

APPROVAL CRITERIA-CCHP

iCCHP STATUS	Drug Name	CRITERIA
PA	<p>Acute Migraine Treatments</p> <p>Ubrelvy (ubrogepant) - PREFERRED</p> <p>Nurtec ODT (rimegepant)</p> <p>Reyvow (lasmiditan)</p> <p>Zavzpret (zavegepant)</p>	<p>For Nurtec ODT: If the request is for migraine prevention please refer to the Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention criteria</p> <p><u>Initial Authorization:</u> Nurtec ODT, Reyvow, Ubrelvy, and Zavzpret will be approved when all of the following criteria are met:</p> <ul style="list-style-type: none"> • Prescribed by, or in consultation with a neurologist, headache specialist, migraine specialist, pain specialist, or other relevant specialist • Diagnosis of migraine headache • Requested dose is within FDA approved dosing guidelines • Documented trial and failure of (or medical justification for not using) an analgesic medication and two triptan products <ul style="list-style-type: none"> ○ One preferred 1st line triptan and one preferred 2nd line triptan • Attestation the patient was counseled regarding not driving or operating machinery until at least 8 hours after taking each dose (Reyvow only) • If the medication request is for a non-preferred acute migraine treatment medication, the patient has a documented medical reason (intolerance, hypersensitivity, contraindication, treatment failure etc.) for not using Ubrelvy <p><u>Criteria for Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation of improvement in migraine pain and symptom (s) (e.g., photophobia, nausea, phonophobia) <p>Nurtec ODT QL of 8 units per month. Reyvow QL of 8 units per month. Ubrelvy QL of 16 units per month Zavzpret QL of 6 units per month</p> <p><u>Criteria for exceeding the quantity limit (note all of the above criteria must also be met)</u></p> <ul style="list-style-type: none"> • Documented trial and failure (or a medical justification for not using e.g. hypersensitivity, baseline bradycardia or hypotension, adverse events experienced from previous trial, etc.) with at least one drug from two categories below for at least 4 weeks EACH, at minimum effective doses: <ul style="list-style-type: none"> ○ Beta-adrenergic blockers ○ Topiramate or divalproex ER or DR ○ Amitriptyline or venlafaxine ○ Frovatriptan, zolmitriptan or naratriptan (for menstrual migraine prophylaxis) <p>If all of the criteria are met, the initial request will be approved for 3 months. For continuation of therapy, the request will be approved for 6 months.</p> <p>Last reviewed 6/2025</p>

* QL: QUANTITY LIMIT

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PA: REFERRING TO A NON-PREFERRED DRUG, REQUIRING A PRIOR AUTHORIZATION.

C1: CODE 1 RESTRICTION, REFERRING TO A NON-PREFERRED DRUG REQUIRING A CERTAIN CRITERIA WHICH COULD BE CITED ON THE PRESCRIPTION OR COMMUNICATED TO THE PHARMACIST. A PHARMACIST COULD ALSO OBTAIN THIS INFORMATION. NO PA FORM IS NECESSARY TO BE FILLED FOR THIS CONDITION.

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PA	Acyclovir (Zovirax®) 5% Cream	<ul style="list-style-type: none"> • Diagnosis of herpes labialis (cold sores). • Documented trial and failure or intolerance to Abreva AND a preferred oral antiviral, such as acyclovir AND Acyclovir 5% Ointment <p>Last review: 12/2025</p>
PA	Acyclovir (Zovirax®) 5% Ointment	<p>Criteria for use for diagnosis of Cold Sores:</p> <ul style="list-style-type: none"> • Documented trial and failure or intolerance to Abreva AND a preferred oral antiviral, such as acyclovir. <p>Criteria for use for diagnosis of Venereal Herpes:</p> <ul style="list-style-type: none"> • Documented trial and failure or intolerance to a preferred oral antiviral, such as acyclovir <p>Last review: 12/2025</p>
PA	<p>Adapalene 0.1%/benzoyl peroxide 2.5% topical gel (Epiduo gel)</p> <p>Epiduo Forte (adapalene / benzoyl peroxide) 0.3 %-2.5 % Topical Gel</p>	<p>Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <p><u>Adapalene 0.1%/ benzoyl peroxide 2.5% topical gel (Epiduo gel) Formulary <= 30 years old.</u></p> <p>Qty Limit: Unless PA indicates treatment area includes back – Limit to 1 tube/30 days (up to 90-days supply)</p> <p>For members >30 years of age</p> <ul style="list-style-type: none"> • Clinically diagnosed acne vulgaris • Trial and failure, intolerance, contraindication or inability to use the following formulary alternatives: adapalene (Differin) 0.1% gel OTC OR topical antibiotics OR • For severe or comedonal acne, member must only try and fail one of the following: adapalene (Differin) 0.1% gel OTC, topical benzoyl peroxide, a topical antimicrobial <p><u>Epiduo Forte (adapalene / benzoyl peroxide) 0.3 %-2.5 % Topical Gel</u></p> <ul style="list-style-type: none"> • Clinically diagnosed acne vulgaris • Trial and failure, intolerance, or inability to use topical tretinoin or adapalene alone • Trial and failure, intolerance, or inability to use generic Epiduo 0.1%/ 2.5% gel <p>Last review 12/2025</p>
PA	<p>ADHD Stimulant medications</p> <p><u>F-QL-AL, PA is required for members over 18 years of age</u></p> <p>-amphetamine-dextroamphetamine (Adderall) tablet</p> <p>-amphetamine-dextroamphetamine ER (Adderall XR) capsule</p> <p>-dextroamphetamine sulfate (Dexedrine) tablet</p> <p>-dextroamphetamine sulfate ER (Dexedrine ER) capsule</p> <p>-dexmethylphenidate (Focalin) tablet</p> <p>-dexmethylphenidate ER (Focalin XR) capsule</p> <p>-methylphenidate (Ritalin) tablet</p> <p>-methylphenidate ER (LA) (Ritalin LA) capsule</p>	<p>Criteria for ADHD medications for patients over 18 years of age, for F-QL medications:</p> <p>-Appropriate diagnosis/indication and dose used for the requested medication or use in narcolepsy, if indicated</p> <p>OR</p> <p>-Appropriate diagnosis/indication for requested medication- For use in adults for Attention Deficit Hyperactivity Disorder, the DSM-V criteria must be met.</p> <p>AND</p> <p>-Appropriate dose of medication based on age and indication</p> <p>Criteria for lisdexamfetamine: (bullet points below are all inclusive unless otherwise noted)</p> <ul style="list-style-type: none"> • Clinically diagnosed ADHD. • Must be older than 6 years of age. • Tried and failed long acting methylphenidate. • Tried and failed long acting amphetamine mixed salts

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<p>-methylphenidate ER (CD) (Metadate CD) capsule</p> <p>-methylphenidate ER (OSM) (Relexxii) tablet</p> <p>-methylphenidate ER (Concerta) tablet</p> <p>-methylphenidate (Methylin) oral solution</p> <p>-methylphenidate (Methylin) tablet/chewable tablet</p> <p><u>F-PA</u></p> <p>-methamphetamine (Desoxyn) tablet</p> <p>-Lisdexamfetamine (Vyvanse) oral capsule</p> <p>-Lisdexamfetamine (Vyvanse) chewable tablet</p> <p><u>Non-formulary</u></p> <p>-Adzenys XR-ODT (amphetamine) ER ODT & ER suspension</p> <p>-Dyanavel XR ER suspension</p> <p>amphetamine sulfate (Evekeo) tablets</p> <p>-Zenedi (dextroamphetamine) tablets</p> <p>dextroamphetamine (Procentra) oral solution</p> <p>-Mydayis (dextroamphetamine/amphetamine) ER capsules</p> <p>- Methylphenidate (Daytrana)transdermal patch</p> <p>-Aptensio XR (methylphenidate HCl) ER capsules</p> <p>-Quillivant XR (methylphenidate HCl) oral suspension & Quillichew ER chewable tablets</p> <p>-Cotempla XR-ODT (methylphenidate) ODT</p> <p>-Jornay PM (methylphenidate) capsule</p> <p>Azstarys (serdexmethylphenidate/dexmethylphenidate)</p> <p>Any other newly approved medication in this class</p>	<p>Criteria for ADHD medications for patients over 18 years of age, for F-PA (T3-PA) medications, or non-formulary medications (apart from Vyvanse):</p> <ul style="list-style-type: none"> • Appropriate diagnosis/indication and dose used for the requested medication for use in narcolepsy, if indicated <p>OR</p> <ul style="list-style-type: none"> • Appropriate diagnosis/indication for requested medication- For use in adults for Attention Deficit Hyperactivity Disorder, the DSM-V criteria must be met. <p>AND</p> <ul style="list-style-type: none"> • Appropriate dose of medication based on age and indication <p>AND</p> <ul style="list-style-type: none"> • If request is for a T3-PA or non-formulary medication, documented trial and failure or intolerance with up to three formulary medications used to treat the documented diagnosis. For medications where there is only one formulary agent, only that agent must have been ineffective or not tolerated <p>OR</p> <ul style="list-style-type: none"> • No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia. <p>OR</p> <ul style="list-style-type: none"> • All other formulary medications are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy <p>If the criteria are met, the request will be approved with up to a 12 month duration</p> <p>Last review 6/2025</p>
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PA	Akynzeo (Netupitant and palonosetron)	<p>1. Documented diagnosis and FDA labeled dosing regimen</p> <p>AND</p> <p>2. Documentation that the patient is undergoing moderately or highly emetogenic chemo</p> <p>AND</p> <p>3. Documentation that dexamethasone will be given in combination with Akynzeo, unless documentation of contraindication to dexamethasone is provided</p> <p>AND</p> <p>4. Documentation that the patient has experienced inadequate response or contraindication to aprepitant/ fosaprepitant AND ondansetron OR granisetron WITH dexamethasone</p> <p>Last review: 3/2025</p>
	Albendazole (Albenza)	<p>Criteria for Use, ALL of the following criteria must be met:</p> <ul style="list-style-type: none"> • Prescriber is an Infectious disease specialist or has consulted with an Infectious disease specialist • A confirmed diagnosis of ONE of the following: <ul style="list-style-type: none"> o Parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, Taenia solium o Cystic hydatid disease of the liver, lung, and peritoneum caused by the larval form of the dog tapeworm, Echinococcus granulosus <p>Authorization will be issued for up to 6 months</p> <ul style="list-style-type: none"> • Off-label use for Enterobius vermicularis (pinworm) requires: <ul style="list-style-type: none"> o A trial and failure of OTC pyrantel pamoate products such as Reese's Pinworm or Pin-X <p>Last review: 9/2025</p>

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PA	Allergic conjunctivitis agents	<p><u>Formulary</u></p> <ul style="list-style-type: none"> • Azelastine Hydrochloride (Optivar®) • Cromolyn sodium (Crolom®) • Ketotifen eye drops (Alaway™ OTC or Zaditor® OTC) • Olopatadine Hydrochloride 0.1% (Pataday Twice Daily) • Olopatadine Hydrochloride 0.2% (Pataday Once Daily) <p><u>Formulary PA and Non-formulary</u></p> <ul style="list-style-type: none"> • Pataday Once Daily 0.7% (Olopatadine Hydrochloride 0.7%) • Epinastine HCl (Elestat®) • Nedocromil Sodium (Alocril®) • Zerviate (cetirizine) 0.24% • Lastacaft (alcaftadine) • Bepotastine (Bepreve) <p><u>Criteria for approval</u></p> <ul style="list-style-type: none"> • Diagnosis of allergic conjunctivitis AND <p>For formulary PA and Non-formulary medications</p> <ul style="list-style-type: none"> ○ Documented trial and failure, intolerance or contraindication to ketotifen eye drops (Alaway™ OTC or Zaditor® OTC) AND cromolyn AND Olopatadine 0.1% drops (Pataday Twice Daily), or olopatadine 0.2% drops (Pataday Once Daily) <p>If the above conditions are met, the request will be approved with up to a 12 month duration</p> <p>Last review 3/2025</p>
	<p>Anticholinergic Medications:</p> <p>Scopolamine (TransdermScop) Patch</p> <p>Glycopyrrolate Oral Solution (Cuvposa)</p> <p>Qbrexza (glycopyrronium) 2.4% cloth</p>	<p>TransdermScop</p> <ul style="list-style-type: none"> • For prevention of motion sickness, requires a trial and failure of, or inability to use at least 2 preferred formulary medications such as: Meclizine (Antivert), dimenhydrinate (Dramamine), promethazine(Phenergan), or chlorpheniramine (Chlor-trimeton). • For the treatment of chemotherapy-induced nausea, requires a trial and failure, or inability to use of at least 3 preferred formulary medications such as: ondansetron (Zofran), metoclopramide (Reglan), chlorpromazine (Thorazine), lorazepam (Ativan), or dexamethasone(Decadron) <p>Glycopyrrolate oral solution (Cuvposa)</p> <ul style="list-style-type: none"> • Patient has severe drooling caused by a neurologic disorder and cannot take glycopyrrolate as the tablet formulation, and proof that the patient cannot take the tablet formulation is provided. <p>Qbrexza (glycopyrronium) 2.4% cloth</p> <ul style="list-style-type: none"> • For primary axillary hyperhidrosis • Requires a trial and failure of, or inability to use antiperspirants (OTC and Rx-strength) <p>If the criteria are met, the request will be approved with up to a 12 month duration.</p> <p>Last review 3/2025</p>

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PA	Antihypertensive-Beta Blockers	<p>Formulary NON-Selective Beta-Blockers</p> <ul style="list-style-type: none"> • Nadolol • Propranolol (IR and ER) • Carvedilol • Labetalol (IR and ER) <p>Formulary Selective Beta-Blockers</p> <ul style="list-style-type: none"> • Acebutolol • Atenolol • Bisoprolol • Metoprolol (IR and ER). <p>Formulary with PA:</p> <ul style="list-style-type: none"> • Pindolol • Timolol <p>PA criteria for approval</p> <ul style="list-style-type: none"> • Documented trial and failure, intolerance or contraindication to at least one formulary beta- <p>If the criteria are met, the request will be approved with up to a 12 month duration.</p> <p>Last reviewed 3/2025</p>
PA	Antihypertensive-Calcium Channel Blockers	<p>Formulary:</p> <ul style="list-style-type: none"> • Amlodipine • Diltiazem • Diltiazem CD • Diltiazem ER (XR/XT) capsule • Felodipine • Nifedipine • Nifedipine ER • Verapamil SR <p>Formulary with step therapy:</p> <ul style="list-style-type: none"> • Isradipine <p>Formulary with PA:</p> <ul style="list-style-type: none"> • Diltiazem ER tablet • Diltiazem CD 360mg capsule • Nicardipine • Nisoldipine SR • Verapamil ER (Verelan PM) <p>PA criteria for approval</p> <ul style="list-style-type: none"> • Documented trial and failure, intolerance or contraindication to at least one formulary calcium channel blocker. <p>Notes:</p> <ul style="list-style-type: none"> • For diltiazem ER (Cardizem LA®, Matzim LA®) tablet, must try and fail generic Cardizem CD or ER 24 hour capsule formulations • For diltiazem CD 360mg capsule, use 2x diltiazem 180mg capsules • For verapamil sustained release (Verelan®) 360mg pellet capsule, use 2x180mg capsules of verapamil (DDID 55957) <p>Last review 3/2025</p> <p>If the criteria are met, the request will be approved with up to a 12 month duration.</p>

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PA	<p>Anti-Obesity Medications</p> <p>Preferred: Orlistat (Alli®, Xenical®) Phentermine (Adipex-P®)</p> <p>Non-preferred: Lomaira (phentermine) Naltrexone/bupropion extended-release (Contrave®) Phentermine/topiramate (Qsymia®) Liraglutide (Saxenda®) Wegovy (semaglutide) pen injector Zepbound (tirzepatide)</p> <p>Any newly approved medication indicated for the treatment of obesity or weight management</p>	<p>**Please Note: If the request is for Wegovy to reduce the risk of major adverse cardiovascular events, MASH, or for Zepbound for OSA, please refer to the “GLP-1 Receptor Agonists (Wegovy/Zepbound) for Non-Weight Loss Indications” criteria**</p> <p>Initial Authorization Preferred agents</p> <ul style="list-style-type: none"> • Documentation of trial and failure of lifestyle modifications such as diet and exercise • Requested dose is appropriate per labeling • Requires baseline weight and BMI • <u>For adults BMI must be one of the following:</u> <ul style="list-style-type: none"> ○ For BMI ≥ 30 kg/m² ○ For BMI ≥27 kg/m² , must have one or more comorbidities (e.g. DM, sleep apnea, HTN, OA, CAD, venous stasis, etc.) • For pediatric patients: BMI/percentile for BMI must align with package labeling <ul style="list-style-type: none"> ○ American Academy of Pediatric guidelines will also be taken under consideration • For phentermine requests, documentation member does NOT have: history of cardiovascular disease (arrhythmias, congestive heart failure, coronary artery disease, stroke or uncontrolled hypertension), history of drug abuse, and is NOT currently pregnant • For orlistat requests, documentation member does NOT have a chronic malabsorption syndrome or cholestasis and is NOT currently pregnant • For Xenical (orlistat): trial and failure or medical reason for not using Alli (orlistat) • If above criteria is met, approval is for 3 months at a time <ul style="list-style-type: none"> ○ ***Orlistat 60 mg capsules are preferred to 120 mg capsules. Package size #120 capsules/40 days should be approved, if possible.*** <p>Non-preferred agents:</p> <ul style="list-style-type: none"> • <u>For ALL non-preferred agents the following must be met:</u> • Documentation of trial and failure of lifestyle modifications such as diet and exercise must include: <ul style="list-style-type: none"> ○ A consultation has taken place between the member and a physician (or dietician or nutritionist or weight management expert, etc) during which a reduced calorie diet plan (~500 Kcal or more) and exercise plan (~150mins/week activity) has been discussed. Dated medical chart notes must be submitted to demonstrate consultation. ○ Documentation of a second consultation with member must demonstrate compliance to the diet and physical activity plan for a minimum of 3 months <ul style="list-style-type: none"> ▪ Patient must provide a daily log of diet and physical activity, which must include calories and minutes of physical activity each day. Documentation of this daily log must be submitted with the prior authorization request. -OR- ○ Documentation that the member has been and is currently following a dietary and behavior modification program for weight loss for several months. Examples of acceptable programs include, but are not limited to Weight watchers, 18 reasons, etc. ○ Requires baseline weight and BMI ○ Requested dose is appropriate per labeling <ul style="list-style-type: none"> • For Lomaira: trial and failure or medical reason for not using generic phentermine • For naltrexone/bupropion ER (Contrave) requests, patient does NOT have HTN; current or history of seizure disorder; is not currently using opioids; and is NOT currently pregnant • For phentermine/topiramate (Qsymia) requests, patient does NOT have hyperthyroidism, glaucoma and is NOT currently pregnant • For Saxenda, Wegovy, and Zepbound documentation of trial and failure of, contraindication to, or inability to use Contrave or phentermine/topiramate (Qsymia) • If above criteria is met, approval is for 3 months (4 months for Saxenda) at a time
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	<p>(continuation of Anti-obesity)</p>	<p>Reauthorization</p> <ul style="list-style-type: none"> • Documentation of at least 3-5% reduction in baseline body weight after initiation of treatment according to these timeframes: <ul style="list-style-type: none"> ○ Phentermine/topiramate (Qsymia) requires documented weight loss of at least 3% of baseline body weight after 12 weeks of initial treatment on a dose of at least 7.5mg/46mg daily. For continuation beyond 6 months, the member must demonstrate continued weight loss, or maintain the plateau weight achieved with diet and exercise ○ Contrave (naltrexone/bupropion) requires documented weight loss of at least 5% of baseline body weight after the first 12 weeks of initial treatment. For continuation beyond 6 months, the member must demonstrate continued weight loss, or maintain the plateau weight achieved with diet and exercise. ○ Saxenda (liraglutide) requires documented weight loss of at least 4% of baseline body weight after the first 16 weeks of initial treatment. For continuation beyond 6 months, the member must demonstrate continued weight loss, or maintain the plateau weight achieved with diet and exercise. ○ Wegovy (semaglutide) requires documented weight loss of at least 5% of baseline body weight after the first 12 weeks of initial treatment. For continuation beyond 6 months, the member must demonstrate continued weight loss, or maintain the plateau weight achieved with diet and exercise and requires the member to be on 2.4mg <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • If a weight-related comorbidity was previously noted, an objective improvement is documented (e.g. reduction in blood pressure, cholesterol, hemoglobin A1c, etc) • For phentermine monotherapy requests, NOT approved for weight loss beyond 6 months therapy • For orlistat requests, NOT approved for weight loss beyond 4 years therapy <ul style="list-style-type: none"> • If above criteria is met, approval is for 6 months at a time <p style="margin-top: 20px;">Last review 12/2025</p>
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	Anzupgo (delgocitinib)	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Medication is prescribed at an FDA approved dose • Diagnosis of moderate to severe chronic hand eczema (CHE) • Documentation of hand eczema persisting for >3 months or recurring ≥2 times within 12-month time frame • Trial and failure, or contraindication to, ≥2 formulary moderate/high-potency topical corticosteroids <p><u>Exclusion:</u> Current use of Opzelura (ruxolitinib), systemic JAK inhibitors, or potent immunosuppressants</p> <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (i.e. significant clearing of the skin, reduction in itching) • Medication is prescribed at an FDA approved dose <p><u>Coverage Duration:</u> If all the criteria are met, the initial request will be approved for 6 months and reauthorization request will be approved for 12 months</p> <p>Last review: 12/2025</p>
PA	APAP/Caffeine/Butalbital/Codeine (Floricet/Codeine®)	<p>Max 6 capsules in 24 hours Tried and failed OR contraindications to preferred alternatives.</p> <p>Last review 6/2025</p>
PA	Asenapine SL tabs (Saphris)	<p>Criteria for Use: (all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • Clinically diagnosed with Schizophrenia or Bipolar disorder, including manic and mixed episodes associated with Bipolar Disorder. • The drug is being prescribed for an FDA approved age • Must have tried and failed or been intolerant to at least 2 formulary atypical antipsychotic agents such as olanzapine, quetiapine, risperidone, clozapine or ziprasidone <p>Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

