. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR Note: Examples include, but may not be limited to, Altavera, Aviane, Falmina, Lessina, levonorgestrel-ethinyl estradiol, Portia, Vienva. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.
Udenyca	pegfilgrastim-cbqv subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Ziextenzo, Nyvepria, Fylnetra, or Stimufend **[documentation required]**; AND **Note:** If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Ultravate Lotion	halobetasol propionate lotion 0.05%	Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. **Note:** The products must be chemically unique.
Upneeq	oxymetazoline hydrochloride 0.1% ophthalmic solution	No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Upneeq. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)
Urimar-T	methenamine 120 mg, sodium phosphate monobasic 40.8 mg, phenyl salicylate 36.2 mg, methylene blue 10.8 mg, hyoscyamine sulfate 0.12 mg capsule	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH of the following, if formulary: Uro-MP capsules AND Uro-SP capsules. If neither are formulary, approve.
Urneva	methenamine 120 mg, sodium phosphate monobasic 40.8 mg, phenyl salicylate 36.2 mg, methylene blue 10.8 mg, hyoscyamine sulfate 0.12 mg capsule	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH of the following, if formulary: Uro-MP capsules AND Uro-SP capsules. If neither are formulary, approve.
Uzedy ER	risperidone extended-release subcutaneous injection	**1.** Approve if the patient has tried one of Risperdal Consta, Invega Sustenna, Perseris ER, or Rykindo ER, if one is formulary. If none are formulary, approve. **2.** If the patient is taking oral risperidone (Risperdal), approve if the patient has tried one of Risperdal Consta, Perseris ER, or Rykindo ER, if formulary. If none are formulary, approve. **3.** Approve if the patient has taken Uzedy ER at any time in the past.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		4. Approve if the patient has already been started on Uzedy ER.
Vafseo	vadadustat tablets	Treatment of anemia due to chronic kidney disease in a patient ≥ 18 years of age. Approve if the patient meets the following (1 and 2): **1.** Patient has been receiving dialysis for at least 3 consecutive months; AND **2.** Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of the following: an epoetin alfa product or Aranesp or Mircera. Note: Examples of epoetin alfa products are Procrit, Epogen, and Retacrit.
Valsartan oral solution (previously Prexxartan)	valsartan oral solution	**1.** Direct the patient to valsartan tablets. **2.** Approve if the patient is unable to or has difficulty swallowing oral tablets.
Vanatol LQ	butalbital 50 mg, acetaminophen 325 mg, caffeine 40 mg per 15 mL oral solution	**1.** Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing.
Vanatol S	butalbital 50 mg, acetaminophen 325 mg, caffeine 40 mg per 15 mL oral solution	**1.** Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing.
Vanflyta	quizartinib tablets	FLT3-ITD Mutation-positive Acute Myeloid Leukemia. **1.** Approve if the patient has tried Rydapt. If Rydapt is non-formulary, approve. **2.** If Vanflyta is being used in the maintenance setting, approve. Note: The maintenance setting is therapy after consolidation chemotherapy.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		3. If, according to the prescriber, the patient has or is at risk for pulmonary toxicity, approve. **4.** Approve if the patient has already been started on Vanflyta therapy.
Veltin	clindamycin phosphate and tretinoin gel	Approve if the patient has tried BOTH a clindamycin- AND a tretinoin- containing product. Examples include: Ziana, generic clindamycin/tretinoin, Retin-A, generic tretinoin, Cleocin-T, generic clindamycin.
Venlafaxine besylate ER 112.5 mg (formerly Venbysi XR)	venlafaxine extended-release 112.5 mg tablets	**1.** Approve if the patient has tried two products from the following list (if two are formulary; or one if one is formulary): desvenlafaxine succinate ER (Pristiq, generics), Fetzima, Drizalma Sprinkle, venlafaxine ER capsules (Effexor XR, generics), duloxetine capsules (Cymbalta, generics), or venlafaxine ER tablets. If none are formulary, approve. **Note:** If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the patient is currently taking or has taken venlafaxine besylate ER at any time in the past. **3.** Suicidal ideation: approve.
Ventolin HFA and authorized generic	albuterol sulfate inhalation aerosol	Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve.
Verdeso	desonide foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. **Note:** Examples of topical steroid products include: desonide, alclometasone dipropionate, betamethasone valerate, fluocinolone acetonide, triamcinolone, flurandrenolide, hydrocortisone butyrate. **Note:** The five products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).