<p>PA</p>	<p>Atovaquone (Mepron®)</p>	<ul style="list-style-type: none"> ▪ Diagnosis of PCP or diagnosis with the need to prevent PCP infection ▪ Documented trial and failure with therapeutic doses or intolerance to trimethoprim-sulfamethoxazole (TMP-SMZ) (first line therapy). <p>If the above conditions are met, the request will be approved with a 12 month duration</p> <p>FDA INDICATIONS: Pneumocystis jirovecii pneumonia</p> <p><u>DOSAGE AND ADMINISTRATION:</u> Prevention of PCP: Adults and adolescents 13 years of age and above: 1500 mg once daily with a meal. Treatment of mild-to-moderate PCP: Adults and adolescents 13 years of age and above: 750 mg administered with food twice daily for 21 days (total daily dose 1500 mg).</p> <p>Last review 9/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Azelaic acid (Finacea®) 15% gel, foam	<p>Criteria for Use (ALL of the following must be met):</p> <ul style="list-style-type: none"> • Must be diagnosed with rosacea and prescribed by a dermatologist • Must have a trial and failure or intolerance to topical metronidazole • For approval of Finacea 15% foam, must have a trial and failure or intolerance to generic azelaic acid (Finacea) 15% gel <p>Quantity Limit: 50gm per 30 days</p> <p>Last review 6/2025</p>
PA	Becaplermin (Regranex®)	<p>Approvable for diabetic neuropathic ulcers in the lower extremities that extend into the subcutaneous tissue or beyond and have an adequate blood supply. It is not indicated in children under the age of 16 years. Ulcer size must be submitted on PA form. Approve 15 gm/month x12 weeks of therapy. Therapy beyond 12 weeks requires another PA submission including a re-measurement of ulcer size. Ulcer size must be ~30% smaller for additional approval. If yes, approve for additional 8 weeks of therapy. Maximum treatment duration is 20 weeks. Approve one 15-gram tube per month only.</p> <p>Professional service info: the weight of Regranex® from 15 gram tubes is 0.65 gram per inch length and 0.25 g per centimeter length. . (One 15gm tube provides a total of 60cm in length or 23 inches in length of ointment)</p> <p>Additional fax back message: the amount of Regranex® to be applied should be recalculated by the physician or wound caregiver at weekly or biweekly intervals depending on the rate of change in ulcer area.</p> <p><u>Tube size formula (CENTIMETERS)</u> 15 g tube Length X width divided by 4</p> <p><u>Tube size formula (INCHES)</u> 15 g tube Length X width x 0.6</p> <p>Exceptions to the 15 gm tube size limit may be made for wound sizes exceeding the formulas above</p> <p>Last review 12/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Brexpirazole (Rexulti)	<ul style="list-style-type: none"> • Criteria for Use for Schizophrenia <ul style="list-style-type: none"> • Age ≥ 13 years old • Clinically diagnosed with schizophrenia • Must have tried and failed or intolerant to at least 2 formulary atypical antipsychotic agents such as olanzapine, quetiapine, risperidone, clozapine or ziprasidone <p>Criteria for Use for Major Depressive Disorder (MDD)</p> <ul style="list-style-type: none"> • Age ≥ 18 years old • Clinically diagnosed with MDD • Must be used as adjunct treatment to ADT and not as monotherapy • Must have tried and failed or intolerant to at least 2 formulary atypical antipsychotic agents such as olanzapine, quetiapine, risperidone, clozapine or ziprasidone <p>Criteria for agitation associated with Alzheimer’s Disease</p> <ul style="list-style-type: none"> • Age ≥ 18 years old • Patient must have a diagnosis of probable Alzheimer's disease according to National Institute of Neurological and Communicative Diseases and Stroke/Alzheimer’s Disease and Related Disorders Association (NINCDS-ADRDA) criteria • Patient must have a Mini-Mental State Examination (MMSE) score of ≥ 5 and ≤ 22 and have a total score of ≥4 by the agitation/aggression item of the Neuropsychiatric Inventory/Neuropsychiatric Inventory - Nursing Home Version (NPI/NPI-NH) <p>Last review 6/2025</p>
P A	Brimonidine (Alphagan P®)	<p>Must try and fail or have reason not to use brimonidine (Alphagan) 0.2%</p> <p>Last review: 9/2025</p>
	Brinsupri (brensocatib)	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescribed by or in consultation with a pulmonologist • Diagnosis of bronchiectasis confirmed by chest CT scan • Documentation patient does not have Cystic Fibrosis • At least 2 exacerbations in the past 12 months requiring an antibiotic prescription, urgent care or emergency room visit, or hospitalization • Medication is prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (i.e. decrease in cough, sputum production, exacerbations, etc.) • Medication is prescribed at an FDA approved dose <p><u>Coverage Duration:</u> If all the criteria are met, the initial and reauthorization requests will be approved for 12 months</p> <p>Last review: 12/2025</p>

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APPROVAL CRITERIA-CCHP

<p>PA</p>	<p>Buprenorphine (Butrans)</p>	<p>Usual Dosage <u>Opioid-naïve (<30 mg of oral morphine equivalent):</u> Initial: 5 mcg/hour</p> <p><u>Patients receiving daily dose of 30-80 mg of oral morphine equivalents:</u> Initial: 10 mcg/hour applied once every 7 days and taper current around-the-clock opioid for up to 7 days to ≤30mg/day oral morphine or equivalent.</p> <p><u>Patients who were receiving daily dose of >80mg of oral morphine equivalents:</u> Consider the use of an alternative analgesic. The maximum dose is 20 mcg/hr every 7 days</p> <p>Criteria for commercial member use (unless otherwise noted)</p> <ol style="list-style-type: none"> 1. Diagnosis of pain severe enough to require daily, around-the-clock, long-term opioid treatment 2. Documented trial and failure or intolerance to at least three opioid or Non-opioid formulary therapies such as oral NSAIDs, topical analgesics, Corticosteroids, opioids and anticonvulsants 3. If approved, maximum quantity limit: #4 patches every 28 days <p>Not approved if:</p> <ol style="list-style-type: none"> 1. Used for acute or as-needed pain relief. 2. Patient with long QT syndrome <p>Last review 6/2025</p>
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APPROVAL CRITERIA-CCHP

P A		<p>Dovonex cream/oint available as 60/120gm Dovonex solution avail in 60mL Dosing: Cream & Oint and solution - apply BID</p> <p>IF approved, max limit of a) 240 grams/ month of cream/ointment b) 120 mL/month of solution</p> <p>Requests for > 240 grams/month of cream/oint or >120mL/month of soln, provider must provide the size and description of areas to be treated.</p> <p><u>If prescriber is a dermatologist, approve.</u> If not, the following criteria must be met</p> <p>Criteria for calcipotriene cream, ointment, or solution (First line)</p> <ul style="list-style-type: none"> • Diagnosis of psoriasis • Tried and failed or inability to use at least two preferred formulary agents (ex: topical corticosteroids) <p>Criteria for Taclonex ointment and calcipotriene/betamethasone (Taclonex) suspension (2nd line)</p> <ul style="list-style-type: none"> • Diagnosis of psoriasis • Tried and failed or inability to use at least one preferred formulary agent (ex: topical corticosteroids) AND • Tried and failed or inability to use calcipotriene cream, ointment, or solution and betamethasone (as separate products) simultaneously <p>Criteria for (calcipotriene) Sorilux foam and Vectical ointment (3rd line)</p> <ul style="list-style-type: none"> • Diagnosis of psoriasis • Tried and failed or inability to use at least two preferred formulary agents (ex: topical corticosteroids) AND • Sorilux foam and Vectical ointment: Tried and failed or inability to use calcipotriene cream, ointment, or solution <p style="text-align: right;">Last review 12/2025</p>
	<p>Topical Vitamin D analogs</p> <p>Calcipotriene (Dovonex) cream, ointment</p> <p>Calcipotriene solution</p> <p>Calcipotriene/betamethasone (Taclonex) ointment</p> <p>Calcipotriene/betamethasone (Taclonex) suspension</p> <p>Calcipotriene (Sorilux) foam 60 g</p> <p>Calcitriol (Vectical) 3 mcg/g ointment</p>	

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APPROVAL CRITERIA-CCHP

<p style="text-align: center;"><u>Chelators</u></p> <p>Deferoxamine mesylate (Desferal) Vial Deferasirox (Jadenu) Tablet Deferasirox (Exjade) Tablet for Oral Suspension Deferasirox (Jadenu) Granule Pack Deferiprone (Ferriprox) tablet Ferriprox (2 times a day) (deferiprone) 1,000mg tablet Ferriprox (deferiprone) 100mg/mL oral solution Penicillamine (Cuprimine, Depen, D-penamamine) capsule, tablet Trientine (Syprine) capsule Cuvrior (trientene tetrahydrochloride) tablet Galzin (Zinc acetate) capsule</p>	<p><u>Requests for deferasirox (Exjade, Jadenu) only:</u> Chronic iron overload due to blood transfusions:</p> <ul style="list-style-type: none"> • Dose is appropriate for age and weight • Diagnosis of chronic iron overload due to blood transfusions • Patient receiving blood transfusions on a regular basis/participating in blood transfusion program • Serum Ferritin concentration is consistently > 1000 mcg/L. If the serum ferritin levels fall consistently below 500 mcg/L, deferasirox (Exjade, Jadenu) must be discontinued • Documentation that patient is unable to use deferoxamine (Desferal) parenterally (does not apply for pediatric patients) • Requests for deferasirox (Exjade) dispersible tablets require documentation of trial and failure of, intolerance, or inability to use deferasirox (Jadenu) tablets • Requests for deferasirox (Jadenu Sprinkle) oral granules in packet must meet all criteria above AND documentation of difficulty or inability to swallow tablets <p>Chronic iron overload in non-transfusion dependent thalassemia syndromes:</p> <ul style="list-style-type: none"> • Dose is appropriate for age and weight • Diagnosis of thalassemia syndrome • Liver iron content (LIC) by liver biopsy of ≥ 5 mg Fe/g dry weight • ≥ 2 measurements of serum ferritin levels > 300mcg/L at least one month apart • Requests for deferasirox (Exjade) dispersible tablets require documentation of trial and failure of, intolerance, or inability to use deferasirox (Jadenu) tablets • Requests for deferasirox (Jadenu Sprinkle) oral granules in packet must meet all criteria above AND documentation of difficulty or inability to swallow tablet <p><u>Requests for Ferriprox (deferiprone) only:</u> <u>Transfusion Iron overload due to thalassemia syndrome OR transfusion iron overload due to sickle cell disease and other anemias</u></p> <ul style="list-style-type: none"> • Dose is appropriate for age and weight • Diagnosis of thalassemia syndrome, sickle cell disease or other anemia • Patient receiving blood transfusions on a regular basis/participating in blood transfusion program • Serum Ferritin concentration is consistently > 1000 mcg/L. If the serum ferritin levels fall consistently below 500 mcg/L, Ferriprox must be discontinued • Documentation that patient is unable to use deferoxamine (Desferal) parenterally • Documented trial and failure of deferasirox (Exjade, Jadenu) or medical reason why deferasirox cannot be used • Requests for Ferriprox (2 times a day) brand tablets require documentation of trial and failure of, intolerance, or inability to use deferiprone generic tablets • Requests for Ferriprox (deferiprone) 100 mg/mL oral solution must meet all criteria above AND documentation of difficulty or inability to swallow tablets <p><u>Requests for Wilson’s Disease:</u> <u>Cuvrior (trientene tetrahydrochloride) only:</u></p> <ul style="list-style-type: none"> •Diagnosis of Wilson’s disease •Patient is de-coppered •Patient is tolerant to penicillamine and will discontinue penicillamine before starting therapy with Cuvrior •The medication requested is being prescribed at an FDA approved dose <p><u>Trientine (Syprine) only:</u></p> <ul style="list-style-type: none"> •Diagnosis of Wilson’s disease •Documented trial and failure, intolerance, or contraindication to penicillamine •The medication requested is being prescribed at an FDA approved dose <p><u>Requests for all other drugs and indications:</u></p> <ul style="list-style-type: none"> •The drug, dose, and duration requested are for an appropriate use <p style="text-align: center;">Last review: 9/2025</p>
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APPROVAL CRITERIA-CCHP

	CGM	<p>A CGM PA request must meet the following requirements:</p> <p style="color: blue;">>>The member meets one of the following requirements:</p> <ul style="list-style-type: none"> — Insulin-dependence — The member has claims history of regularly administered insulin in the past year; or — Documentation of regularly administered insulin use via chart notes, medical records, or additional clinical supportive documentation; or — The member is a new start, issued a new prescription, and will be using insulin administered on a continuing and regular basis. <p>-OR-</p> <p style="color: blue;">>>History of problematic hypoglycemia with documentation demonstrating recurrent (more than one) level 2 hypoglycemic events (glucose <54 mg/dl [3.0 mmol/L]) that persist despite attempts to adjust medication(s) and/or modify the diabetes treatment plan within the past year; or attestation from the provider the member has problematic hypoglycemic events.</p> <p>-OR-</p> <p>Pregnancy-Related Diabetes Diagnoses:</p> <ul style="list-style-type: none"> — Restricted to approval for the duration of the pregnancy and 12 months postpartum; and — Estimated and/or actual date of delivery must be included on the request. <p style="color: blue;">>>A recent HbA1c value must be documented on the PA request; and the member's HbA1C value will be assessed as part of medical necessity</p> <p>Last review: 6/2025</p>
PA	Cholinesterase Inhibitors	<p>Formulary Drugs-1st line</p> <ul style="list-style-type: none"> • Donepezil (Aricept) 5mg & 10mg tablet • Donepezil (Aricept) ODT 5mg & 10mg tablet • Rivastigmine capsule <p>PA Required:-2nd line</p> <ul style="list-style-type: none"> • Donepezil (Aricept) 23mg tablet • Galantamine ER capsule • Galantamine tablet • Galantamine oral solution <p>PA required-3rd line</p> <ul style="list-style-type: none"> • Rivastigmine (Exelon) patch • Adlarity (donepezil) weekly patch <p>PA required 4th line</p> <ul style="list-style-type: none"> • Zunveyl (benzgalantamine) tablet <p>Criteria for approval of 2nd line agents</p> <ul style="list-style-type: none"> • Documented trial and failure or intolerance to or contraindication to one first line agent <p>Criteria for approval of 3rd line agents</p> <ul style="list-style-type: none"> • Documented trial and failure or intolerance to or contraindication to any two first line and/or second line agents <p>Criteria for approval of 4th line agents</p> <ul style="list-style-type: none"> • Documented trial and failure or intolerance to or contraindication to any two first line and/or second line agents, followed by one 3rd line agent <p>If the criteria are met, the request will be approved with up to a 12 month duration.</p> <p>Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Cinacalcet (Sensipar)	<p>Criteria for use (bullet points below are all inclusive unless otherwise noted): The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient's medical records</p> <p>Serum calcium level must be ≥ 8.4 mg/dL Patient must have one of the following documented clinical conditions:</p> <ul style="list-style-type: none"> o Hypercalcemia in patients with Parathyroid Carcinoma (PC) <p>OR</p> <ul style="list-style-type: none"> o Hypercalcemia leading to symptoms or end organ damage in patients with primary HPT who are unable to undergo parathyroidectomy <p>OR</p> <ul style="list-style-type: none"> o Secondary Hyperparathyroidism (HPT) in patients with chronic kidney disease (CKD) on dialysis- For this indication, the member must also meet all of the following conditions: o Patient must have tried and failed or been intolerant to, or have a medical reason not to use at least one phosphate binder o Patient must have tried and failed or been intolerant to, or have a medical reason not to use calcitriol or paricalcitol o Baseline iPTH level is at least 2x the ULN for the PTH assay. <p>last review 12/2025</p>
P A	Clocortolone pivalate 0.1% (Cloderm®)	<p>Approve x 1 year if patient has t/f 3 of the following: betamethasone valerate OR fluocinolone acetonide OR triamcinolone OR other steroid classified as high to very high potency, AND MD indicates that stronger topical corticosteroids are not appropriate.</p> <p>Last review 12/2025</p>
P A	Clonidine ER (Kapvay®)	<p>Criteria for use:</p> <ul style="list-style-type: none"> • Documented diagnosis of ADHD • Must be 6 -17 years of age • Trial and failure, intolerance, or relative contraindication to clonidine IR or guanfacine ER • Must have tried both of the following stimulants: <ul style="list-style-type: none"> o Short-acting or long-acting methylphenidate o Short-acting or long-acting mixed amphetamine salt <p>— OR —</p> <ul style="list-style-type: none"> o Patient has a contraindication to the use of stimulants such as tics, sleep problems, anxiety, anorexia or aggression. o Patient or member of patient's household has history or potential for substance abuse. <p>If criteria are met, the request will be approved with up to a 12 month duration</p> <p>Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

	<p>Cobenfy (xanomeline and trospium chloride)</p>	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Member must be 18 years of age and older • Prescriber must be a psychiatrist or in consultation with a psychiatrist • Diagnosis of schizophrenia, consistent with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria • Documented trial and failure with two alternative formulary/preferred antipsychotic agents, or a medical reason is provided for not using any typical or atypical antipsychotic agents. • Medication is prescribed at an FDA approved dose. • Provider attestation is provided patient does not have any of the following: <ul style="list-style-type: none"> ▪ Moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment ▪ Untreated Narrow-Angle Glaucoma ▪ Urinary Retention ▪ Gastric Retention <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (i.e. improvement in positive and/or negative symptoms of schizophrenia) • Medication is prescribed at an FDA approved dose <p>If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.</p> <p>Last review: 12/2025</p>
<p>P A</p>	<p><u>Formulary with quantity limit (30/30)</u> Colchicine (Colcrys®) oral tablet 0.6mg</p> <p><u>Formulary prior authorization required, with quantity limit</u> Colchicine (Mitigare) oral capsule 0.6mg</p>	<p>** If the request is for Lodoco, refer to the Lodoco criteria**</p> <p><u>Criteria for use for treatment following acute gout attack</u></p> <p>1. Colchicine (Colcrys) oral tablet is available on formulary for quantities up to 30 tablets every 30 days.</p> <p><u>Criteria for use for prophylaxis for chronic gout</u></p> <p>1. Documented trial and failure or intolerance to at least one (1) formulary urate-lowering therapy such as allopurinol or probenecid. OR 2. Concurrent use of a urate-lowering agent. Requests for colchicine (Mitigare) 0.6mg oral capsule require documentation of trial and failure, contraindication, intolerance, or inability to use colchicine (Colcrys) 0.6mg oral tablet</p> <p>**Rheumatology providers Dr. Stone and Dr. Bajpai are exempt from the above criteria.</p> <p><u>Familial Mediterranean Fever (FMF (colchicine (Colcrys) only:</u></p> <ul style="list-style-type: none"> • is 4 years of age or older <p>If the above condition is met, the request will be approved with a 12 month duration; if the above conditions are not met, the request will be referred to a Pharmacist for medical necessity review.</p> <p>Last review 12/2025</p>

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APPROVAL CRITERIA-CCHP

	<p style="text-align: center;">Lodoco (colchicine) tablets</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Prescriber must be, or in consultation with, a specialist in the treatment of cardiovascular disease, such as a cardiologist • Patient has established atherosclerotic disease or multiple risk factors for cardiovascular disease • Patient is currently receiving statin therapy, or documentation has been provided that the member has a medical reason statin therapy is not appropriate • Documentation is provided that guideline directed medical therapies targeted to patient's specific risk factors are being maximized, such as medications targeted at reduction in cholesterol, blood pressure, antiplatelet therapies, and diabetes • Patient does not have pre-existing blood dyscrasias (ex. leukopenia, thrombocytopenia) • Patient does not have renal failure (CrCl less than 15 ml/min) or severe hepatic impairment • Patient is not currently taking medications contraindicated for concurrent use with Lodoco <ul style="list-style-type: none"> ○ Strong CYP3A4 inhibitors (ex. atazanavir, clarithromycin, darunavir/ritonavir, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, tipranavir/ritonavir) ○ P-glycoprotein inhibitors (ex. cyclosporine, ranolazine) <p>If all of the criteria are met, the request will be approved for 12 months.</p> <p>Last review: 12/2025</p>
	<p><u>Corticosteroids for Ulcerative Colitis and Crohn's disease</u></p> <p><u>Formulary</u> budesonide (Entocort EC) capsule Hydrocortisone (Cortenema) rectal enema</p> <p><u>Formulary-PA</u> budesonide (Uceris) 9mg tablet Cortifoam 10%</p> <p>Budesonide (Uceris) 2 mg foam Ortikos (budesonide) capsule</p>	<p>Budesonide (Uceris) tablet is approved when all of the following criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of mild to moderate ulcerative colitis • Dose is appropriate per label or supported by compendia/standard of care guidelines • Documentation of trial and failure, contraindication, intolerance, or inability to use maximum tolerated and therapeutic dose of oral aminosalicylates (i.e. sulfasalazine or balsalazide) for 8 weeks AND rectal mesalamine for up to 6 weeks <p>Budesonide (Uceris) foam and Cortifoam are approved when all of the following criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of ulcerative colitis. • Dose is appropriate per label or supported by compendia/standard of care guidelines • Documentation of a trial and failure, intolerance, contraindication, or inability to use formulary rectal mesalamine and formulary topical rectal corticosteroids. <p>Ortikos (budesonide) capsule is approved when all of the following criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of mild to moderate Crohn's disease involving the ileum and/or the ascending colon • Dose is appropriate per label or supported by compendia/standard of care guidelines • Documentation of trial and failure, contraindication, intolerance, or inability to use budesonide (Entocort EC) capsule <p>Last review: 9/2025</p>

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APPROVAL CRITERIA-CCHP

	<p>Cortrophin (corticotropin)</p> <p><u>Formulary:</u> Cortrophin (corticotropin)</p> <p><u>Non-formulary:</u> Acthar Gel (corticotropin)</p>	<p>Criteria for Use</p> <ul style="list-style-type: none"> Medication is being requested for an FDA approved indication Member has a documented trial and failure of corticosteroids, or a documented medical reason for why the member cannot use corticosteroids for treatment Prescriber is a specialist in the condition they are treating If the request is for a non-formulary product, trial and failure of, contraindication to or medical reason for not using the preferred product is required <p>Coverage Duration</p> <ul style="list-style-type: none"> If all of the criteria are met, the initial request will be approved for 4 weeks. For continuation of therapy, the request will be approved for 4 weeks. <p>Last review: 6/2025</p>
<p style="text-align: center;">PA</p>	<p>Diabetes Medications- Thiazolidinedione</p>	<p>Formulary (pays at point of sale)</p> <ul style="list-style-type: none"> Pioglitazone <p>Non-Formulary:</p> <ul style="list-style-type: none"> Pioglitazone/Glimepiride (Duetact) Pioglitazone/Metformin (Actoplus Met) <p>PA CRITERIA FOR APPROVAL</p> <ul style="list-style-type: none"> Diagnosis of Type 2 diabetes mellitus Patient is ≥ 18 years old Documented trial and failure with therapeutic doses, intolerance, or contraindication to the two separate components: metformin and pioglitazone OR glimepiride and pioglitazone <p>If the above conditions are met, the request will be approved with a 12 month duration.</p> <p>Last review 6/2025</p>
<p style="text-align: center;">PA</p>	<p>Dry eye therapies</p> <p>Cyclosporine ophthalmic emulsion 0.05% (Restasis) dropperette-- PREFERRED</p> <p>Restasis multidose 0.05%</p> <p>Xiidra (lifitegrast)</p> <p>Cequa 0.09% (cyclosporine)</p> <p>Tyrvaya (varenicline) 0.03mg nasal spray</p> <p>Miebo (perfluorohexyloctane) solution 1.338g/ml</p> <p>Vevye 0.1% (cyclosporine) ophthalmic solution</p> <p>Tryptyr 0.003% (acoltremon) ophthalmic solution</p>	<p>Criteria for use:</p> <ul style="list-style-type: none"> Age ≥ 16 years old (Cequa, Xiidra, Miebo, Vevye, Tryptyr, and Tyrvaya approved ≥ 18 years old) Must be prescribed by an ophthalmologist or optometrist Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye for Restasis or Cequa OR Treatment of the signs and symptoms of dry eye disease for Xiidra, Miebo, Vevye, Tryptyr, or Tyrvaya Must have tried and failed at least 4 weeks of both an ophthalmic solution and an ophthalmic gel or ointment formulation of artificial tears. (Drops must be given four times per day). Requests for Restasis Multidose, Cequa, Xiidra, Vevye, Miebo, Tryptyr, or Tyrvaya: documented trial and failure, intolerance, contraindication, or inability to use cyclosporine 0.05% (Restasis) dropperette Authorization will be issued for 6 months, if clinically significant improvement seen, authorization will be issued for 12 months <p>Last review 9/2025</p>

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APPROVAL CRITERIA-CCHP

P A	Cystic Fibrosis Agents (Pulmozyme, TOBI, Kalydeco)	<p>*Check to see if patient qualifies for GHPP</p> <p><u>Initial criteria for the use of Kalydeco® (ivacaftor), Orkambi® (lumacaftor/ivacaftor), Symdeko™ (tezacaftor/ivacaftor), Trikafta (elexacaftor/tezacaftor/ivacaftor), Alyftrek (vanzacaftor/tezacaftor/deutivacaftor)</u></p> <ul style="list-style-type: none"> •Documentation provided includes a copy of the FDA-cleared cystic fibrosis (CF) mutation test OR documentation from the National Cystic Fibrosis Registry (e.g. screen shot) with member’s genetic mutations. •The request is appropriate for member (e.g. age/weight) per package insert or standard of care guidelines •The request is for an FDA approved indication for the member’s genotype and within dosing guidelines <p><u>Initial criteria for the use of inhaled tobramycin (Tobi®, Kitabis Pak® Bethkis), Pulmozyme® (dornase alfa), Tobi® Podhaler</u></p> <ul style="list-style-type: none"> •The request is appropriate for member (e.g. age/weight) •If the request is for a brand name tobramycin product, documentation has been provided why member is unable to use generic tobramycin •The medication is being prescribed at a dose that is within FDA approved guidelines. <p><u>Initial criteria for the use of Cayston® (aztreonam lysine)</u></p> <ul style="list-style-type: none"> •The medication is being prescribed for a cystic fibrosis patient colonized with P. aeruginosa AND •Documentation has been provided why member is unable to use generic tobramycin AND •The medication is being prescribed at a dose that is within FDA approved guidelines <p><u>Initial criteria for the use of Bronchitol</u></p> <ul style="list-style-type: none"> • The medication is being prescribed at a dose that is within FDA approved guidelines • The prescriber attests that the patient has not had an episode of hemoptysis (>60 mL) in the 3 months prior to beginning therapy • Member has documented trial and failure or medical reason for not using generic hypertonic saline nebulization solution (sodium chloride 3% or 7%) <p><u>Re-authorization criteria for all medications</u></p> <ul style="list-style-type: none"> •Documentation has been submitted that patient has obtained clinical benefit from medication (i.e. improvement in FEV1, BMI, decrease in number or frequency of pulmonary exacerbations, or improvement in quality of life) •The medication is being prescribed at a dose that is within FDA approved guidelines. <p>Initial approval: 6 months Later approvals: 12 months</p> <p>Last review 3/2025</p>
P A	Savaysa (edoxaban)	<p><u>PA CRITERIA FOR APPROVAL:</u></p> <ul style="list-style-type: none"> • The request is for an FDA approved indication for the member’s disease state and within dosing guidelines <p>AND</p> <ul style="list-style-type: none"> • Documented trial and failure with Eliquis (apixaban) or Xarelto (rivaroxaban) or Pradaxa (dabigatran) <p>Last review 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Dalfampridine (Ampyra)	<p><u>Criteria for use (bullet points below are all inclusive unless otherwise noted):</u></p> <ul style="list-style-type: none"> • The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient’s medical records. • Must be prescribed by a neurologist • Must have a confirmed diagnosis of multiple sclerosis. • Member is ambulatory but has walking impairment. Documentation of objective measure of walking ability (e.g. 25 foot walk test, 6 minute walk distance, Multiple Sclerosis Walking Scale (MSWS-12)) must be submitted with the request. • Patient does not have a history of seizures. • Patient must have normal renal function (CrCl_≥ 50mL/min) (must provide recent Scr and Bun levels.) • Must be 18-70 years of age. (unknown adverse effects with patients older than 70 due to decrease renal function and increase risk of seizures) • Quantity limit of 60/month. • Currently on disease modifying therapy for MS <p><u>Criteria for continuation of therapy:</u></p> <ul style="list-style-type: none"> • Documentation of improvement in objective measure of walking ability from baseline was submitted with request • Member continues to be ambulatory • Documentation was submitted that the patient is receiving disease-modifying treatment for MS or documentation of a medical reason (intolerance, hypersensitivity) as to why patient is unable to use one of these agents to treat their medical condition • Drug is being requested at an FDA-approved dose <p>Last review: 3/2025</p>
	Elmiron (pentosan polysulfate sodium)	<p><u>Initial Authorization</u></p> <ul style="list-style-type: none"> • The prescriber must be a urologist, obstetrician/gynecologist, or other specialist in the treatment of genitourinary disorders • Member has a confirmed diagnosis of bladder pain or discomfort associated with interstitial cystitis • The member has tried and failed treatment with amitriptyline, cimetidine, or hydroxyzine, or has a documented medical reason why these medications cannot be used • Documentation of baseline Genitourinary Pain Index (GUPI), Interstitial Cystitis Symptom Index (ICSI), or Interstitial Cystitis Problem Index (ICPI) AND urinary frequency or urgency • Requested dose is within FDA approved guidelines • The drug is being prescribed for an FDA approved age <p><u>Reauthorization</u></p> <ul style="list-style-type: none"> • Documentation is provided that the member has obtained a clinical benefit (e.g reduction in baseline symptom scale score, reduced pelvic or bladder pain, reduced urinary frequency or urgency) • Requested dose is within FDA approved guidelines <p>If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.</p> <p>Last review: 6/2025</p>

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APPROVAL CRITERIA-CCHP

		<p>Initial Authorization:</p> <ul style="list-style-type: none"> • The prescriber must be a hematologist or nephrologist • Member has a diagnosis of chronic kidney disease (CKD) and has been undergoing dialysis for minimum time required by FDA-approved labeling • Member has a documented hemoglobin between 8.0 and 11.0 g/dL • Member has documentation of trial and failure, intolerance, contraindication, or inability to use erythropoietin stimulating agents (ESA) • The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning therapy, to correct the deficiency: <ul style="list-style-type: none"> ○ Serum ferritin level (> 100ng/mL) ○ Transferrin saturation (TSAT) (> 20%) • Provider attests that member has no history of myocardial infarction, cerebrovascular event, or acute coronary syndrome in the past 3 months • Member will not be receiving concurrent treatment with an ESA • Request is for an FDA-approved dose • All submitted lab results have been drawn within 30 days of the request <p>Exclusion:</p> <ul style="list-style-type: none"> • Diagnosis of uncontrolled hypertension <p>If all conditions are met, the request will be approved with a 6 month duration.</p> <p>Reauthorization:</p> <ul style="list-style-type: none"> • All submitted lab results have been drawn within 30 days of the reauthorization request. • Member has a documented increase in hemoglobin from baseline • The following lab results must be submitted and demonstrate normal values, otherwise, the member MUST be receiving, or is beginning therapy, to correct the deficiency: <ul style="list-style-type: none"> ○ Serum ferritin level (> 100ng/mL) ○ Transferrin saturation (TSAT) (> 20%) • Member will not be receiving concurrent treatment with an ESA • Request is for an FDA-approved dose <p>Last review: 3/2025</p>
	<p>HIF-PH Inhibitors (Hypoxia-inducible Factor Prolyl Hydroxylase Inhibitors) for CKD Anemia</p> <p>Vafseo (vadadustat)</p>	

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APPROVAL CRITERIA-CCHP

PA	Desmopressin Acetate Nasal Solution	<p><u>PA CRITERIA FOR APPROVAL</u></p> <p><u>Nasal Spray:</u></p> <ul style="list-style-type: none"> • Diagnosis of central cranial (neurogenic) diabetes insipidus. <p>OR</p> <ul style="list-style-type: none"> • Management of temporary polyuria and polydipsia following head trauma or surgery in the pituitary region. <p>NOTE: Nasal Spray formulation will not be approved for the indication of primary monosymptomatic nocturnal enuresis.</p> <p>If one the above conditions are met, the request will be approved for a 12 month duration; if the above conditions are not met, the request will be referred to a Medical Director or clinical pharmacist for review.</p> <p><u>FDA INDICATIONS</u></p> <p><u>Nasal Spray:</u></p> <ul style="list-style-type: none"> • Antidiuretic replacement therapy in the management of central cranial diabetes insipidus. • Management of temporary polyuria and polydipsia following head trauma or surgery in the pituitary region. <p>NOTE: Ineffective for the treatment of nephrogenic diabetes insipidus.</p> <p><u>DOSAGE AND ADMINISTRATION</u></p> <p><u>Nasal Spray:</u></p> <p>Central Cranial Diabetes Insipidus: Dosage must be determined for each individual patient and adjusted according to the diurnal pattern of response. Response should be estimated by two parameters: adequate duration of sleep and adequate, not excessive, water turnover. Patients with nasal congestion and blockage have often responded well to intranasal DDAVP. The usual dosage range in adults is 10-40mcg daily, either as a single dose or divided into two or three doses. Most adults require 20mcg daily in two divided doses. The morning and evening doses should be separately adjusted for an adequate diurnal rhythm of water turnover. For children aged > 4 years, the usual dosage range is 10-30mcg daily, either as a single dose or divided into two doses. About 1/4 to 1/3 of patients can be controlled by a single daily dose of DDAVP administered intranasally.</p> <p style="margin-top: 20px;">Last review 12/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Desoximetasone (Topicort®) cream/gel/ointment	<p>Patient < 12yo: Approve x 1 year if patient has t/f betamethasone dipropionate AND fluocinonide.</p> <p>Patient >= 12yo: Approve x 1 year if patient has t/f betamethasone dipropionate AND fluocinonide AND MD indicates that stronger topical corticosteroids are not appropriate.</p> <p>Otherwise, please Defer and request consideration of formulary agents. Please provide list of all formulary corticosteroids not yet tried/failed with response.</p> <p>Last review 12/2025</p>
	Diabetic Test Strips (True Metrix & True Track are the preferred products)	<p>Preferred manufacturer of test strips & glucometer MUST BE USED, unless there is a compelling reason noted by the requesting provider (such as the need for a certain strips for communication with an insulin pump etc.) – evaluate on a case-by-case basis with medical director and/or clinical pharmacist.</p> <p>Quantity limits:</p> <ul style="list-style-type: none"> • #150/30 days if member is on insulin • #150/30 days if female between the ages of 15 and 45 (possible gestational) • #100/90 days if not on insulin and not a woman of child-bearing age <p>Special consideration:</p> <ul style="list-style-type: none"> • T1DM during pregnancy can obtain up to #250/30 with PA (up to 9 months) • Patients not on insulin, but taking 3 PO/parenteral diabetes meds OR members with an A1C >9 can obtain #100/30 with PA <p>Last review 12/2025</p>
	Diclegis (doxylamine/pyridoxine)	<p>Diagnosis of nausea and vomiting associated with pregnancy</p> <p style="text-align: center;">AND</p> <p>Tried and failed over-the-counter Vitamin B6 (pyridoxine) and doxylamine</p> <p>Approved for 9 months</p> <p>Last review 6/2025</p>