Veregen	sinecatechins ointment 15%	**1.** Approve if the patient has tried both 1) podofilox topical solution or Condylox gel AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If none are formulary, approve. **2.** For perianal warts, approve if the patient has tried both 1) Condylox gel AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If neither are formulary approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Verkazia	cyclosporine 0.1% ophthalmic emulsion	Moderate to Severe Vernal Keratoconjunctivitis. **1.** Approve if the patient meets one of the following (A or B): A. Patient has tried two single-action ophthalmic medications (i.e., ophthalmic mast-cell stabilizers or ophthalmic antihistamines) for the maintenance treatment of vernal keratoconjunctivitis; OR **Note:** Examples of single-action ophthalmic medications for the maintenance treatment of vernal keratoconjunctivitis include ophthalmic mast-cell stabilizers (e.g., cromolyn ophthalmic solution, Alomide ophthalmic solution) and ophthalmic antihistamines (e.g., Zerviate [cetirizine solution]). B. Patient has tried one dual-action ophthalmic mast-cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis. **Note:** Examples of dual-action ophthalmic mast-cell stabilizer/antihistamine products include azelastine ophthalmic solution, beoptastine ophthalmic solution, epinastine ophthalmic solution, ketotifen ophthalmic solution, Lastacaft, olopatadine ophthalmic solution. **Note:** An exception to the requirement for a trial of two single-action ophthalmic medications (i.e., ophthalmic mast-cell stabilizers or ophthalmic antihistamines) or one dual-action ophthalmic mast-cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis can be made if the patient has already tried at least one ophthalmic cyclosporine product .
Vesicare LS	solifenacin succinate oral suspension	**1.** Approve if the patient has tried oxybutynin solution/syrup OR Myrbetriq Granules, if formulary. If neither are formulary, approve. **2.** Patient is < 5 years of age: approve if the patient has tried Myrbetriq Granules, if formulary. If Myrbetriq Granules are non-formulary, approve. **3.** Patients < 3 years of age, approve. **Note:** If the patient has tried any oxybutynin-containing product (e.g., immediate-release or extended-release tablets), this would meet the requirement for a trial of an oxybutynin

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		product. **Note:** If the patient has tried Mybetriq tablets, this would meet the requirement for a trial of Myrbetriq granules.
Victoza and generic	liraglutide (rDNA origin) injection	Type 2 Diabetes Mellitus. If requesting brand Victoza: Approve if the patient has tried and cannot take generic liraglutide due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary. If requesting generic liraglutide or generic liraglutide is non-formulary: **1.** Approve if the patient has tried both Ozempic and Trulicity **[documentation required]**, if formulary (or one if one is formulary). If neither are formulary, approve. **2.** If the patient is less than 18 years of age, approve if the patient has tried Trulicity **[documentation required]**, if formulary. If Trulicity is non-formulary, approve.
Vigafyde	vigabatrin oral solution	Approve if the patient tried and cannot take vigabatrin granules for oral solution (Sabril powder for solution, generics), if formulary. If vigabatrin granules for oral solution (Sabril powder for solution, generics) is non-formulary, approve.
Viibryd 10/20 mg starter pack	vilazodone tablets	Approve if the patient is unable to use vilazodone tablets (which are not packaged in a starter pack).
Vivlodex	meloxicam capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: meloxicam (Mobic, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.
Vuity	pilocarpine 1.25% ophthalmic solution	No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		medication; Denial reason is: Formulary coverage is not provided for this medication.)
Vusion and miconazole-zinc oxide-petroleum	miconazole-zinc oxide-petroleum ointment	Approve if the patient has tried one topical antifungal agent. **Note:** Examples include: miconazole, clotrimazole, ketoconazole, nystatin.
Vyalev	foslevodopa-foscarbidopa subcutaneous infusion	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Onapgo, if formulary. If Onapgo is non formulary, approve if the patient meets ONE of the following (A or B): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following: Crexont capsules, Rytary capsules, or carbidopa-levodopa extended-release tablets, if formulary. If none are formulary, approve; OR B**.** Patient is unable to swallow oral dosage forms or has difficulty swallowing oral dosage forms. **2.** Approve if the patient has already been started on therapy with Vyalev.
Vyzulta	latanoprostene bunod ophthalmic solution 0.024%	Approve if the patient has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): latanoprost ophthalmic solution (Xalatan, generics), travoprost ophthalmic solution (Travatan Z, generics), bimatoprost 0.03% ophthalmic solution (generics), Lumigan, or tafluprost ophthalmic solution (Zioptan, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.