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PA	Diclofenac sodium 2% topical solution (Pennsaid)	<p>Bullet Points Below are all inclusive unless otherwise noted</p> <ul style="list-style-type: none"> • Clinically diagnosed with osteoarthritis of the knee • Failure/intolerance/contraindication to at least 2 formulary oral NSAIDs • Failure/intolerance to Voltaren (diclofenac sodium) 1% gel • Failure/intolerance to diclofenac sodium 1.5% topical solution <p>Per P&T committee, this medication must be reviewed for medical necessity by CCHP medical director prior to approval-not to be approved without CCHP MD guidance</p> <p>Last review 6/2025</p>
PA	Vumerity (diroximel fumarate)	<p>Vumerity criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient's medical records. • Must be clinically diagnosed with relapsing-remitting multiple sclerosis, clinically isolated syndrome, or active secondary progressive disease • Must be 18 years of age or older <p>Requests for Vumerity will be approved if the criteria above is met, AND documented trial and failure, contraindication, or inability to use dimethyl fumarate (Tecfidera)</p> <p>Last Review: 3/2025</p>
PA	Dronabinol (Marinol®)	<p>Tried and failed, or any contraindications to at least one preferred alternative. Restricted to use in Cancer patients or the treatment of anorexia associated with weight loss in patients with AIDS.</p> <p>Last review: 12/2025</p>
PA	Dronedarone (Multaq)	<p>Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • Diagnosis or history of paroxysmal or persistent atrial fibrillation (AF) or atrial flutter (AFL) documented in the patient's medical records. • Must be prescribed by a cardiologist • Must be in normal sinus rhythm or have AF that can be cardioverted into normal sinus rhythm (cannot have a diagnosis of permanent AF) • Must not have symptomatic heart failure with recent decompensation requiring hospitalization or NYHA class III or IV heart failure symptoms • Documented trial failure, intolerance or contraindication to amiodarone <p>If the criteria are met, the request will be approved with up to a 12 month duration</p> <p>Last review 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Duvyzat (givinostat)	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Prescriber must be a neurologist or a provider who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) • Medication is prescribed at an FDA approved dose according to body weight • Genetically confirmed diagnosis of DMD and copies of testing were submitted with request • Patient has been stable on baseline corticosteroids for at least 6 months • Patient is ambulatory <p>Re-Authorization:</p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (such as improved muscle function, muscle strength, or disease stabilization) • Patient is on concurrent corticosteroid treatment • Patient is ambulatory • Medication is prescribed at an FDA approved dose according to body weight <p>Coverage Duration:</p> <ul style="list-style-type: none"> • If all of the criteria are met, the initial and reauthorization requests will be approved for 12 months <p>Last review: 9/2025</p>
PA	Efinaconazole (Jublia)	<p>Criteria for Use (ALL of the following must be met):</p> <ul style="list-style-type: none"> • Diagnosis of onychomycosis must be confirmed by KOH preparation, fungal culture, or nail biopsy • Must be prescribed by a dermatologist or podiatrist • Must have documented trial and failure, intolerance or contraindication to oral terbinafine for a minimum of 12 weeks • Must have documented trial and failure, intolerance or contraindication to ciclopirox for a minimum of 12 weeks <p>THEN</p> <ul style="list-style-type: none"> • Must have documented trial and failure, intolerance or contraindication to oral itraconazole after a minimum of 12 weeks <p>Last reviewed 12/2025</p>
PA	Encelto (revakinagene taroretcel-lwey)	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Prescriber must be an ophthalmologist or specialist in the treatment of macular telangiectasia (MacTel) type 2 • Confirmed diagnosis of idiopathic MacTel type 2 • Inner segment (IS)/outer segment (OS) photoreceptor (PR) break (loss) in ellipsoid zone (EZ) between 0.16 and 2.00 mm² measured by spectral domain-optical coherence tomography (SD-OCT) • Best corrected visual acuity (BCVA) score of 54 letters or better (20/80 or better Snellen equivalent) measured by the Early Treatment Diabetic Retinopathy Study (ETDRS) chart • Prescriber attests that member has no evidence of neovascular MacTel type 2 • Member has not previously received an Encelto implant for treated eye <p>***Reauthorizations are not permitted, as members are limited to a single implant per eye per lifetime***</p> <p>Coverage Duration:</p> <p>If all criteria are met, the request will be approved for a single implant per eye per lifetime</p> <p>Last review: 9/2025</p>

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APPROVAL CRITERIA-CCHP

	<p>Eohilia (budesonide)</p>	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> Prescribed by or in consultation with a gastroenterologist, allergist, immunologist, or other provider who specializes in the treatment of eosinophilic esophagitis (EoE) Diagnosis of EoE as confirmed by esophageal biopsy indicating ≥ 15 eosinophils per high-power field (eos/hpf) Member must have experienced dysphagia for at least 4 days over a 2-week period Documented trial and failure, intolerance, or contraindication to one proton pump inhibitor (PPI) at a maximally tolerated dose for a minimum of 8 weeks Documented trial and failure, intolerance, or contraindication to an inhaled corticosteroid that can be swallowed (i.e., fluticasone propionate) Request is for an FDA-approved dose <p><u>Coverage Duration:</u></p> <ul style="list-style-type: none"> If all criteria are met, the request will be approved for 3 months <p>***Reauthorization requests for maintenance therapy will not be approved as Eohilia has not been shown to be safe and effective for the treatment of EoE for longer than 12 weeks. Requests for subsequent courses for induction therapy will be handled on a case-by-case basis***</p> <p>Last Review: 6/2025</p>
	<p>Epidermolysis Bullosa Agents Vyjuvek (beremagene geperpavec-svdt), Filsuvez (birch triterpenes)</p>	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> Prescriber must be a dermatologist, geneticist, or specialist experienced in the treatment of epidermolysis bullosa. Patient has a diagnosis of dystrophic or junctional epidermolysis bullosa, with genetic mutation(s) confirmed via genetic testing. Requested product is FDA approved for the patient's epidermolysis bullosa subtype Documentation is provided that wound(s) to be treated are clean with adequate granulation tissue, excellent vascularization, and do not appear infected Documentation is provided that there is no evidence of, or history of squamous cell carcinoma in the wound(s) to be treated Medication is prescribed at an FDA approved dose, and maximum dispensable amount is not exceeded <ul style="list-style-type: none"> Vyjuvek: Requests exceeding more than one vial per week will not be approved. Filsuvez: documentation of size of treatment area(s) and frequency of dressing changes is required. One single use tube of Filsuvez covers up to 250 cm² surface area. Requests exceeding use more than once daily will not be approved. <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> Documentation or provider attestation of positive clinical response (i.e. improvement in wound appearance, wound closure, healing, etc.) Documentation indicating need for continued treatment is needed (either to partially healed wounds or to other wound sites) Documentation is provided that wound(s) to be treated are clean with adequate granulation tissue, excellent vascularization, and do not appear infected Documentation is provided that there is no evidence of, or history of squamous cell carcinoma in the wound(s) to be treated Medication is prescribed at an FDA approved dose, and maximum dispensable amount is not exceeded.

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APPROVAL CRITERIA-CCHP

		<ul style="list-style-type: none"> ○ Vyjuvek: Requests exceeding more than one vial per week will not be approved. ○ Filsuvez: documentation of size of treatment area(s) and frequency of dressing changes is required. One tube of Filsuvez covers up to 250 cm² surface area. Requests exceeding use more than once daily will not be approved. <p><u>Exclusion:</u></p> <ul style="list-style-type: none"> • Other forms of epidermolysis bullosa, such as epidermolysis bullosa simplex, kindler epidermolysis bullosa • Concurrent use of Vyjuvek and Filzuvez <p><u>Coverage Duration:</u></p> <ul style="list-style-type: none"> • If all of the criteria are met, the initial request will be approved for three (3) months. Subsequent requests will be approved for six (6) months. <p style="text-align: right;">Last Review 6/2025</p>
	<p>Evenity (romosozumab)</p>	<p>Criteria for use:</p> <p>The member is postmenopausal with osteoporosis and ANY of the following criteria are met:</p> <ul style="list-style-type: none"> • Multiple vertebral fractures • Severe osteoporosis such as a low T-score < -2.5 • Osteopenia with a -2.5 <T-score <-1 and a high risk of fracture (elderly, glucocorticoid risk, high risk of falls) • There has been a trial and failure or intolerance to zoledronic acid, teriparatide, or denosumab. • Patient has had a trial of an oral bisphosphonate for at least one year with less than optimal results, has a contraindication to their use, or the patient is intolerant to two different bisphosphonates. <p>Approval duration is for 12 monthly doses.</p> <p>Do not approve if a myocardial infarction or stroke within the preceding year has occurred OR there is hypocalcemia.</p> <p style="text-align: right;">Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

		<p><u>Initial Authorization for all requests:</u></p> <ul style="list-style-type: none"> • Medication is prescribed at an FDA approved dose • Prescribed by or in consultation with an obstetrician/gynecologist • If patient is of childbearing potential, prescriber attests the patient is not currently pregnant • Prescriber attests the patient does not have a history of osteoporosis • Prescriber attests they have reviewed the patient's liver function <p><u>For a diagnosis of endometriosis associated with moderate to severe pain:</u></p> <ul style="list-style-type: none"> • Request is for Orilissa or Myfembree only • Documented trial and failure or medical reason for not using an analgesic pain reliever (e.g., NSAIDs, COX-2 inhibitors) taken in combination with combined estrogen progestin oral contraceptive pills (OCPs): <ul style="list-style-type: none"> ○ If one of the following drugs has been tried previously, a trial of OCPs is not required: progestins, gonadotropin releasing hormone (GnRH) agonists, danazol, or aromatase inhibitors (e.g., anastrozole, letrozole) <p><u>For a diagnosis of diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids):</u></p> <ul style="list-style-type: none"> • Request is for Oriahnn or Myfembree only • Documented trial and failure or medical reason for not using estrogen-progestin contraceptive therapy • If one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: <ul style="list-style-type: none"> ○ gonadotropin-releasing hormone (GnRH) agonists, ○ progestin-releasing intrauterine device ○ tranexamic acid <p><u>Exclusions:</u></p> <ul style="list-style-type: none"> • Pregnancy • History of osteoporosis • History of hepatic impairment (Myfembree, Oriahnn), or severe hepatic impairment (Orilissa) <p><u>Coverage Duration:</u></p> <ul style="list-style-type: none"> • Initial Authorization: 6 months • Reauthorization: 6 months • Eligible maximum lifetime treatment duration: 24 months <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (i.e., reduction in pain, reduced menstrual bleeding) • Maximum lifetime treatment duration based on previous dosing and/or hepatic functioning has not been exceeded • Medication is prescribed at an FDA approved dose <p style="text-align: center;">Last reviewed: 6/2025</p>
	<p>Gonadotropin Releasing Hormone Antagonists</p> <p>Oriahnn (elagolix, estradiol, and norethindrone acetate)</p> <p>Myfembree (relugolix, estradiol, and norethindrone acetate)</p> <p>Orilissa (elagolix)</p>	

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APPROVAL CRITERIA-CCHP

	<p>Esketamine (Spravato)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • A diagnosis of one of the following: <ul style="list-style-type: none"> • Major depressive disorder with treatment-resistant depression • Major depressive disorder with acute suicidal ideation or behavior • For the diagnosis of Major depressive disorder with acute suicidal ideation or behavior, medication will be used in conjunction with an oral antidepressant <ul style="list-style-type: none"> • This is not required for treatment-resistant depression diagnosis • Medication is being prescribed at an FDA approved dosage. <p>Additionally, if member has diagnosis for major depressive disorder or treatment-resistant depression only (i.e. without suicidal ideation or behavior):</p> <ul style="list-style-type: none"> • Documented trial and failure of two preferred oral antidepressants (eg. SSRIs, SNRIs, TCAs) of at least a minimum effective dose for four (4) weeks or longer OR a medical justification as to why the patient cannot use preferred alternative(s). <p>Re-authorization:</p> <ul style="list-style-type: none"> • Medication is prescribed at an FDA-approved dosage. • Medication is being used in conjunction with an oral antidepressant (not required for diagnosis of treatment-resistant depression). • Documentation was submitted indicating the member has clinically benefited from therapy. <p>If the initial criteria are met, the initial request will be approved for 4 weeks. For continuation of therapy the request will be approved for 6 months.</p> <p>Last review 6/2025</p>
<p>PA</p>	<p>Epidiolex (cannabidiol)</p>	<p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • Prescribed by a neurologist or specialist in treatment of seizure disorders • Member is ≥ 1 year old • Patient is currently taking a stable dose of at least one other antiepileptic medication • Dose is within FDA approved limits • Documentation of member's weight <p><u>Lennox-Gastaut syndrome:</u> If the request is for a member with Lennox-Gastaut syndrome, documented trial and failure or intolerance of clobazam AND At least three antiepileptics within the member's lifetime</p> <p><u>Dravet syndrome:</u> If the request is for a member with Dravet syndrome, documented trial and failure or intolerance of at least two antiepileptics within the member's lifetime is required.</p> <p><u>Tuberous sclerosis complex:</u> If the request is for a member with tuberous sclerosis complex, documented trial and failure or intolerance of at least two antiepileptics within the member's lifetime is required</p> <p>Approval duration: 6 months; continuation of therapy requires demonstrated reduction or stabilization of seizure frequency</p> <p>Last review 6/2025</p>
<p>PA</p>	<p>Eplerenone (Inspra®)</p>	<ul style="list-style-type: none"> • Diagnosis of CHF or hypertension • Documented trial and failure (or a medical justification for not using) spironolactone <p>Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p>Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists for Headache Prevention</p> <p>Preferred Agents:</p> <p>Aimovig® (Erenumab-aooe)</p> <p>Ajovy (fremanezumab-vfrm)</p> <p>Nurtec ODT (rimegepant)</p> <p>Non-Preferred Agents</p> <p>Emgality (galcanezumab-gnlm)</p> <p>Vyepti (eptinezumab)</p> <p>Qulipta (atogepant)</p>	<p>Criteria for Initial Authorization:</p> <p>Cluster Headache:</p> <ul style="list-style-type: none"> • Request for Emgality (galcanezumab) for diagnosis of episodic cluster headache • Requested dose is within FDA approved dosing guidelines <p>Migraine Headache Prophylaxis:</p> <ul style="list-style-type: none"> • Diagnosis of episodic or chronic migraine • Provider should note on the prior authorization request the number of headache days per month • Requested dose is within FDA approved dosing guidelines • Trial and failure (or a medical justification for not using e.g. hypersensitivity, baseline bradycardia or hypotension, adverse events experienced from previous trial, etc.) with at least one of the following: <ol style="list-style-type: none"> 1. Beta-adrenergic blockers 2. Topiramate or divalproex ER or DR 3. Amitriptyline or venlafaxine 4. Frovatriptan, zolmitriptan or naratriptan (for menstrual migraine prophylaxis) • If the medication request is for a non-preferred CGRP Receptor Antagonist, the patient has a documented medical reason (intolerance, hypersensitivity, contraindication, treatment failure etc.) for not using Ajovy, Aimovig, or Nurtec ODT. <p>Criteria for Re-Authorization:</p> <p>Cluster Headache:</p> <p>Reduction in the frequency of headaches (clinical benefit)</p> <p>Migraine:</p> <p>Reduction of greater than or equal to a 50% in the number of headache days relative to pre-treatment baseline (clinical benefit). Provider should note on the prior authorization request the number of headache days per month.</p> <p>Approval duration: 6 months; continuation of therapy requires response after 6 months</p> <p>Last review 6/2025</p>
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APPROVAL CRITERIA-CCHP

PA	<u>Proton Pump Inhibitors</u>	<p style="text-align: center;"><u>FORMULARY STATUS</u> Preferred, Pays at Point-of-Sale (First Line)</p> <p><u>OMEPRAZOLE OTC</u> (generic) Tablet: 20mg <u>NEXIUM</u> (esomeprazole) Capsule: 20mg, 40mg <u>PREVACID</u> (lansoprazole) SoluTab: 15mg, 30mg (Patients 9 years of age and younger) <u>PRILOSEC RX</u> (omeprazole) Capsule: 10mg, 20mg, 40mg <u>PROTONIX</u> (pantoprazole) Tablet: 20mg, 40mg <u>ACIPHEX</u> (rabeprazole) Tablet: 20mg <u>PREVACID 24HR OTC</u> (lansoprazole) Capsule: 15mg <u>PREVACID</u> (lansoprazole) Capsule: 15mg, 30mg</p> <p style="text-align: center;"><u>FORMULARY STATUS</u> Non-preferred, Requires Prior Authorization</p> <p><u>ZEGERID OTC</u> (omeprazole/sodium bicarbonate) Capsule: 20mg/1100mg <u>DEXILANT</u> (dexlansoprazole) Capsule: 30mg, 60mg <u>PREVACID</u> SoluTab: 15 mg, 30 mg (Patients 10 years of age and older) <u>PRILOSEC RX</u> (omeprazole) Packet for Oral Suspension: 2.5mg, 10mg <u>ZEGERID</u> (omeprazole/sodium bicarbonate) Capsule: 20mg/1100mg, 40mg/1100mg; Packet for Oral Suspension: 20mg/1680mg, 40mg/1680mg <u>PROTONIX</u> (pantoprazole) granule packet for suspension 40mg Rabeprazole capsule sprinkle 10mg NEXIUM (esomeprazole) DR Packet for Oral Suspension: 2.5mg, 5mg, 10mg, 20mg, 40mg</p> <p style="text-align: center;">NOTE: Patient must meet #1 & #2 criteria for approval of initial PA request.</p> <p><u>PA CRITERIA FOR APPROVAL</u></p> <ol style="list-style-type: none"> 1. Presumed or documented diagnosis of duodenal ulcer, H.pylori, gastric ulcer, GERD, erosive esophagitis, or hypersecretory disease. 2. Documented trial and failure or intolerance with omeprazole, pantoprazole, lansoprazole, AND rabeprazole <p style="text-align: center;">If the above conditions are met, the request will be approved with up to a 12 month duration</p> <p><u>Doses Greater Than Once Daily After Meeting Criteria for PPI:</u></p> <ul style="list-style-type: none"> • Confirmed diagnosis of GERD, erosive esophagitis,, <i>H. pylori</i> infection, or hypersecretory disease. <p>OR</p> <ul style="list-style-type: none"> • Evaluation made by gastroenterologist or otolaryngologist recommending higher doses of PPI. <p style="text-align: center;">If the above conditions are met, the request will be approved with up to a 12 month duration.</p> <p><u>Concomitant Plavix (Clopidogrel) and Proton Pump Inhibitor Therapy:</u></p> <ul style="list-style-type: none"> • Omeprazole (all formulations) will deny at the point-of-sale if patient is currently on Plavix (clopidogrel) therapy, and vice versa. Physicians should be detailed on interaction and pantoprazole should be offered as an alternative for therapy. <p>Last review: 9/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Repatha® (evolocumab) Praluent® (alirocumab)	<p><u>Formulary, prior authorization</u> Repatha® (evolocumab) Praluent® (alirocumab)</p> <p><u>INITIAL CRITERIA FOR PCSK9 monoclonal antibodies (mAbs):</u> <u>For all requests</u></p> <ul style="list-style-type: none"> • Prescriber must be cardiologist or a specialist in the treatment of lipid disorders. • Request is appropriate for member (e.g. age) as indicated in package labeling or standard of care guidelines • Patient has tried and failed atorvastatin 40mg-80mg or rosuvastatin 20-40mg (consistently for 3 months via claim history or chart notes). If patient is not able to tolerate atorvastatin or rosuvastatin, documentation was provided that patient is taking another statin at the highest tolerated dose, or a medical reason was provided why the member is not able to use these therapies. • Patient has tried and failed ezetimibe in combination with highest-tolerated intensity statin (if clinically appropriate) consistently for 3 months, OR, patient has an LDL-C that is >25% above goal LDL-C while adherent to treatment with highest-tolerated intensity statin (if clinically appropriate) consistently for 3 months • If prescriber indicates member is “statin intolerant”, documentation was provided including description of the side effects, duration of therapy, “wash out”, re-trial, and then change of agents. • Documentation was provided indicating provider has counseled member on smoking cessation and following a “heart healthy diet”. <p><u>Diagnosis of Familial Hypercholesterolemia (FH)</u></p> <ul style="list-style-type: none"> • Member has a diagnosis of familial hypercholesterolemia, as evidenced by one of the following: <ul style="list-style-type: none"> ○ Documentation provided including two fasting lipid panel lab reports with baseline abnormal low density lipoprotein (LDL) levels ≥190 for FH in adults or ≥160 for FH in children. • Results of positive genetic testing for an LDL-C-raising gene defect (LDL receptor, apoB, or PCSK9) <p><u>Diagnosis of hyperlipidemia (Primary OR Secondary Prevention):</u></p> <ul style="list-style-type: none"> • If the diagnosis is primary severe hyperlipidemia (i.e. baseline LDL ≥ 190 mg/dL) <ul style="list-style-type: none"> ○ LDL remains ≥ 100 mg/dL despite maximally tolerated LDL-lowering therapy • If the diagnosis is secondary atherosclerotic cardiovascular disease (ASCVD) prevention <ul style="list-style-type: none"> ○ The patient is “very high risk” (both of the following) <ul style="list-style-type: none"> ▪ (i.e. a history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions, see table below) <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle;">Major ASCVD Events</td> <td>Recent ACS (within past 12 months)</td> </tr> <tr> <td>History of MI (other than recent ACS event above)</td> </tr> <tr> <td>History of ischemic stroke</td> </tr> <tr> <td>Symptomatic PAD</td> </tr> <tr> <td rowspan="7" style="text-align: center; vertical-align: middle;">High-risk Conditions</td> <td>Age ≥ 65 years</td> </tr> <tr> <td>Heterozygous familial hypercholesterolemia</td> </tr> <tr> <td>History of prior CABG or PCI intervention outside the major ASCVD event(s)</td> </tr> <tr> <td>DM</td> </tr> <tr> <td>HTN</td> </tr> <tr> <td>CKD (eGFR 15-59 mL/min/1.73 m2)</td> </tr> <tr> <td>Current smoker</td> </tr> <tr> <td>CHF</td> </tr> </table> <p style="margin-top: 10px;"><i>ACS – acute coronary syndrome; CABG coronary artery</i></p>	Major ASCVD Events	Recent ACS (within past 12 months)	History of MI (other than recent ACS event above)	History of ischemic stroke	Symptomatic PAD	High-risk Conditions	Age ≥ 65 years	Heterozygous familial hypercholesterolemia	History of prior CABG or PCI intervention outside the major ASCVD event(s)	DM	HTN	CKD (eGFR 15-59 mL/min/1.73 m2)	Current smoker	CHF
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APPROVAL CRITERIA-CCHP