Wainua	eplontersen subcutaneous injection	Approve if the patients meets the following criteria (A and B): A. Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR). Approve if the patient meets ALL of the following (i, ii, iii, iv, and v): i. Patient is ≥ 18 years of age; AND ii. Patient has a transthyretin (TTR) pathogenic variant as confirmed by genetic testing; AND iii. Patient has symptomatic polyneuropathy; AND Note: Examples of polyneuropathy include reduced motor strength/coordination, and impaired sensation (e.g., pain, temperature, vibration, touch). Examples of assessments for symptomatic disease include history and clinical exam, electromyography, or nerve conduction velocity testing. iv. Patient does not have a history of liver transplantation; AND v. The medication is prescribed by or in consultation with a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis; AND

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		B. The patient meets one of the following criteria (i, ii, or iii): i. Patient has tried Amvuttra, if formulary; OR ii. If Amvuttra is non-formulary; OR iii. Patient has already been started on Wainua.
Wezlana IV	ustekinumab for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B): A. Patient has tried ALL of the following: 1) Stelara IV, 2) Steqeyma IV, 3) Yesintek IV, 4) Pyzchiva IV or ustekinumab-ttwe IV, 5) Otulfi IV, and 6) Selarsdi IV, if formulary; AND Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative. B. Patient cannot continue to use all the formulary ustekinumab products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Yesintek IV, Pyzchiva IV, or ustekinumab-ttwe IV, or Otulfi IV, approve if the patient meets ONE of the following (1 or 2): **1.** Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age. Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve.
Wezlana SC	ustekinumab for SC injection	See standard *Inflammatory Conditions – usteknumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary policies*.
Winlevi	clascoterone cream 1%	Acne Vulgaris in a patient ≥ 12 years of age. Approve if the patient meets the following (A and B): A. Patient has tried at least one prescription topical retinoid **[documentation required]**; AND Note: Examples of a prescription topical retinoid are adapalene (Differin generic), Aklief (trifarotene 0.005% cream), tazarotene 0.1% cream (Tazorac 0.1% cream, generic), tazarotene 0.1% gel (Tazorac 0.1% gel, generic), and tretinoin.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		B. Patient has tried at least three other prescription non-retinoid topical therapies **[documentation required]**. Note: Topical retinoids do not count. Examples of other prescription non-retinoid topical therapies for acne include: dapsone gel (Aczone, generic), Azelex (azelaic acid 20% cream), topical clindamycin, topical erythromycin, and topical minocycline (Amzeeq [minocycline 4% foam]). For combination products, each active chemical entity counts as one trial. Example: If one prescription product has 2 non-retinoids, this would fulfill a trial of 2 non-retinoid topical therapies.
Xadago	safinamide tablets	**1.** Approve if the patient has tried two products from the following list, if formulary (or one if one is formulary): selegiline tablets/capsules, rasagiline tablets (Azilect, generics), or Zelapar. If none are formulary, approve. **2.** Patient is already started on Xadago, approve.
Xatmep	methotrexate 2.5 mg/mL oral solution	Approve if the patient has tried Jylamvo, if formulary. If Jylamvo is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient cannot swallow or has difficulty swallowing oral methotrexate tablets; OR **2.** The dose prescribed cannot be obtained using whole methotrexate tablets.
Xelpros	latanoprost 0.005% ophthalmic emulsion	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of 1) latanoprost ophthalmic solution (Xalatan, generics) or 2) Iyuzeh, if formulary. If none are formulary, approve. **2.** If, according to the prescriber, the patient has a significant benzalkonium chloride allergy/sensitivity: approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Iyuzeh, if formulary. If Iyuzeh is non-formulary, approve.
Xelstrym	dextroamphetamine transdermal system	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products, if formulary (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 2) Adzenys XR-ODT tablets, 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) 4) Dyanavel XR oral suspension, or 5) dextroamphetamine extended-release capsules. If none are formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Xerese	acyclovir and hydrocortisone cream, 5% /1%	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), acyclovir 5% cream (Zovirax 5% cream, generics), penciclovir 1% cream (Denavir, generics), Sitavig tablets, or over-the-counter (OTC) Abreva 10% cream.
Ximino and authorized generic	minocycline ER capsule	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve
Xolegel	ketoconazole 2% gel	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. **Note:** naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Luzu 1% cream, Mentax 1% cream.
Xopenex HFA and and levalbuterol HFA	levalbuterol inhalation aerosol	Approve if the patient has tried one single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve.
Xphozah	tenapanor tablets	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried at least two phosphate binders; AND Note: Examples of phosphate binders include: sevelamer, lanthanum, ferric citrate, and sucroferric oxyhydroxide, calcium carbonate, and calcium acetate. B. Patient had an inadequate response and/or intolerance to at least two phosphate binders; OR **2.** Patient meets one of the following (A or B): A. Patient has a contraindication to at least two phosphate binders; OR Note: Contraindication to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia. B. Patient meets BOTH of the following (i and ii):

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		i. Patient has inadequate response and/or intolerance to at least one phosphate binder; AND ii. Patient has a contraindications to at least one phosphate binder. Note: Contraindication to phosphate binders include bowel obstruction, iron overload, or hypercalcemia.
Xpovio	selinexor tablets	Multiple Myeloma. Approve if the patient meets ONE of the following (A or B): A. Patient meets ONE of the following (i, ii, or iii): i. Patient has tried at least FOUR prior regimens for multiple myeloma; OR ii. Patient meets both of the following (a and b): a) Patient has tried at least TWO prior regimens for multiple myeloma; AND b) The medication will be taken in combination with Pomalyst (pomalidomide capsules); OR iii. Patient meets both of the following (a and b): a) Patient has tried at least ONE prior regimen for multiple myeloma; AND b) The medication will be taken in combination with bortezomib, Darzalex (daratumumb infusion), Darzlaex Faspro (daratumumab and hyaluronidase-fihj injection), or Kyprolis (carfilzomib intravenous infusion); OR Note: Examples of prior regimens include Darzalex (daratumumab intravenous infusion)/bortezomib/lenalidomide/dexamethasone, bortezomib/lenalidomide/dexamethasone, Kyprolis (carfilzomib intravenous infusion)/lenalidomide/dexamethasone, Darzalex (daratumumab intravenous infusion)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody. B. Patient has already been started on therapy with Xpovio. Diffuse Large B-Cell Lymphoma; High-grade B-Cell Lymphoma; HIV-related B-Cell Lymphoma; Post-transplant lymphoproliferative disorders. Note: Diffuse Large B-Cell Lymphoma includes patients with histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma. Approve if the patient meets ONE of the following (A or B): A. Patient has tried at least TWO prior therapies; OR B. Patient has already been started on therapy with Xpovio.
Xtampza ER	oxycodone extended-release capsules (with DETERx)	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, hydrocodone ER

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		(Zohydro ER, Hysingla ER, generics), OxyContin, or oxycodone ER tablets [generics]. **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), oxycodone ER tablets (generics), or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), oxycodone ER tablets (generics), or OxyContin. If none are formulary, approve.
Xultophy	insulin degludec/liraglutide injection	Approve if the patient has tried Soliqua, if formulary. If Soliqua is non-formulary, approve if the patient has tried two formulary basal insulins (if two are formulary or one if one is formulary): a glargine product (Basaglar, Lantus, Insulin Glargine [YFGN], Semglee [YFGN], Toujeo, Insulin glargine U300), or a degludec product (Tresiba or Insulin Degludec) AND three formulary glucagon-like peptide-1 (GLP-1) agonists (if three are formulary, or two if two are formulary or one if one is formulary): 1) an exenatide product (Bydureon BCise, Byetta), 2) Ozempic, 3) Trulicity, or 4) liraglutide (Victoza, generics). If none of the basal insulin products or none of the GLP-1 agonists are formulary, approve. Note: Lantus, Insulin Glargine (YFGN), Semglee (YFGN), Basalgar, Toujeo, and Insulin glargine U300 would count as one alternative. Note: Tresiba and Insulin Degludec would count as one alternative. Note: Bydureon BCise and Byetta would count as one alternative. Victoza and its generic would count as one alternative. Note: A trial of Rybelsus or Mounjaro would also count as a trial of a GLP-1 agonist.
Xyrem (brand)	sodium oxybate oral solution	Cataplexy Treatment in Patients with Narcolepsy: Direct the patient to one of 1) sodium oxybate oral solution (authorized generic of Xyrem) [by Hikma] OR 2) sodium oxybate oral solution (authorized generic of Xyrem) [by Amneal], if formulary. If neither are formulary, approve if the patient meets (1 or 2): **1.** Patients ≥ 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve. **2.** Patients ≥ 7 years of age and < 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Lumryz or Xywav, if formulary. If neither are formulary, approve. Excessive Daytime Sleepiness in Patients with Narcolepsy:

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		Direct the patient to one of 1) sodium oxybate oral solution (authorized generic of Xyrem) [by Hikma] OR 2) sodium oxybate oral solution (authorized generic of Xyrem) [by Amneal], if formulary. If neither are formulary, approve if the patient(≥ 7 years of age) has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve.