PA	<p>(Continued-)</p> <p>Repatha® (evolocumab) Praluent ® (alirocumab)</p>	<p><i>bypass graft; CHF – congestive heart failure; CKD – chronic kidney disease; DM – diabetes mellitus; HTN – hypertension; MI – myocardial infarction; PAD – peripheral artery disease; PCI – percutaneous coronary intervention</i></p> <ul style="list-style-type: none"> • LDL remains \geq 55 mg/dL or non-HDL (i.e. total cholesterol minus HDL) \geq 85 mg/dL despite maximally tolerated LDL-lowering therapy ○ The patient is not at very high risk: <ul style="list-style-type: none"> • LDL remains \geq 70 mg/dL or non-HDL (i.e. total cholesterol minus HDL) \geq 100 mg/dL despite maximally tolerated LDL-lowering therapy <p>If the above criteria are met, the request will be approved for up to a 3 month duration; if all of the above criteria are not met, the request will be sent to a clinical reviewer.</p> <p><u>REAUTHORIZATION CRITERIA FOR PCSK9 monoclonal antibodies (mAbs):</u></p> <ul style="list-style-type: none"> • Prescriber must be cardiologist or a specialist in the treatment of lipid disorders. • Documentation submitted indicates that the member has obtained clinical benefit from the medication including repeat fasting lipid panel lab report, and the member has had a reduction in LDL from baseline, prior to starting PCSK9 inhibitor therapy • The patient's claim history shows consistent therapy (i.e. monthly fills) <p>For reauthorization, If the above criteria are met, the request will be approved for up to a 6 month duration.</p> <p>Last review 12/2025</p>
	<p>Fecal microbiota</p> <p>Rebyota (fecal microbiota, live-jslm) Vowst (fecal microbiota spores, live-brpk)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Medication is prescribed at an FDA approved dose • Diagnosis of at least 1 recurrent episode of CDI (\geq2 total CDI episodes) • Current episode of CDI must be controlled (<3 unformed/loose stools/day for 2 consecutive days) • Positive stool test for C. difficile within 30 days before prior authorization request • Administration will occur 24–72 hours following completion of antibiotic course for CDI treatment • For Vowst only: attestation patient will bowel cleanse using magnesium citrate or polyethylene glycol electrolyte solution the day before the first dose of Vowst <p>*Rebyota and Vowst are limited to 1 treatment course only*</p> <p>Exclusion Criteria: Treatment of Clostridioides difficile infection (CDI)</p> <p>Last review: 12/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p><u>GLP-1 Receptor Agonists</u> <u>Preferred agents, F-ST (trial and failure of metformin)</u></p> <ul style="list-style-type: none"> • Trulicity (dulaglutide) • Ozempic (semaglutide) • Rybelsus (semaglutide) <p>Victoza (liraglutide) <u>Non-preferred agents, require prior authorization</u></p> <ul style="list-style-type: none"> • Mounjaro (tirzepatide) • Byetta (exenatide) • Bydureon BCISE (exenatide microspheres) 	<p><u>PA CRITERIA FOR APPROVAL of non-preferred agents, all of the following criteria must be met:</u></p> <ul style="list-style-type: none"> ▪ Documented diagnosis of Type 2 Diabetes Mellitus ▪ Documented trial and failure of or intolerance to metformin ▪ Documented trial and failure of or intolerance to one of the preferred products Victoza, Ozempic, Rybelsus, or Trulicity <p>If the above conditions are met, the request will be approved for a maximum duration of 12 months</p> <p><u>DOSAGE AND ADMINISTRATION of Byetta:</u></p> <ul style="list-style-type: none"> ▪ Initial dose: 5mcg SQ injection twice daily 60 minutes before morning and evening meals and should not be administered after a meal. <p>Maximum dose: 10mcg SQ twice daily 60 minutes before morning and evening meals and should not be administered after a meal. This dose should only be utilized once patient fails 5mcg after 1 month of treatment.</p> <p>Last review 3/2025</p>
PA	<p>Fentanyl (Duragesic®)</p>	<p>F-PA Status</p> <p>IF approvable, max limit of #10 patches per 30 days (#30 per 90 days). APPROVE with max limits IF:</p> <ol style="list-style-type: none"> 1. Dx: Terminal Cancer or Terminal Disease <p>AND</p> <ol style="list-style-type: none"> 2. Provide medical justification why oral agents (tabs/liquid) cannot be used. <p>AND</p> <ol style="list-style-type: none"> 3. T/f other oral narcotics within past 60 days (morphine, oxycodone) including morphine extended-release tablets <p>Continuation of Therapy Requests: Approve WITH max limits x 6 months.</p> <p>REQUESTS FOR > #10/30 (or #30/90 days):</p> <ol style="list-style-type: none"> 1. 12/25/50/75 MCG: Evaluate for possible approval for #10/month 2. 100 MCG: approve up to #20/month for 6 months at a time. <p>Intent is to have step therapy with preferred oral agents (morphine) --> Duragesic</p> <ul style="list-style-type: none"> • If the request is for non-formulary fentanyl 37.5, 62.5, or 87.5 mcg/h patches, the member must have documentation of trial and failure, contraindication, or inability to use formulary fentanyl strengths: 12, 25, 50, 75, 100 mcg/h transdermal patches • If a non-formulary strength of fentanyl patch is requested, return with suggestion of separate patches (ex: 37.5mcg/hr, suggestion of 12mcg/hr + 25mcg/hr separate patches) <p>Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p style="text-align: center;">Fertility Agents</p> <p> cetorelix (Cetrotide) ganirelix (Fyremadel) clomiphene (Clomid) chorionic gonadotropin (Novarel, Pregnyl) Ovidrel (choriogonadotropin alfa) Follistim AQ (follitropin beta) Gonal-F, Gonal-F RFF, Gonal-F RFF Rediject (follitropin alfa) Menopur (menotropins) </p> <p>Any other newly approved medication for fertility</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Prescriber is experienced in fertility treatment, such as OB/GYN, fertility specialist, endocrinologist, etc. • Medication is prescribed for an FDA-approved indication for treatment of infertility • Medication is prescribed at an FDA-approved or compendia supported dose and duration of therapy <p>Exclusion:</p> <ul style="list-style-type: none"> • Pregnancy <p>Coverage Duration: If all criteria are met, the request will be approved for 12 months, and if the request is for in vitro fertilization, the request will be approved for up to 3 cycles</p> <p>Last review: 06/2025</p>
PA	<p>Fingolimod (Gilenya) 0.5mg</p> <p>Tascenso ODT (fingolimod) 0.25 mg tablet</p>	<p>Forward to CCHP for PA Review:</p> <p>CCHP criteria: Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient's medical records. • Must be clinically diagnosed with relapsing remitting multiple sclerosis clinically isolated syndrome, or active secondary progressive disease • Must be 10 years of age or older • Patient's weight is required • Patients must be observed for 6 hours after the initial dose, the first 0.5 mg dose when switching from 0.25 mg in pediatric patients, and all other doses where the patient has not received the medication for two weeks or longer <p>Criteria for continuation of therapy:</p> <ul style="list-style-type: none"> · Continued response – decrease or stabilization in number of, or no relapses <p>Last review 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Freestyle Libre Reader and Sensor	<p>ALL of the following must be met:</p> <ul style="list-style-type: none"> • Patient diagnosed with diabetes • One of the following: <ul style="list-style-type: none"> ○ Patient is currently on insulin therapy requiring multiple per day and/or frequent changes in insulin dose ○ Patient has a recent history of problematic hypoglycemia (frequent/severe hypoglycemia, nocturnal hypoglycemia, hypoglycemia unawareness) or frequent hospitalizations. ○ Patient is using an insulin pump/continuous subcutaneous insulin infusion ○ Patient is child/adolescent with type 1 DM ○ Patient is diagnosed with gestational DM and treated with insulin therapy ○ Continuation of therapy with existing CGM • Appointment with prescribing provider at least every 6 months <p>Initial authorization will be for 6 months. Continuation of therapy will require appointment with the provider to assess adherence to CGM regimen and diabetes treatment plan and will be re-approved for 12 months.</p> <p>Last review 6/2025</p>
PA	Granisetron Patch (Sancuso)	<p>FDA approved use:</p> <ol style="list-style-type: none"> 1. Prevention of nausea and vomiting in patients receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days (patch can be worn for up to 7 days) <p>Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • Trial and failure of granisetron (oral) AND ondansetron (oral) • Trial and failure of palonosetron <p>Not approved if:</p> <ul style="list-style-type: none"> • Greater than one (1) administration per chemotherapy cycle • Breakthrough nausea and vomiting <p>Last review 9/2025</p>
PA	<p>Growth Hormone</p> <p>(recombinant human growth hormone)</p> <p>Brand Names:</p> <p>Humatrope® Serostim® Genotropin® Genotropin Miniquick Norditropin Flexpro® Nutropin AQ NuSpin® Omnitrope® Zomacton Skytrofa Ngenla (somatrogen) Sogroya (somapacitan)</p>	<p>Criteria for use (all of the following must be met):</p> <ul style="list-style-type: none"> ○ Prescribed by endocrinologist, nephrologist, or specialist in the stated diagnosis <p><u>Adult-onset Growth Hormone Deficiency (AO-GHD)</u> If the diagnosis is adult-onset GH deficiency (AO-GHD), documentation of <u>ONE</u> of the following:</p> <ul style="list-style-type: none"> ○ Insulin Growth Factor (IGF-1) deficiency (< -2 SD below reference range for age and gender)* and multiple (≥3) pituitary hormone deficiencies (MPHD) ○ Evidence of genetic defects affecting the hypothalamic pituitary axes (HPA) ○ Evidence of hypothalamic pituitary structural brain defects ○ Positive results of GH stimulatory test (e.g. insulin tolerance test [ITT], glucagon, or macimorelin) <p><u>Childhood-onset Growth Hormone Deficiency (CO-GHD)</u> If diagnosis is childhood-onset GH deficiency (CO-GHD)</p> <ul style="list-style-type: none"> • And patient is currently pediatric, ALL of the following: <ul style="list-style-type: none"> ▪ IGF-1 and insulin-like growth factor binding protein-3 (IGFBP-3) deficiency (< 0 SD below reference range for age and gender)* with prescriber attestation of growth failure; AND

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APPROVAL CRITERIA-CCHP

- Provider attests that MRI or CT has been completed to exclude possibility of a pituitary tumor; AND
 - Patient's epiphysis are open (as documented by a radiograph)
- And patient is currently adult, ONE of the following
 - If diagnosis is idiopathic isolated GHD, documentation was provided that indicates GH therapy is still medically necessary (IGF-1 retesting during the transition period after a minimum 1 month of therapy discontinuation reveals continued GH deficiency)
 - Diagnosis is GHD associated with multiple (≥3) pituitary hormone deficiencies (MPHD), genetic defect affecting the HPA axes, or patient with hypothalamic pituitary structural brain defect
- **Growth failure due to chronic renal insufficiency / chronic kidney disease (CKD):**
 - Patient's epiphysis are open (as documented by a radiograph)
 - Either pretreatment height is < -1.88 standard deviations (SD) below the mean for age OR a height velocity–for–age < 3rd percentile that persists beyond 3 months
- **Short stature associated with Turner Syndrome, Prader-Willi Syndrome, Noonan Syndrome, Short Stature Homeobox-Containing Gene (SHOX) or other underlying genetic cause:**
 - Documentation of confirmatory genetic test

Requests may be approved for 1 year

******For members <21 years old, CCHP will check CCS eligibility******

Idiopathic Short Stature Note: CCHP does not consider idiopathic short stature an illness, disease, or injury. Accordingly, coverage would not be available under most plans, which provide coverage only for treatment of illness, injury or disease. If the benefit plan only covers treatment for disease, illness or injury and the diagnosis is idiopathic short stature, GH is not a covered benefit. When GH is not a covered plan benefit, medical necessity language should not be included within the review determination rationale. This is a contractual denial and not based on medical necessity.

Continuation of therapy:

- For growth hormone deficiency, may be approved for one year. Continuation of therapy or renewal requires a clinical response to growth hormone therapy including increase in height, height velocity or insulin growth factor 1 level normalization
- Documented IGF-1 levels do not exceed upper limit of normal (ULN) (> 2 SD above reference range for age and gender)*, or if the IGF-1 levels do not exceed ULN, the dose has been reduced
- In CO-GHD, growth response (as demonstrated by length/height and calculated height velocity within previous 6 months).

**IGF-1 levels are highly age and gender specific. In the event the form provides a value and not the corresponding reference range, refer to published reference ranges for interpretation

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PA	<p>Hepatitis C medications: Elbasvir/grazoprevir (Zepatier), Ledipasvir/Sofosbuvir (Harvoni), Sofosbuvir (Sovaldi), Sofosbuvir/velpatasvir (Epclusa), Glecaprevir/pibrentasvir (Mavyret) Vosevi sofosbuvir/velpatasvir/voxilaprevir)</p>	<p>Preferred products: Mavyret, sofosbuvir/velpatasvir (Epclusa), and Zepatier</p> <p>Approval of non-preferred products requires trial and failure of, intolerance, or inability to use a preferred medication</p> <p>Last review 6/2025</p>
	<p>Hepatitis B Drugs</p> <p>Formulary Tenofovir disoproxil fumarate (Viread) 300mg</p> <p>(Viread (tenofovir disoproxil fumarate) 150mg, 200mg, 250mg tablet, 40mg/gm oral powder Entecavir (Baraclude®)</p> <p><u>Formulary- PA required</u> Vemlidy® (tenofovir alafenamide fumarate) Lamivudine (EpiVir HBV®)</p>	<p>INITIAL CRITERIA for formulary medications:</p> <ul style="list-style-type: none"> • Diagnosis of Hepatitis B; <p>AND</p> <ul style="list-style-type: none"> • Medication is being prescribed at an appropriate FDA approved dose (for age and weight); <p>NON-FORMULARY/PA REQUIRED CRITERIA for Vemlidy and Lamivudine</p> <ul style="list-style-type: none"> • Patient is currently established on Vemlidy or lamivudine <p>OR</p> <ul style="list-style-type: none"> • Trial and therapy failure, or contraindication to, or inability to use entecavir (Baraclude) tablet AND tenofovir disoproxil fumarate (Viread) tablet, such as: • Compromised renal function or renal disease (CrCl <60 mL/min) OR <ul style="list-style-type: none"> • Bone disease (osteopenia or osteoporosis diagnosis) • Lamivudine may be approved for members with HBV and HIV coinfection without trial and failure of other medications <p>Requests for other prior authorization required or non-formulary medications will default to CCHP non-formulary PA criteria</p> <p>Tablet splitting is not required</p> <p>Last Review: 9/2025</p>

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	<p style="text-align: center;">Hereditary Angioedema (HAE) Treatments</p> <p>Preferred: icatibant (Firazyr) Berinert (C1 esterase inhibitor, human) Ruconest (C1 esterase inhibitor, recombinant) Haegarda (C1 esterase inhibitor, human) Orladeyo (berotralstat)</p> <p>Non-preferred: Cinryze (C1 esterase inhibitor, human) Kalbitor (ecallantide) Takhzyro (Icanadelumab-flyo) Ekterly (sebetralstat) Andembry (garadacimab-gxii) Dawnzera (donidalorsen)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Prescriber must be an immunologist, allergist, rheumatologist, or hematologist • Documentation submitted indicates the medication is being prescribed at FDA approved dose • The patient is not taking ACE inhibitors or estrogen containing oral contraceptives/hormone replacement therapy • Diagnosis of one of the following: <ul style="list-style-type: none"> ○ HAE with deficient or dysfunctional C1INH (e.g. type I, type II, or acquired C1INH deficiency) ○ HAE with normal C1INH: <ul style="list-style-type: none"> ▪ If known origin, documentation of results of confirmatory genetic test (e.g. mutations in gene for factor XII, angiotensin-converting enzyme, plasminogen, kininogen-1, myoferlin, heparan sulfate-glucosamine 3-O-sulfotransferase 6) ▪ If unknown origin (U-HAE), documentation of a prolonged trial of high-dose non-sedating antihistamines <p>For acute treatment (Ruconest, Berinert, Kalbitor, icatibant, Ekterly):</p> <ul style="list-style-type: none"> ○ The patient is receiving only one agent for the treatment of acute attacks ○ If the request is for a non-preferred agent, the member has documented trial and failure of, or intolerance to a preferred agent or medical reason why the member cannot use a preferred agent <p>For prophylaxis (Haegarda, Takhzyro, Cinryze, Orladeyo, Andembry, Dawnzera):</p> <ul style="list-style-type: none"> • Pre-procedural <ul style="list-style-type: none"> ○ Documentation that patient will be undergoing a medical, surgical, or dental procedure associated with mechanical impact to the upper aerodigestive tract • Long-term <ul style="list-style-type: none"> ○ The patient has a history of at least two severe attacks/month (e.g. with swelling of the face, throat, or GI tract) or at least one laryngeal attack, and chart notes have been submitted indicating the date and severity of attack ○ The patient is only receiving one medication for long-term prophylaxis • If the request is for a non-preferred agent, the member has documented trial and failure of or medical reason why patient cannot use a preferred agent
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APPROVAL CRITERIA-CCHP

		<p><u>Re-Authorization:</u> For acute treatment (Ruconest, Berinert, Kalbitor, icatibant, Ekterly):</p> <ul style="list-style-type: none"> • Documentation was submitted that the patient has clinically benefited from medication • The patient is receiving no other medications for acute treatment • The medication is being prescribed at FDA approved dose <p>For prophylaxis (Haegarda, Takhzyro, Cinryze, Orladeyo, Andembry, Dawnzera):</p> <ul style="list-style-type: none"> • Documentation was submitted that the patient has clinically benefited from prophylactic therapy as demonstrated by a reduced number of attacks • The medication is being prescribed at an FDA approved dose • The patient is receiving no other medications for prophylaxis <p><u>Coverage Duration:</u> If criteria are met, the request will be approved as follows:</p> <ul style="list-style-type: none"> • Acute treatment: 1 + 5 refills • Pre procedural prophylaxis: 1 treatment • Long-term prophylaxis: <ul style="list-style-type: none"> ○ Initial: 6 months ○ Reauthorization: 12 months <p>Last review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