Yosprala and authorized generic	aspirin and omeprazole delayed-release tablets	Approve if the patient has tried aspirin AND at least five proton pump inhibitors (e.g., omeprazole [Prilosec, generics], rabeprazole tablets [Aciphex, generics], lansoprazole [Prevacid, generics], esomeprazole [Nexium, generics], pantoprazole [Protonix, generics]).
Yuflyma and adalimumab-aaty	adalimumab-aaty subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Yusimry	adalimumab-aqvh subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Choice OR FLEX Formulary* policies.
Zavzpret	zavegepant nasal spray	Approve if the patient meets the following (A and B): A. Patient meets one of the following (i or ii): i. Patient has tried both Nurtec ODT AND Ubrelvy, if both are formulary (or only one if one is formulary); OR ii. If the patient is unable to swallow or has difficulty swallowing tablets, the patient has tried Nurtec ODT, if formulary. If Nurtec ODT is non-formulary, criteria A is met; AND **Note:** The patient would still need to meet criteria B even if criteria A is met. B. Patient meets one of the following (i or ii): i. Patient has tried two triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR ii. Patient meets one of the following (1 or 2): 1. Per the prescriber, the patient has a contraindication to triptans; OR 2. Per the prescriber, the patient has had a significant intolerance to one or more triptans.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Zcort	dexamethasone 1.5 mg tablets (7-day pack)	**1.** Direct to the dexamethasone 1.5 mg tablets (not packed as dose packs). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use dexamethasone 1.5 mg tablets (not packed as dose packs).
Zegalogue	dasiglucagon subcutaneous injection	Approve if the patient has tried BOTH of Gvoke and Baqsimi, if formulary (or one if one is formulary). If neither are formulary, approve.
Zegerid capsules	omeprazole/ sodium bicarbonate capsules	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules, lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension. **Note**: The requested agent would NOT count as a trial of an alternative.
Zegerid packets	omeprazole/ sodium bicarbonate powder for oral suspension (packets)	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generics, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules, lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension. **Note**: The requested agent would NOT count as a trial of an alternative.
Zejula	niraparib capsules and tablets	**1.** Ovarian, Fallopian Tube, or Primary Peritoneal Cancer in the Maintenance setting (after complete or partial response to chemotherapy): Approve if the patient meets one of the following (A or B): A) Patient meets one of the following (i or ii): i. Patient has tried Lynparza **[documentation required]**. If Lynparza is non-formulary, approve; OR ii. Patient has already been started on therapy with Zejula; OR B) Patient meets both of the following (i and ii): i. Patient has had a complete or partial response to first-line platinum-based chemotherapy; AND

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		ii. Patient does not have a BRCA mutation **[documentation required]**. **2.** Uterine Leiomyosarcoma: Approve if the patient meets one of the following (A or B): A) Patient has tried one of Rubraca or Lynparza **[documentation required]**. If neither is formulary, approve; OR B) Patient has already started on Zejula.
Zelapar	selegiline orally disintegrating tablets	**1.** Approve if the patient has tried one product from the following list, if formulary (or one if one is formulary): selegiline tablets/capsules, rasagiline tablets (Azilect, generics), or Xadago. If none are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing selegiline tablets.
Zelnorm	tegaserod tablets	Patient ≥ 18 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list: Linzess AND Trulance, if two are formulary or one if one is formulary. If neither are formulary, approve.
Zercapli and sertraline 150 mg, 200 mg capsules	sertraline 150 mg, 200 mg capsules	**1.** Direct the patient to sertraline 50 mg and/or 100 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the sertraline 50 mg and/or 100 mg tablet.
Zerviate	cetirizine 0.24% ophthalmic solution	Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, or olopatadine solution (generics).
Zetonna	ciclesonide nasal aerosol	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Qnasl. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.