	<p>Siklos (hydroxyurea)</p>	<p>Initial authorization:</p> <ul style="list-style-type: none"> • Diagnosis of sickle cell disease • Member must be 2 years old or older • Request is for an FDA approved dose • Prescribed by a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease. • Documented trial and failure or intolerance to hydroxyurea at a maximum tolerated dose OR • Medical reason why patient is unable to use hydroxyurea capsules <p>Reauthorization:</p> <ul style="list-style-type: none"> • Prescriber attests member experienced a reduction in number of sickle cell crises or their condition is stable as a result of Siklos therapy • Request is for an FDA approved dose <p>If the criteria are met, the initial request may be approved for up to a 12-month duration. Reauthorization requests may be approved for 12 months</p> <p>Last Review: 9/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Icosapent Ethyl (Vascepa)	<p>Criteria for use:</p> <p>Cardiovascular risk reduction</p> <ul style="list-style-type: none"> ○ Member is over 18 years of age ○ Member has a diagnosis of moderate hypertriglyceridemia (pre-treatment triglyceride \geq 150 mg/dL) and ONE of the following is true: <ul style="list-style-type: none"> ▪ Member is \geq 45 years of age and has established cardiovascular disease as evidenced by a history of at least ONE of the following: <ul style="list-style-type: none"> ▪ Myocardial infarction or acute coronary syndrome ▪ Stroke or transient ischemic attack ▪ Coronary artery disease with stable angina ▪ Coronary or other arterial revascularization ▪ Peripheral vascular disease ▪ Aortic aneurism ○ Member is \geq 50 years of age, has diabetes mellitus and at least TWO of the following: <ul style="list-style-type: none"> ▪ Men \geq 55 years or women \geq 65 years ▪ Cigarette smoker or stopped smoking within the past 3 months ▪ Hypertension (pretreatment blood pressure \geq 140 mmHg systolic or \geq 90 mmHg diastolic) ▪ HDL-C \leq 40 mg/dL for men or \leq 50 mg/dL for women ▪ High-sensitivity C-reactive protein $>$ 3.0 mg/L ▪ Renal dysfunction (CrCl $>$ 30 mL/min and $<$ 60 mL/min) ▪ Retinopathy ▪ Micro- or macro-albuminuria ▪ Ankle-brachial index (ABI) $<$ 0.9 without symptoms of intermittent claudication ○ Member is taking and will continue on maximum tolerated statin dose while receiving Icosapent ethyl (Vascepa), or documentation has been provided that the member is not able to tolerate a statin. ○ Documentation was provided indicating provider has counseled member on smoking cessation (if applicable) and following a “heart healthy diet.” ○ The request is for an FDA approved dose. <p>Triglyceride reduction</p> <ul style="list-style-type: none"> • Member has a diagnosis of severe hypertriglyceridemia (pre-treatment triglyceride level \geq 500 mg/dL). • Member has tried and failed an OTC fish oil or omega-3-ecid ethyl ester (generic Lovaza) • Documentation was provided indicating provider has counseled member on smoking cessation (if applicable) and following a “heart healthy diet.” • The request is for an FDA approved dose. <p>Last review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Leqvio (Inclisiran)	<p>Criteria for use:</p> <ul style="list-style-type: none"> • The patient has one of the following diagnoses: <ul style="list-style-type: none"> ○ Heterozygous familial hypercholesterolemia with baseline LDL-C (prior to any lipid-lowering pharmacologic therapy) was \geq 190 mg/dL ○ Atherosclerotic cardiovascular disease (ASCVD) ○ Primary hyperlipidemia • Patient has tried and failed at least two high potency statins (i.e., atorvastatin 40-80mg, rosuvastatin 20-40mg), one of which in combination with ezetimibe, after a trial of at least 12 weeks at the maximum tolerated dose, or has an intolerance or contraindication to use. If stable on statin in combination with ezetimibe further trials of statins are not required. • Patient has tried and failed to achieve LDL goal using PCSK9 inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)] for at least 12 weeks with or without a statin or contraindication to use. <p>Approval duration is for 1 year</p> <p>Last review: 9/2025</p>
PA	Semglee yfgn Basaglar	<p>Preferred (1st line): Insulin Glargine-yfgn Insulin glargine (branded, Winthrop) Rezvoglar (insulin glargine-aglr) Lantus (insulin glargine)</p> <p>Criteria for use:</p> <ul style="list-style-type: none"> • Must have a trial and failure or intolerance to two preferred first line agents before Semglee, or Basaglar is approved <p>Last reviewed: 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p><u>Antifibrotic Respiratory Tract Agents</u></p> <p>Ofev (nintedanib esylate)</p> <p>Esbriet (pirfenidone)</p>	<p>INITIAL CRITERIA FOR ALL DIAGNOSES:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • MD is a pulmonologist or lung transplant specialist • Provider attests that they have reviewed the patient’s other medications, and addressed all potential drug interactions • Documentation has been provided that the patient does not smoke <p>INITIAL CRITERIA FOR IDIOPATHIC PULMONARY FIBROSIS:</p> <ul style="list-style-type: none"> • Pulmonary function test indicates patient has a Forced Vital Capacity (FVC) greater than or equal to 50% within 30 days of the request • Confirmed diagnosis of Idiopathic Pulmonary Fibrosis as documented by evidence, including, but not limited to the following: <ul style="list-style-type: none"> • Exclusion of other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, CTD, drug toxicity), AND one of the following: <ul style="list-style-type: none"> • The presence of the high resolution computed tomography (HRCT) pattern of usual interstitial pneumonia (UIP) <p>OR</p> <ul style="list-style-type: none"> • If HRCT pattern is “Probable UIP” or “Indeterminate for UIP,” diagnosis has been confirmed by histopathology pattern (see table) <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th colspan="2" rowspan="2">EEAAGAGAGAG</th> <th colspan="4">Histopathology pattern</th> </tr> <tr> <th>UIP</th> <th>Probable UIP</th> <th>Indeterminate for UIP</th> <th>Alternative diagnosis</th> </tr> </thead> <tbody> <tr> <th rowspan="4">HRCT pattern</th> <th>UIP</th> <td style="background-color: #4CAF50;">IPF</td> <td style="background-color: #4CAF50;">IPF</td> <td style="background-color: #4CAF50;">IPF</td> <td style="background-color: #F44336;">Non-IPF dx</td> </tr> <tr> <th>Probable UIP</th> <td style="background-color: #4CAF50;">IPF</td> <td style="background-color: #4CAF50;">IPF</td> <td style="background-color: #FFEB3B;">IPF (Likely)**</td> <td style="background-color: #F44336;">Non-IPF dx</td> </tr> <tr> <th>Indeterminate for UIP</th> <td style="background-color: #4CAF50;">IPF</td> <td style="background-color: #FFEB3B;">IPF (Likely)**</td> <td style="background-color: #F44336;">Indeterminate for IPF***</td> <td style="background-color: #F44336;">Non-IPF dx</td> </tr> <tr> <th>Alternative diagnosis</th> <td style="background-color: #FFEB3B;">IPF (Likely)** Non-IPF dx</td> <td style="background-color: #F44336;">Non-IPF dx</td> <td style="background-color: #F44336;">Non-IPF dx</td> <td style="background-color: #F44336;">Non-IPF dx</td> </tr> </tbody> </table> <p><i>Idiopathic pulmonary fibrosis (IPF) diagnosis on the basis of high-resolution computed tomography (HRCT) and biopsy patterns, developed using consensus by discussion. **Clinically suspected of having IPF” is defined as unexplained patterns of bilateral pulmonary fibrosis on chest radiography or chest computed tomography, bibasilar inspiratory crackles, and age > 60 years. Middle-aged adults (>40 and <60 yr old) can rarely present with otherwise similar clinical features, especially in patients with features suggesting familial pulmonary fibrosis. †Diagnostic confidence may need to be downgraded if histopathological assessment is based on transbronchial lung cryobiopsy given the smaller biopsy size and greater potential for sampling error compared with surgical lung biopsy.</i></p> <p><i>#IPF is the likely diagnosis when any of the following features are present:</i></p> <ol style="list-style-type: none"> 1) moderate to severe traction bronchiectasis and/or bronchiolectasis (defined as mild traction bronchiectasis and/or bronchiolectasis in four or more lobes, including the lingula as a lobe, or moderate to severe traction bronchiectasis in two or more lobes) in a man >50 years old or in a woman >60 yr old, 2) extensive (>30%) reticulation on HRCT and age > 70 yr, 3) increased neutrophils and/or absence of lymphocytosis in BAL fluid, 4) multidisciplinary discussion produces a confident diagnosis of IPF. <p><i>§Indeterminate for IPF</i></p> <ol style="list-style-type: none"> 1) without an adequate biopsy remains indeterminate and 2) with an adequate biopsy may be reclassified to a more specific diagnosis after multidisciplinary discussion and/or additional consultation. dx = diagnosis; UIP = usual interstitial pneumonia 	EEAAGAGAGAG		Histopathology pattern				UIP	Probable UIP	Indeterminate for UIP	Alternative diagnosis	HRCT pattern	UIP	IPF	IPF	IPF	Non-IPF dx	Probable UIP	IPF	IPF	IPF (Likely)**	Non-IPF dx	Indeterminate for UIP	IPF	IPF (Likely)**	Indeterminate for IPF***	Non-IPF dx	Alternative diagnosis	IPF (Likely)** Non-IPF dx	Non-IPF dx	Non-IPF dx	Non-IPF dx
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APPROVAL CRITERIA-CCHP

		<p><u>INITIAL CRITERIA FOR SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSc-ILD (Ofev only)):</u></p> <ul style="list-style-type: none"> • Confirmed diagnosis of SSc-ILD <ul style="list-style-type: none"> • Exclusion of other etiologies of ILD (i.e. heart failure, drug-induced lung toxicity, recurrent aspiration, or pulmonary vascular disease) • HRCT pattern of fibrotic nonspecific interstitial pneumonia (NSIP), UIP, or centrilobular fibrosis • FVC \geq 40% within 30 days of request • Trial and failure of mycophenolate mofetil (MMF), cyclophosphamide or azathioprine. <p><u>INITIAL CRITERIA FOR CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (Ofev only)::</u></p> <ul style="list-style-type: none"> • Diagnosis of chronic fibrosing ILD (e.g. connective tissue disease [CTD]-associated ILD, chronic fibrosing hypersensitivity pneumonitis [HP], idiopathic non-specific interstitial pneumonia [iNSIP], unclassifiable idiopathic interstitial pneumonia [IIP], environmental/occupational lung disease or sarcoidosis) with a progressive phenotype • Confirmed fibrosing features as evidenced by <ul style="list-style-type: none"> • HRCT demonstrating reticular abnormality with traction bronchiectasis with or without honeycombing • Confirmed progressive phenotype as evidenced by one of the following <ul style="list-style-type: none"> • Clinically significant decline in FVC % predicted based on a relative decline of \geq10% • Marginal decline in FVC % predicted based on a relative decline of \geq5-$<$10% combined with worsening of respiratory symptoms • Marginal decline in FVC % pred based on a relative decline of \geq5-$<$10% combined with increasing extent of fibrotic changes on chest imaging • Worsening of respiratory symptoms as well as increasing extent of fibrotic changes on chest imaging • Recent (12 month) history of treatment with at least one medication to treat ILD (e.g. corticosteroid, azathioprine, mycophenolate mofetil (MMF), n-acetylcysteine (NAC), rituximab, cyclophosphamide, cyclosporine, or tacrolimus. • FVC \geq 45% predicted within 30 days of request <p><u>REAUTHORIZATION CRITERIA:</u></p> <ul style="list-style-type: none"> ▪ MD is a pulmonologist or lung transplant specialist ▪ Documentation submitted indicates that the member has obtained clinical benefit from the medication ▪ Documentation has been provided that the patient does not smoke <p>Initial approval and later approval: 6 months</p> <p>Last review 3/2025</p>
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APPROVAL CRITERIA-CCHP

PA	<p>Inhaled corticosteroid/ long-acting beta agonist (+LAMA) combinations:</p> <p>Advair HFA (fluticasone /salmeterol) aerosol inhaler</p> <p>Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)</p> <p>Breztri Aerosphere (budesonide/ glycopyrrolate/ formoterol fumarate)</p>	<p>Criteria for use for Advair HFA :</p> <ul style="list-style-type: none"> • Asthma <ul style="list-style-type: none"> ○ Diagnosis of asthma ○ Trial and failure of generic Symbicort or generic AirDuo RespiClick Dulera, fluticasone/vilanterol (Breo Ellipta), or generic Advair Diskus/Wixela Inhub ○ Advair HFA should only be approved in patients 12 and older <p>Criteria for use of Trelegy Ellipta or Breztri Aerosphere</p> <ul style="list-style-type: none"> • Diagnosis of COPD or asthma (Trelegy Ellipta) OR • Diagnosis of COPD (Breztri Aerosphere) • Trial and failure of any LAMA/LABA or LABA/ICS within the past 90 days <p>If the criteria are met, the request will be approved with up to a 12 month duration</p> <p>Last review 3/2025</p>
PA	<p><u>Injectable Atypical Antipsychotic Medications</u></p> <p>Risperidone microspheres ER (Risperdal Consta®)</p> <p>Invega Sustenna® (paliperidone palmitate)</p> <p>Abilify Maintena® (aripiprazole)</p> <p>Invega Trinza® (paliperidone palmitate)</p> <p>Invega Hafyera (paliperidone palmitate)</p> <p>Aristada (aripiprazole lauroxil)</p> <p>Aristada Initio (aripiprazole lauroxil)</p> <p>Abilify Asimtufii (aripiprazole)</p> <p>Uzedy (risperidone)</p> <p>Rykindo (risperidone)</p> <p>Erzofri (paliperidone palmitate)</p>	<p><u>CRITERIA FOR INITIAL AUTHORIZATION</u></p> <ul style="list-style-type: none"> • Member has claims history or physician attestation that member has tolerated treatment with the oral agent of the drug that is being requested • Prescriber attestation of one of the following : <ul style="list-style-type: none"> ○ The member has a long-term history (>3 months) of uncertain compliance or noncompliance with oral anti-psychotic medications ○ The member has a documented medical reason (i.e. documented treatment failure to maximum doses and/or has intolerable side effects or drug interactions) for not using oral formulary atypical antipsychotic medication ○ The prescriber attests that the member has stated preference for injectable atypical antipsychotic therapy • Request is for an FDA approved indication at an approved dose. • If the request is for Aristada Initio, only a single dose will be approved if documentation has been provided that the member is initiating Aristada • If request is for Invega Trinza, documentation has been provided that the member has been stable on Invega Sustenna for 4 months, and at the same dose for the last 2 months • If the request is for Invega Hafyera, documentation has been provided that the member has been stable on Invega Sustenna for 4 months and at the same dose for the last 2 months OR has been stable on Invega Trinza for the last 3 months <p><u>CRITERIA FOR REAUTHORIZATION</u></p> <ul style="list-style-type: none"> • Request is for an FDA approved indication at an approved dose. • Documentation submitted indicating member is stable and tolerating medication. • Member has been compliant with filling their medication OR documentation was provided indicating why the member missed dosing <p>Last review: 6/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p style="text-align: center;">Biologic Agents for Nasal Polyposis</p> <p><u>Formulary, Prior Authorization Required:</u> Dupixent (dupilumab) Xolair (omalizumab) Nucala (mepolizumab)</p>	<p>**Xolair: For asthma, urticaria, and IgE-mediated food allergy, please refer to the “Xolair for Asthma, Urticaria, and IgE-Mediated Food Allergy” policy**</p> <p>**Dupixent: For atopic dermatitis, please refer to the “Agents for Atopic Dermatitis” policy; For asthma & COPD, please refer to the “Pulmonary Biologics for Respiratory and Eosinophilic Conditions” policy**</p> <p>**Nucala: For asthma, COPD, or other eosinophilic conditions, please refer to the “Pulmonary Biologics for Respiratory and Eosinophilic Conditions” policy**</p> <p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescribed by or in consultation with an immunologist, allergist or otolaryngologist • Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) • Medication is being prescribed at an FDA approved dosage • Documentation of ONE of the following: <ul style="list-style-type: none"> ○ Trial and failure, or medical reason for not using, all of the following therapies: <ul style="list-style-type: none"> ▪ an intranasal corticosteroid ▪ a systemic corticosteroid ○ Prior surgery for nasal polyps • Patient is currently using an intranasal corticosteroid, will be prescribed at an intranasal corticosteroid, or has a documented medical reason for not using an intranasal corticosteroid • Use of Dupixent, Xolair, or Nucala concomitantly or with another pulmonary biologic (e.g. Fasenna, Cinqair) is not covered <p><u>Re-authorization:</u></p> <ul style="list-style-type: none"> • Medication is prescribed at an FDA-approved dosage • Member will continue to use an intranasal corticosteroid, or has a medical reason for not using an intranasal corticosteroid • Documentation has been provided that demonstrates a clinical benefit (e.g. improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS], nasal obstruction symptom visual analogue scale [VAS]) <p>Last review date: 9/2025</p>
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APPROVAL CRITERIA-CCHP

PA	<p>Isotretinoin</p> <p>Requires Prior Authorization, Preferred:</p> <ul style="list-style-type: none"> • Claravis (isotretinoin) • Zenatane (isotretinoin) • Amnesteem (isotretinoin) • Accutane (isotretinoin) • Isotretinoin <p>Requires Prior Authorization, Non-Preferred:</p> <ul style="list-style-type: none"> • Isotretinoin (Absorica) • Absorica LD (isotretinoin) 	<p>All of the following conditions must be met for approval:</p> <ul style="list-style-type: none"> • Medication must be prescribed by a dermatologist • Diagnosis of moderate to severe recalcitrant nodular acne. • Documented treatment with a therapeutic trial and failure or intolerance to two of the following treatments for at least 3 months: <ul style="list-style-type: none"> ○ Oral antibiotic ○ Topical therapies (topical retinoid or topical antibiotic) ○ Hormonal contraceptives ○ Spironolactone • If the request is for a non-preferred drug, documentation has been provided that the member has tried and failed two preferred drugs or has a medical reason why these drugs cannot be used <p>Last review 9/2025</p>
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APPROVAL CRITERIA-CCHP