Zilbrysq	zilucoplan subcutaneous injection	Anti-acetylcholine receptor antibody positive generalized myasthenia gravis in a patient ≥ 18 years of age. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B):

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		A. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with ONE of 1) an eculizumab product (Soliris, Bkemv, Epysqli) or 2) Ultomiris, if formulary; OR Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli). ii. Patient is unable to obtain intravenous access; AND Note: If neither are formulary, would still need to meet criterion B. B. Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of Vyvgart intravenous, Vyvgart Hytrulo, or Rystiggo, if formulary; OR Note: If none are formulary, would still need to meet criterion A. Note: If there are no formulary alternatives from criterion A or B, approve. **2.** Approve if the patient has already been started on therapy with Zilbrysq.
zileuton extended-release tablets	zileuton extended-release tablets	Approve if the patient has tried one of the following, if one is formulary: montelukast (Singulair, generics) or zafirlukast (Accolate, generics). If none are formulary, approve.
Zilxi	minocycline 1.5% topical foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one formulary product from three of the four groups below, if there is a formulary product in the group: Group 1: An topical azelaic acid product (azelaic acid 15% gel [Finacea 15% gel, generics], Finacea 15% foam, Azelex 20% cream); Group 2: A topical sodium sulfacetamide 10%/sulfur 5% product. (any generic sodium sulfacetamide10%/sulfur 5% product, Rosula); Group 3: A topical metronidazole product (metronidazole 0.75% or 1% [MetroGel, generics; MetroCream, generics; MetroLotion, generics, Noritate]); Group 4: a topical ivermectin product (generic ivermectin cream or Soolantra).
Zimhi	naloxone hydrochloride intramuscular or subcutaneous injection 5 mg/ 0.5 ml	**1.** Approve if the patient has tried naloxone syringes, if formulary. If naloxone syringes are non-formulary, approve. **2.** Approve, if according to the prescriber, a higher-strength naloxone product is needed.
Zituvio and authorized generic sitagliptin	sitagliptin 100 mg, 50 mg, 25 mg tablets	Approve if the patient has tried Januvia, if formulary. If Januvia is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried three products from the following

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
		list (if three are formulary or two if two are formulary, or one if only one is formulary): saxagliptin (Onglyza, generics), Tradjenta, or alogliptin tablets (Nesina, authorized generics). If none are formulary, approve. Note: Saxagliptin and Onglyza count as one alternative. Alogliptin and Nesina count as one alternative. **2.** Patients with a history of heart failure or a history of renal impairment: approve if the patient has tried Tradjenta, if formulary. If Tradjenta is non-formulary, approve.
Zma Clear	sodium sulfacetamide 9% and sulfur 4.5% suspension	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 9.8%-4.8% topical cleanser, generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide-sulfur.
zolpidem 7.5 mg capsules (brand)	zolpidem 7.5 mg capsules	Approve if the patient has tried three of the following agents, if three are formulary (or two if two are formulary, or one if only one is formulary): zolpidem tablets (other strengths) [Ambien, Ambien CR, generics], eszopiclone tablets (Lunesta, generics), or zaleplon. If none are formulary, approve.
Zomacton (formerly Tev-Tropin)	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Approve if the patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Saizen. **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.
Zonisade oral suspension	zonisamide oral suspension	Approve if the patient is unable to swallow or has difficulty swallowing zonisamide capsules. If zonisamide capsules are non-formulary, approve.

Non-Covered Product	Chemical Name and Dosage Form	Exception Criteria
Zorvolex and authorized generic	diclofenac capsules	Approve if the patient has tried five prescription-strength, oral NSAIDS. **Note**: Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.
Zoryve 0.15% Cream	roflumilast 0.15% cream	Atopic dermatitis in a patient ≥ 6 years of age. Approve if the patient has tried TWO of pimecrolimus cream (Elidel cream, generics), tacrolimus ointment, Eucrisa, or Vtama (if two are formulary or one if one is formulary). If none are formulary, approve.
Zyclara 2.5% and 3.75%	imiquimod 2.5% and 3.75% cream	Approve if the patient has tried imiquimod 5% cream (Aldara, generics), if formulary. If imiquimod 5% cream (Aldara, generics) is non-formulary, approve.
Zyflo	zileuton tablets	Approve if the patient has tried one of the following, if one is formulary: montelukast (Singulair, generics) or zafirlukast (Accolate, generics). If neither are formulary, approve.
Zylet	tobramycin 0.3%/ loteprednol etabonate 0.5% ophthalmic suspension	**1.** Approve if the patient has tried one of tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics) or TobraDex ST, if formulary. If neither are non-formulary, approve. **2.** Patients < 2 years of age, approve. **3.** For the treatment of currently active eye infections: approve in patients already receiving Zylet to complete the course of therapy.