PA	<p>Itraconazole (Sporanox®) 100mg capsule</p> <p>Itraconazole (Sporanox) 10mg/ml solution</p> <p>Tolsura (itraconazole) 65mg capsule</p>	<p>Approve x 12 months (3 months for non-systemic infections):</p> <p><u>Aspergillosis, Blastomycosis, Histoplasmosis</u></p> <ul style="list-style-type: none"> • Member is immunocompromised; OR • Member has had a documented trial and failure, or intolerance, to a preferred oral antifungal taken at an appropriate dose and duration; OR • Member is stepping down after initial therapy with, is intolerant to, or is refractory to treatment with, amphotericin B <p><u>Oropharyngeal or Esophageal Candidiasis</u></p> <ul style="list-style-type: none"> • Member is immunocompromised; OR • Member has had a documented trial and failure, or intolerance, to oral fluconazole taken at an appropriate dose and duration <p><u>Onychomycosis:</u></p> <ul style="list-style-type: none"> • Member is immunocompromised; OR • Member has had a documented trial and failure, or intolerance, to oral terbinafine taken at an appropriate dose and duration (e.g., 6 weeks for fingernail onychomycosis, 12 weeks for toenail onychomycosis) <p>Requests for itraconazole oral solution require a documented trial and failure, or intolerance, to generic itraconazole oral capsules unless the oral solution is being requested for a diagnosis of oropharyngeal or esophageal candidiasis. If Tolsura is requested, justification must be provided as to why generic itraconazole 100mg capsules cannot be used</p> <p>Last review:9/2025</p>
PA	Leukotriene Receptor Antagonists	<p>Montelukast (Singular) tablets and chewable tablets (PREFERRED)</p> <p>Zafirlukast (Accolate) tablets and Montelukast granules (second line)</p> <ul style="list-style-type: none"> o Requires a trial and failure of montelukast (Singluair) tablets <ul style="list-style-type: none"> • Zileuton (Zyflo) (third line) o Requires a trial and failure of montelukast AND zafirlukast <p>Last review 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Lidocaine (Lidoderm®)	<p>Tried and failed or intolerant to at least THREE of the following:</p> <ul style="list-style-type: none"> • Capsaicin topical cream • Oral NSAIDs • Formulary topical lidocaine 3%, 4% cream or 5% ointment • Diclofenac (Voltaren) 1% topical gel <p>QL: 60 patches per 30 days</p> <p>Last review 6/2025</p>
PA	Lidocaine (Ztlido) patch 1.8%	<p>Criteria for Use:</p> <ol style="list-style-type: none"> 1. Member has tried and failed lidocaine 5% patch AND 2. Member Tried and failed or intolerant to at least THREE of the following: <ul style="list-style-type: none"> ○ Capsaicin topical cream ○ Oral NSAIDs ○ Formulary topical lidocaine 3%, 4% cream or 5% ointment ○ Diclofenac (Voltaren) 1% topical gel <p style="text-align: center;">Last review 3/2025</p>
PA	Linezolid (Zyvox®)	<p><u>PA CRITERIA FOR APPROVAL</u></p> <ul style="list-style-type: none"> • Documented history of treatment with linezolid IV (continuation of therapy, IV to PO conversion). OR <p>Both of the following:</p> <ul style="list-style-type: none"> • Prescribed dosing is within FDA approved indications and/or supported by medical compendium <ul style="list-style-type: none"> • The indicated diagnosis must be supported by documentation from medical records and include any applicable labs • Documentation that the infection is susceptible to Zyvox AND the patient has failed treatment or is contraindicated to treatment with preferred antibiotics to which the organism is susceptible. <p>If the above conditions are met, the request will be approved with up to a 1 month duration depending on the type of infection</p> <p>Last review 9/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p><u>Gastrointestinal Agents</u></p> <p>Lubiprostone (Amitiza®) Linzess (linaclotide) Trulance (plecanatide) Prucalopride (Motegrity) Movantik (naloxegol) Relistor (methylnaltrexone) Symproic (naldemedine) Ibsrela (tenapanor)</p>	<p><u>CCHP Criteria for all requests:</u></p> <ul style="list-style-type: none"> • Must have a GI consult. • Over the age of 18 years , except for Linzess: functional constipation in pediatric patients 6-17 years • Medication is prescribed at an FDA approved dosage <p>Criteria for irritable bowel syndrome with constipation predominate (IBS-C):</p> <ul style="list-style-type: none"> • The patient has a clinical diagnosis of irritable bowel syndrome constipation predominate (IBS-C) • Documentation of trial and failure, contraindication, or intolerance of a soluble fiber (e.g. psyllium) within the last 90 days • If the above criteria are met, for requests for Linzess, Trulance, or lubiprostone (Amitiza): approve. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • For requests for other formulary, prior authorization required medications, the above criteria must be met, AND documentation of trial and failure, contraindication, or intolerance of Linzess, Trulance, or lubiprostone (Amitiza) within the last 90 days is required <p>Criteria for chronic idiopathic constipation (CIC):</p> <ul style="list-style-type: none"> • The patient has a clinical diagnosis of chronic idiopathic constipation (CIC) • Documentation of trial and failure, intolerance, or inability to use a soluble fiber (e.g. psyllium) within the last 90 days • Documentation of trial and failure, contraindication, or intolerance, to at least 2 formulary alternative laxatives (example: milk of magnesia, polyethylene glycol, docusate sodium, senna) within the last 90 days- • If the above criteria are met, for requests for Linzess, Trulance, prucalopride (Motegrity), or lubiprostone (Amitiza): approve. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • For requests for other formulary, prior authorization required medications, the above criteria must be met, AND documentation of trial and failure, contraindication, or intolerance to Linzess, Trulance, prucalopride (Motegrity), or lubiprostone (Amitiza) within the last 90 days is required <p>Criteria for OPIOID-INDUCED CONSTIPATION (OIC) with chronic non-cancer pain:</p> <ul style="list-style-type: none"> • The patient has a clinical diagnosis of opioid-induced constipation with chronic non-cancer pain • Documentation of trial and failure contraindication, or intolerance to at least 2 formulary alternatives (example: milk of magnesia, polyethylene glycol, docusate sodium, senna) within the last 90 days • If the above criteria are met, for requests for Movantik, Symproic, or lubiprostone (Amitiza): approve. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • For requests for other formulary, prior authorization required medications, the above criteria must be met, AND documentation of trial and failure, contraindication, or intolerance to Movantik, Symproic, or lubiprostone (Amitiza) within the last 90 days is required <p>Criteria for OPIOID-INDUCED CONSTIPATION (OIC) with advanced illness:</p> <ul style="list-style-type: none"> • The patient has a clinical diagnosis of opioid-induced constipation with advanced illness • Documentation of trial and failure contraindication, or intolerance to at least 2 formulary alternatives (example: milk of magnesia, polyethylene glycol, docusate sodium, senna) within the last 90 days • If the above criteria are met, for requests for Relistor injectable (e.g. vial or syringe) approve. <p style="text-align: center;">OR</p>
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APPROVAL CRITERIA-CCHP

	(Continued)	<ul style="list-style-type: none"> For requests for other formulary, prior authorization required medications, the above criteria must be met, AND documentation of trial and failure, contraindication, or intolerance to Relistor injectable (e.g. vial or syringe) within the last 90 days is required <p>Criteria for Functional constipation (FC) in pediatric patients 6-17 years old (Linzess only):</p> <ul style="list-style-type: none"> The patient has a clinical diagnosis of functional constipation (FC) Documentation of trial and failure, contraindication, or intolerance to at least 2 formulary alternatives (example: polyethylene glycol, lactulose, milk of magnesia, docusate sodium, senna) within the last 90 days <p>Last review: 9/2025</p>
PA	Kerendia (finerenone)	<p>For Chronic Kidney Disease (CKD) Associated with Type 2 Diabetes (T2DM):</p> <ul style="list-style-type: none"> Diagnosis of chronic kidney disease associated with type 2 diabetes Patient is currently taking (or has a medical justification for not using) maximum tolerated dose of angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) Documented trial and failure of (or has a medical justification for not using) an SGLT2 inhibitor Documentation of all of the following: <ul style="list-style-type: none"> estimated glomerular filtration rate (eGFR) ≥ 25 ml/min per 1.73 m² Urine Albumin-to-Creatinine Ratio (UACR) albuminuria > 30 mg/g serum potassium concentration ≤ 5.0 mEq/L <p>For Heart Failure with Left Ventricular Ejection Fraction $\geq 40\%$:</p> <ul style="list-style-type: none"> Documentation of diagnosis of heart failure with left ventricular ejection fraction $\geq 40\%$ Documentation of all of the following: <ul style="list-style-type: none"> Serum potassium levels ≤ 5.0 mEq/L eGFR ≥ 25 mL/min/1.73 m² <p>Last reviewed: 12/2025</p>
PA	Lurasidone (Latuda®)	<p>Criteria for Use for Schizophrenia:</p> <ul style="list-style-type: none"> Age ≥ 13 years old Clinically diagnosed with schizophrenia Failure/intolerance/contraindication to at least 3 formulary atypical antipsychotic agents such as: olanzapine, quetiapine, risperidone, aripiprazole, clozapine or ziprasidone <p>Criteria for Use for Bipolar 1 acute depressive:</p> <ul style="list-style-type: none"> Age ≥ 10 years old Clinically diagnosed with bipolar 1 disorder, acute depressive Failure/intolerance/contraindication to at least one formulary atypical antipsychotic agents such as quetiapine <p>Last review 6/2025</p>
PA	<p><u>Pediculicide and Scabicide Agents:</u></p> <p><u>Formulary prior authorization-required</u> Malathion (Ovide) Spinosad (Natroba)</p> <p><u>Non-formulary</u> Croton (crotamiton) 10% lotion</p>	<p>INITIAL: Head Lice:</p> <p>For the approval of malathion (Ovide) and spinosad (Natroba):</p> <ul style="list-style-type: none"> Diagnosis of pediculosis capitis (head lice and its eggs). Documented intolerance or hypersensitivity to a first line agent, Permethrin 1% OTC (Nix-OTC, Elimite) or Pyrethrins/Piperonyl Butoxide OTC (Pyrinyl II, RID-OTC) OR Documented trial and failure of a first line agent, Permethrin 1% OTC (Nix-OTC, Elimite) or Pyrethrins/Piperonyl Butoxide OTC (Pyrinyl II, RID-OTC), within the

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APPROVAL CRITERIA-CCHP

		<p>previous 45 days, but no earlier than 7 days after the original fill. Trial and failure must include a re-application of the product after 7 days</p> <p>Scabies: For the approval of spinosad (Natroba):</p> <ul style="list-style-type: none"> • Diagnosis of scabies (<i>Sarcoptes scabiei</i>) • Documented trial and failure, intolerance, or hypersensitivity to the first line agent: permethrin 5% topical cream <p>For the approval of Crotan, Pruradik:</p> <ul style="list-style-type: none"> • All criteria above must be met AND documented trial and failure of: spinosad (Natroba) 0.9% suspension <p>RENEWAL:</p> <ul style="list-style-type: none"> • For head lice: spinosad can be approved for a second treatment if live lice are present 7 days after the initial treatment. • For head lice: malathion can be approved for a second treatment if live lice are present 7-9 days after the initial treatment. • For scabies: Crotan, Pruradik: can be approved for a second treatment if itching still present or if new burrows or lesions continue to appear 2-4 weeks after the initial treatment & 2nd application 24 hours after the 1st. <p>Last review: 12/2025</p>
PA	Minocycline Tablets	<p style="text-align: center;">Must have tried and failed or intolerant to minocycline capsules</p> <p>Last review: 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p>Sleep Disorder Therapy</p> <p><u>Formulary prior authorization required</u> modafinil (Provigil) tablets</p> <p><u>Non-formulary</u> armodafinil (Nuvigil) tablets Sunosi (solriamfetol) tablets Wakix (pitolisant) tablets Sodium oxybate Solution (Xyrem) Xywav (calcium, magnesium, potassium, and sodium oxybates) Lumryz (sodium oxybate) oral packet</p>	<p><u>For all requests:</u></p> <ul style="list-style-type: none"> • Medication is being prescribed at an FDA approved or medically accepted dose • Prescribed by or in consultation with a sleep specialist, neurologist, or other specialist in the treatment of the member's diagnosis (does not apply for diagnosis of shift-work disorder) <p><u>Modafinil/armodafinil initial authorization:</u></p> <ul style="list-style-type: none"> • For a diagnosis of obstructive sleep apnea (OSA) documentation that the member has been compliant with or is unable to use positive airway pressure [e.g. continuous positive airway pressure (CPAP), bilevel positive airway pressure (BPAP), or automatic positive airway pressure (APAP)]. <p><u>Sunosi initial authorization</u></p> <ul style="list-style-type: none"> • Documented trial and failure of, or medical reason for not using, either modafinil or Armodafinil • Medication is not being taken concurrently or within 14 days of an MAOI • Additionally for members with OSA: <ul style="list-style-type: none"> o Documentation that the member has been compliant with or is unable to use positive airway pressure (CPAP, BPAP, or APAP) <p><u>Wakix initial authorization:</u></p> <ul style="list-style-type: none"> • For a diagnosis of narcolepsy without cataplexy: documented trial and failure of, or medical reason for not using, both of the following: <ul style="list-style-type: none"> o Modafinil or armodafinil o Sunosi (solriamfetol) *For members under 18 years of age, no prerequisite medication trials are required • For a diagnosis of narcolepsy in members 18 years of age and older with cataplexy: Documented trial and failure of, or medical reason for not using, the following: <ul style="list-style-type: none"> o Dextroamphetamine <p><u>Sodium Oxybate (Xyrem/Xywav/Lumryz) initial authorization</u></p> <ul style="list-style-type: none"> • Medication is not being taken concurrently with sedative hypnotics • If member has a history of substance abuse, documentation has been provided that prescriber has referred the member for substance abuse disorder treatment. • For a diagnosis of narcolepsy without cataplexy <ul style="list-style-type: none"> o Documented trial and failure of, or medical reason for not using, ALL of the following: <ul style="list-style-type: none"> ▪ Modafinil or armodafinil (not required for members under 18) ▪ Sunosi (solriamfetol) (not required for members under 18) ▪ Wakix (pitolisant) o For Xyrem, Xywav, or Lumryz: documented trial and failure of, or medical reason for not using generic sodium oxybate • For a diagnosis of narcolepsy with cataplexy <ul style="list-style-type: none"> o Documented trial and failure of, or medical reason for not using, BOTH of the following: <ul style="list-style-type: none"> ▪ Dextroamphetamine (not required for members under 18) ▪ Wakix (pitolisant) (not required for members under 18) o For Xyrem, Xywav, or Lumryz: documented trial and failure of, or medical reason for not using generic sodium oxybate • For a diagnosis of idiopathic hypersomnia (Xywav only): <ul style="list-style-type: none"> o Patient has a documented trial and failure of, or medical contraindication to, the following: modafinil or armodafinil <p><u>Reauthorization:</u></p> <ul style="list-style-type: none"> • Documentation has been submitted indicating member has experienced a clinical benefit from treatment (e.g. improvement on Epworth Sleepiness Score, reduction in frequency of cataplexy attacks) • For a diagnosis of obstructive sleep apnea (OSA), documentation that the member continues to be compliant with or is unable to use positive airway pressure (CPAP, BPAP, or APAP). <p>If the criteria are met, requests for modafinil, armodafinil, Sunosi, and Wakix will be approved with up to a 12 month duration. Requests sodium oxybate (Xyrem/Xyway/Lumryz): will be approved with up to a 3 month duration Last Review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Morphine Sulfate (Avinza®, Kadian®)	<p>Maximum Daily Dose: 2 capsules per day dosing; consolidate dose whenever possible (ex.two 30mg QD consolidate to one 60mg QD).</p> <p>Approve with dosing limits above if patient has tried and failed, or is unable to use MS Contin (e.g. not able to swallow tablet size and requires capsule form, which can be opened). Otherwise, deny and ask if MS Contin can be considered</p> <p>Last review 6/2025</p>
PA	Nasal Steroids	<p><u>STATUS</u> Preferred (1st line), Pays at Point-of-Sale (some with quantity limits)</p> <p>FLONASE (fluticasone) Nasal Suspension: 50mcg FLONASE Sensimist (fluticasone) Nasal Suspension Budesonide Nasal Suspension: 32mcg NASACORT Allergy (triamcinolone) Nasal Solution: 55mcg</p> <p><u>STATUS</u> Non-Preferred (2nd line), Requires Prior Authorization and use of all 1st line agents:</p> <p>BECONASE AQ (beclomethasone) Nasal Suspension: 42mcg NASONEX (mometasone) Nasal Suspension: 50mcg OMNARIS (ciclesonide) Nasal Suspension: 50mcg flunisolide Nasal Solution: 25mcg QNASL (beclomethasone) Nasal Aerosol: 40mcg, 80mcg ZETONNA (ciclesonide) Nasal Aerosol: 37mcg XHANCE 93 MCG NASAL SPRAY (fluticasone) 93mcg</p> <p>Any other non-formulary intranasal steroid</p> <p><u>PA CRITERIA FOR APPROVAL</u></p> <ol style="list-style-type: none"> 1) 1st line agents pay at POS without PA within quantity limits 2) 2nd line agents require PA—will approve if member has t/f all 4 of the 1st line agents <p>If the above conditions are met, the request will be approved with a 12 month duration</p> <p>Last review 9/2025</p>

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APPROVAL CRITERIA-CCHP

C1	Needles & Syringes (not including Diabetic)	Quantity must equal dose of self-injection.
	Nemluvio (nemolizumab-ilto)	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Patient must be 18 years of age or older • Prescriber must be an allergist, immunologist, or a dermatologist • Diagnosis of severe prurigo nodularis (PN) with ≥ 6 weeks of pruritus • Member has ≥ 20 PN lesions • Documentation of patient’s weight • Member has a ≥ 2-week trial of one of the following: <ul style="list-style-type: none"> ▪ Moderate potency or higher topical corticosteroid (TCS) ▪ Topical calcineurin inhibitor (TCI) • Medication is prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (reduced nodular lesion count, decreased pruritus, etc.) • Documentation of patient’s weight • Medication is prescribed at an FDA approved dose <p><u>Coverage Duration:</u> If the criteria are met, the initial request will be approved for a 6 month duration and reauthorization request for a 12 month duration.</p> <p>Last review: 12/2025</p>
PA	Rhopressa (netarsudil) Rocklatan (netarsudil-latanoprost) 0.02%-0.005% ophthalmic drops	<p>Criteria for use (all of the following must be met):</p> <ol style="list-style-type: none"> 1. Member has a diagnosis of open-angle glaucoma or ocular hypertension 2. Member is 18 years of age or older 3. Member has tried and failed or is contraindicated to at least 2 other medications used for reducing IOP such as latanoprost, timolol, brimonidine, pilocarpine or dorzolamide <p>Last review: 9/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p>Nexletol (bempedoic acid) Nexlizet (bempedoic acid -ezetimibe)</p>	<p>Initial Authorization: All Requests:</p> <ul style="list-style-type: none"> Member must have documentation of baseline low density lipoprotein cholesterol (LDL-C) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin Documentation was provided indicating provider has counseled member on smoking cessation and following a "heart healthy diet". Dose is appropriate per label or supported by compendia/standard of care guidelines <p>For Hyperlipidemia:</p> <ul style="list-style-type: none"> One of the following: <ul style="list-style-type: none"> Member has a diagnosis of heterozygous familial hypercholesterolemia (FH) Member has a diagnosis of primary hyperlipidemia Member has tried and failed ezetimibe at a maximum tolerated dose or documentation has been provided that the member is not able to tolerate ezetimibe <p>For Cardiovascular Risk Reduction:</p> <ul style="list-style-type: none"> Member has established cardiovascular disease (documented history of coronary artery disease, symptomatic peripheral arterial disease, and or cerebrovascular atherosclerotic disease) Member does not have established cardiovascular disease but is considered high risk (one of the following): <ul style="list-style-type: none"> Diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age A Reynolds Risk score > 30% or a SCORE Risk score > 7.5% over 10 years A coronary artery calcium score >400 Agatston units at any time in the past. Member must have a fasting LDL-C \geq 70 mg/dL <p>Reauthorization:</p> <ul style="list-style-type: none"> Documentation was provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline) <p>Dose continues to be appropriate per label or supported by compendia/standard of care guidelines</p> <p>If all of the conditions are met, the initial request will be approved with a 3-month duration and all reauthorization requests will be approved with a 12-month duration.</p> <p>Last review: 6/2025</p>
PA	Nicotinamide (niacinamide) vitamin B3	<ul style="list-style-type: none"> Approve if member has a history of nonmelanoma skin cancer and/or actinic keratosis <p>Last review 9/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p>Non-Preferred/ Prior Authorization Required Medications</p> <p>Non-preferred, Non-Formulary and/or specialty drugs without drug or class specific prior authorization criteria</p> <p>Brand drugs and reference biologics when a therapeutic equivalent generic drug or biosimilar/interchangeable biologic is available</p>	<p>Authorization:</p> <ul style="list-style-type: none"> • The drug is requested for an appropriate use (per the references outlined in "Covered Uses") • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses") • Patient meets one of the following criteria: <ul style="list-style-type: none"> ○ Documented trial and failure or intolerance with up to two formulary/preferred medications appropriate for the requested use (per the references outlined in "Covered Uses" or has a medical reason why these drug(s) cannot be used (e.g. intolerance, contraindication). For medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. ○ Documented trial and failure or intolerance with the two separate formulary components of the combination medication OR two separate therapeutic equivalents to the components of the combination medication, if available on formulary OR the provider has submitted a medical reason why the requested combination medication would be superior to the required prerequisite trial(s) with formulary drug(s) [e.g. Yosprala (aspirin/omeprazole), the two separate components would need to be tried and failed] ○ No other preferred medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia. ○ All other preferred medications are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy. • If the request is for a brand drug with a therapeutically equivalent (A-rated) generic drug currently available, documentation of the following: <ul style="list-style-type: none"> ○ The provider either verbally or in writing has submitted a medical or member specific reason why the brand name drug is required based on the member's condition or treatment history; AND if the member had side effects or a reaction to the generic drug, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. The MedWatch form must be included with the prior authorization request • If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available, documentation of one of the following: <ul style="list-style-type: none"> ○ The prescriber has verbally or in writing submitted a medical or member specific reason why the reference biologic is required based on the member's condition or treatment history; AND if the member had side effects or a reaction to all biosimilar or interchangeable biologics, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. The MedWatch form must be included with the prior authorization ○ The currently available biosimilar product(s) does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested <p>COVERED USES: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines</p> <p>If the above conditions are met, the request will be approved with up to a 12 month duration depending upon the diagnosis and usual treatment therapies</p> <p>Last Review 12/2025</p>
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APPROVAL CRITERIA-CCHP

PA	<p>Non-formulary and prior authorization required medication oral liquid formulations</p>	<p>Non-formulary and prior authorization-required oral liquid formulations, where solid oral dosage forms exist, are approved when the following criteria are met:</p> <ul style="list-style-type: none"> • For members ≤ 12 years of age <ul style="list-style-type: none"> ○ Approve • For members > 12 years of age <ul style="list-style-type: none"> ○ Documentation of difficulty swallowing, inability to swallow, or unable to use oral tablet formulation. <p>Last review: 9/2025</p>
	<p>Ocrelizumab (OCREVUS)</p>	<p>Initial Approval: Prescriber is a neurologist or a physician who specializes in the treatment of multiple sclerosis</p> <p style="text-align: center;">AND</p> <p>Diagnosis of Primary-Progressive MS (PPMS)</p> <p style="text-align: center;">OR</p> <p>Diagnosis of Relapsing Multiple Sclerosis:</p> <ol style="list-style-type: none"> 1. Relapsing-Remitting MS (RRMS) 2. Secondary-Progressive MS (SPMS) 3. Clinically isolated syndrome (CIS) <p>Authorization is for 12 months</p> <p>Continuation of therapy: All members who are currently receiving Ocrevus for MS diagnosis</p> <p>They are receiving benefit from therapy Authorization is for 12 months</p> <p>Last reviewed: 9/2025</p>

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APPROVAL CRITERIA-CCHP

	Ohtuvayre (ensifentrine)	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescribed by or in consultation with a pulmonologist • Diagnosis of chronic obstructive pulmonary disease (COPD) • Documentation of a pre- and post-albuterol FEV1/FVC ratio of <0.70 • Documentation of a score of ≥ 2 on the Modified Medical Research Council (mMRC) Dyspnea Scale or a score of ≥ 10 on the COPD Assessment Test (CAT) • Documented trial, intolerance, or contraindication to treatment with a long-acting beta-2 agonist (LABA) plus a long-acting muscarinic antagonist (LAMA) (or a documented medical reason must be provided why the member is unable to use these therapies) • The drug is being prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation that member has clinically benefitted from the medication (e.g. improvement in symptoms and exacerbations, improvement in mMRC or CAT, improvement in FEV1/FVC ratio, etc.) • The drug is being prescribed at an FDA approved dose <p><u>Exclusion:</u></p> <ul style="list-style-type: none"> • Primary diagnosis of asthma • Concomitant use of oral PDE4 inhibitors <p><u>Coverage Duration:</u> If the criteria are met, the initial request will be approved for a 6 month duration and reauthorization request for up to a 12 month duration.</p> <p>Last review: 12/2025</p>
AL PA	Opioid Containing Cough and Cold Preparations	<p>On January 11, 2018, the FDA issued a drug safety communication on labeling changes for prescription opioid cough and cold medicines. Due to the risks of the medicines outweighing the benefits in children younger than 18, the FDA is changing the age range that these products will now be indicated for.</p> <p>CCHP has added age restrictions as follows:</p> <ol style="list-style-type: none"> Codeine products in combination with antihistamines or decongestants (ie. Promethazine with Codeine, guaifenesin with codeine, etc.) will pay in members 18 years of age or older. Hydrocodone products in combination with antihistamines or decongestants (ie. Tussionex) will pay in members 18 years of age or older. <p>Last review 3/2025</p>
PA	<p>Opioid Dependence Agents</p> <p>Zubsolv (Buprenorphine/Naloxone)</p>	<p><u>Non-preferred (PA required):</u> Zubsolv (Buprenorphine/Naloxone)</p> <p>PA CRITERIA FOR APPROVAL INITIAL PA</p> <ul style="list-style-type: none"> • Diagnosis of opioid use disorder • For non-preferred oral opioid dependence agents, provider has documented with medical charts or claims history showing therapeutic failure, contraindication to, intolerance of, or inability to use formulary agents buprenorphine (Subutex) or buprenorphine/naloxone (Suboxone) sublingual tablets or films • For Zubsolv above 17.2 mg/4.2 mg per day the following additional criteria must be met: <ul style="list-style-type: none"> • Provider has documented medical necessity and dose requested is supported by clinical treatment guidelines. <p>Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Oxycodone ER tablets (Oxycontin®)	Tried and failed or contraindications to Morphine Sulfate (extended release) tablets Last review 6/2025
PA	Oxycodone (Roxicodone®) IR tablets, liquid	Requires trial and failure or intolerance to immediate release morphine AND hydromorphone. Last review 6/2025
	Ozurdex (dexamethasone intravitreal implant)	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescribed by or in consultation with an ophthalmologist • Member is 18 years of age or older • The drug is being used for a medically accepted indication and dose as outlined in Covered Uses • The member has tried and failed standard first line therapy for their disease state and/or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc.) for not using first line therapy • Documentation provided indicating all of the following: <ul style="list-style-type: none"> ○ Decrease in visual acuity in at least one eye (20/50 or worse) ○ Visual acuity in the other eye is no worse than 20/200 • Physician attests member does not have history of glaucoma, current ocular/periorcular infection, or a torn or ruptured posterior lens capsule <p><u>Coverage Duration:</u> If all criteria are met, the request will be approved for a one-time treatment</p> <p><u>Covered Uses:</u> Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</p> <p>Last review: 09/2025</p>
PA	Pharmacy compounded medication formulations	<p>Pharmacy compounded medication formulations are approved when the following criteria are met:</p> <ul style="list-style-type: none"> • Documented trial and failure of commercially available, FDA approved formulary alternatives for the prescribed indication • Compound contains at least one active drug ingredient that is FDA approved • Requested compound medication is not a copy of a commercially available FDA approved product • Prescribed indication is supported by FDA approval and/or adequate evidence in medical literature to support its usage <p>Exceptions may be made on a case-by-case basis in situations when formulary alternatives and non-compounded products to treat the prescribed indication are not commercially available</p> <p>Last review: 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p>Phosphate Binders</p> <p>Formulary (T1): Calcium acetate tablets and capsules Sevelamer carbonate (Renvela) 800 mg tablets</p> <p>Formulary, PA (T3): Lanthanum (Fosrenol) chewable tablets Sevelamer HCl (Renagel) 400 mg, 800 mg tablets</p> <p>Non-Formulary: Auryxia (ferric citrate) 210mg tablets Fosrenol (lanthanum carbonate) 750, 1000 mg powder packets Sevelamer carbonate (Renvela) 0.8, 2.4 g powder packets Velphoro (sucroferric oxyhydroxide) 500 mg chewable tablets</p>	<p>Criteria for Use of Lanthanum chewable tablets and sevelamer HCL (Renagel) tablets (bullet points below are all inclusive unless otherwise noted)</p> <ul style="list-style-type: none"> • Clinically diagnosed hyperphosphatemia due to renal failure. • AND failed/ intolerant to (sevelamer carbonate) Renvela tablets <p>Criteria for use of Auryxia tablets, Fosrenol powder packets, sevelamer carbonate (Renvela) powder packets, and Velphoro (bullet points below are all inclusive unless otherwise noted)</p> <ul style="list-style-type: none"> • Clinically diagnosed hyperphosphatemia due to renal failure. • AND failed/ intolerant to (sevelamer carbonate) Renvela tablets • AND failed/ intolerant to Lanthanum chewable tablets OR sevelamer HCL (Renagel) tablets <p>Last review 6/2025</p>
PA	<p>Phosphodiesterase Inhibitors for erectile dysfunction (ED) and benign prostatic hyperplasia (BPH) (tadalafil (Cialis), vardenafil Levitra))</p>	<p>If request is for diagnosis of erectile dysfunction:</p> <ul style="list-style-type: none"> - For BHC members: NOT A COVERED BENEFIT - For COM groups: <p>Sildenafil (Viagra) tablet is preferred at F-QL (15/30)</p> <ul style="list-style-type: none"> o Approval of tadalafil (Cialis) and vardenafil (Levitra) require a trial and failure of sildenafil (Viagra) tablet o Provider attests to no major drug/drug interactions (nitrates etc.), approve for maximum #15/30days for 12 months. <p>For tadalafil (Cialis) 2.5 and 5 mg ONLY If request is for diagnosis of benign prostatic hypertrophy</p> <ul style="list-style-type: none"> - A trial and failure of an alpha blocker (terazosin, doxazosin) AND tamsulosin (0.8mg) AND - A trial and failure of finasteride if indicated for enlarged prostate - Not approved if: <ul style="list-style-type: none"> o Use is primarily indicated for sexual dysfunction o Alpha blockers, tamsulosin and finasteride must be trialed for a minimum of 90 days <p>Last review 6/2025</p>

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APPROVAL CRITERIA-CCHP

	<p>Photrexa (riboflavin 5-phosphate)</p>	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescribed by or in consultation with an ophthalmologist • Diagnosis of one of the following: <ul style="list-style-type: none"> ○ Progressive keratoconus as evidenced by the following: <ul style="list-style-type: none"> ▪ Abnormal posterior elevation ▪ Abnormal corneal thickness distribution ▪ Clinical noninflammatory corneal thinning ○ Corneal ectasia following refractive surgery as evidenced by a consistent change in 2 of the following: <ul style="list-style-type: none"> ▪ Progressive steepening of the anterior corneal surface ▪ Progressive steepening of the posterior corneal surface ▪ Progressive thinning and/or an increase in the rate of corneal thickness change from the periphery to the thinnest point • Provider attestation that requested medication is being used with the KXL System for the corneal collagen cross-linking procedure. • The drug is being prescribed at an FDA approved dose <p>Repeat administration of Photrexa on the same eye will not be approved.</p> <p><u>Coverage Duration:</u> If all the criteria are met, the request will be approved for a one-time treatment (up to one kit per eye)</p> <p style="text-align: center;">Last review: 9/2025</p>
<p>PA</p>	<p>Pramlintide (Symlin®)</p>	<p>Type 1 Diabetes Mellitus:</p> <ul style="list-style-type: none"> • Diagnosis of Type 1 Diabetes Mellitus. • Patient ≥15 years of age. • HbA1C ≤9%. • Documented trial and failure of optimal mealtime insulin therapy. <p>Type 2 Diabetes Mellitus:</p> <ul style="list-style-type: none"> • Diagnosis of Type 2 Diabetes Mellitus. • Patient >15 years of age. • HbA1C ≤9%. • Documented trial and failure with therapeutic doses or intolerance to metformin. • Documented trial and failure of optimal mealtime insulin therapy. <p>If the above conditions are met, the request will be approved with a 12 month duration; if the above conditions are not met, the request will be referred to a Medical Director or clinical pharmacist for review.</p> <p style="text-align: center;">Last review 12/2025</p>

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APPROVAL CRITERIA-CCHP

<p>PA</p>	<p>Pregabalin oral solution (Lyrica® Oral Solution)</p> <p>Pregabalin ER (Lyrica CR)</p>	<p>FOR ALL pregabalin (LYRICA) liquid OR tablet REQUESTS:</p> <p>For solution</p> <ul style="list-style-type: none"> documentation of inability to use pregabalin oral capsules (i.e. inability or difficulty swallowing) <p>For the CR tablets</p> <ul style="list-style-type: none"> trial and failure or inability to use pregabalin (IR) capsule formulation <p>the request will be approved for a 12 month duration</p> <p>Last review 6/2025</p>
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APPROVAL CRITERIA-CCHP

PA	<p>Pulmonary Hypertension (PH) Agents</p> <p>PDE-5 Inhibitors: tadalafil (Adcirca/Tadliq), sildenafil (Revatio/Liqrev)</p> <p>Endothelin Receptor Antagonists (ERA): ambrisentan (Letairis), Opsumit (macitentan), bosentan (Tracleer)</p> <p><u>ERA and Phosphodiesterase-5 (PDE-5) Inhibitor Combinations:</u> Opsynvi (macitentan and tadalafil)</p> <p>Prostaglandin Vasodilators: epoprostenol (Flolan/Veletri), Orenitram/Tyvaso/Tyvaso DPI Yutrepia (treprostinil), treprostinil sodium (Remodulin), Ventavis (Iloprost)</p> <p>Soluble Guanylate Cyclase (sGC) Stimulators: Adempas (riociguat)</p> <p>Prostacyclin Receptor Agonists: Uptravi (selexipag)</p> <p><u>Transforming Growth Factor-beta (TGF-beta) Signaling Modulator:</u> Winrevair (sotatercept-csrk)</p> <p>And any other newly marketed PAH treatment agents.</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Member has a confirmed diagnosis that is indicated in the FDA approved package insert or has other medically-accepted use. • Documentation of the patient’s current weight, dosing, and titration scheduled is provided (if applicable) • For Uptravi, Orenitram, Tyvaso/Tyvaso DPI, Yutrepia, Ventavis, Remodulin, Adempas, ONE of the following: <ul style="list-style-type: none"> ○ Documented trial and failure of one PDE-5 inhibitor (e.g. sildenafil, or tadalafil) AND one Endothelin Receptor Antagonist [bosentan (Tracleer), ambrisentan (Letairis), or Opsumit] ○ Diagnosis of WHO Group 1 FC III with evidence of rapid disease progression or FC IV (Uptravi, Orenitram, Tyvaso, Yutrepia, Ventavis, Remodulin ONLY) ○ Diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) WHO Group 4 after surgical treatment, or inoperable CTEPH (Adempas ONLY) ○ Diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD) WHO Group 3 (Tyvaso, Yutrepia ONLY) • If the request is for sildenafil oral suspension, Liqrev (sildenafil) oral suspension, Tracleer (bosentan) tablet for suspension, or Tadliq (tadalafil) oral suspension, documentation has been submitted as to why patient is unable to use the same ingredient in a tablet dosage form (e.g. difficulty swallowing) • If the request is for Opsumit the patient must have a documented trial and failure, intolerance, or reason not to use generic ambrisentan and bosentan, or provide a medical reason why these therapies are not appropriate. • If the request is for Opsynvi, BOTH of the following: <ul style="list-style-type: none"> ○ Patient has been stable for at least 6 months on combination therapy consisting of a PDE-5 inhibitor AND an ERA ○ Documentation is provided as to why patient is unable to take individual pills for combination therapy (e.g. adherence due to pill burden) • If the request is for Winrevair, ALL of the following: <ul style="list-style-type: none"> ○ Documented trial and failure of, or contraindication to combination therapy including one PDE-5 inhibitor AND one ERA OR Opsynvi ○ Documentation of platelet count of $\geq 50,000/mm^3$ • The medication is prescribed at a dose that is within FDA approved guidelines <p>Re-authorization:</p> <ul style="list-style-type: none"> • Documentation has been submitted indicating the clinical benefit of therapy (e.g. improvement in functional class, improvement in 6-minute walk distance, exercise capacity, or hemodynamics). • Documentation of the patient’s current weight, dosing, and titration schedule is provided (if applicable) • The medication is prescribed at a dose that is within FDA approved guidelines. <p>Coverage duration: Orenitram, Tyvaso, Yutrepia, Adempas, or Ventavis: 3 months for initial request. Opsynvi: 4 months for initial request. Uptravi: Request will be approved for the titration pack for 28 days until the highest tolerated dose (maintenance dose) is achieved. Once the member has achieved maintenance dosing, further refills can be approved for a 6 month duration. For all others, if all of the conditions are met, the initial request will be approved for a 6 month duration. All reauthorization requests will be approved for a 6 month duration.</p> <p>Last review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Quantity Limit Exception	<ul style="list-style-type: none"> The member must have a documented treatment failure with the drug prescribed at the health plan's quantity limit OR the member requires a dose within prescribing guidelines that exceeds the plan's quantity limit. AND The provider has submitted a medical reason why the plan's quantity limit will be inadequate based on the member's condition and treatment history. AND The dose requested is supported by the Medical Compendia or current treatment guidelines. AND Quantity limit may require a member to use an optimized dose and strength. The provider has submitted justification for the approval of doubling (or higher) of the number of tablets/capsules per prescription for a medication that has a higher strength tablet/capsule available, stating why that higher dose tablet/capsule cannot be used (e.g. two lorazepam 0.5mg tablets to equal the dose of lorazepam 1mg, when lorazepam 1mg tablet exists). <p>Last review: 12/2025</p>
PA	Quinine sulfate (Qualaquin®)	<p>Diagnosis of malaria.</p> <p>If the above condition is met, the request will be approved for appropriate dosing duration.</p> <p>Last review 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Ranolazine ER Aspruzyo Sprinkle (ranolazine granules)	<p>Criteria for use (for ranolazine ER :</p> <ul style="list-style-type: none"> • Documented diagnosis of chronic angina • Must have tried, failed or not tolerated one formulary anti-angina therapeutic alternatives from the following classes: <ul style="list-style-type: none"> ○ Beta-blockers or ○ Calcium-channel blockers AND ○ Nitrates <p>Criteria for use (for Aspruzyo Sprinkle):</p> <ul style="list-style-type: none"> • All of the above criteria is met • Must have tried, failed, or not tolerated ranolazine ER <p>Approval Quantity Limits: Requests will be limited to 60 tablets/packets monthly. Duration of therapy: 12 months</p> <p>Last review 3/2025</p>
	Nitroglycerin (Rectiv) rectal ointment 0.4%	<p>The following criteria must be met:</p> <ul style="list-style-type: none"> • Diagnosis of moderate to severe pain associated with chronic anal fissures for at least 6 weeks • The member is not also taking a phosphodiesterase type 5 (PDE5) inhibitor (e.g. sildenafil, vardenafil, tadalafil). • Prescriber attestation that the member has tried and failed, or has a reason not to use (within past 60 days) at least two conservative treatments for the underlying cause of the anal fissure: <ul style="list-style-type: none"> ○ High-fiber diet or fiber supplements ○ Sitz baths ○ Topical analgesia/ medicated creams (e.g. Anusol HC, zinc oxide) ○ Laxative or stool softeners (e.g. psyllium, docusate) <p>If all conditions are met, the request will be approved for a one-time coverage duration of 3 weeks.</p> <p>Last review 6/2025</p>
	Rezdiffra (resmetirom)	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescriber must be a hepatologist, gastroenterologist, endocrinologist, or a specialist in the treatment of liver disease. • Diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis • Documentation of stage F2 to F3 fibrosis confirmed by biopsy or a noninvasive test (NIT) • Prescriber attestation to providing lifestyle counseling on nutrition and exercise • Prescriber attestation that member avoids excess alcohol intake • The drug is being prescribed at an FDA approved dose according to the member's weight <ul style="list-style-type: none"> • In patients without diabetes, or patients not taking another GLP1 receptor agonist: documentation of trial and failure, or documented medical reason for not using Wegovy <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • The member has clinically benefited from the medication (e.g. the resolution of steatohepatitis and no worsening of liver fibrosis, or at least one stage improvement in liver fibrosis and no worsening of steatohepatitis) • The member continues to have a fibrosis stage of ≤ 3 • The drug is being prescribed at an FDA approved dose according to the member's weight <p><u>Exclusion:</u></p> <ul style="list-style-type: none"> • Patients with decompensated cirrhosis

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APPROVAL CRITERIA-CCHP

		<p>Coverage Duration: If all of the criteria are met, the initial and reauthorization requests will be approved for up to a 12 month duration</p> <p>Last Review 12/2025</p>
<p style="text-align: center;">PA</p>	<p style="text-align: center;">Xifaxan (rifaximin)</p>	<p>Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient’s medical records. <p>Traveler’s Diarrhea:</p> <ul style="list-style-type: none"> • Prior authorization not required for 9 pills if treating traveler’s diarrhea. <p>Hepatic encephalopathy:</p> <ul style="list-style-type: none"> • Must have clinically diagnosed condition of hepatic encephalopathy • Patient will be using lactulose concurrently or has a medical reason for being unable to use lactulose or lactitol <p>Irritable Bowel Syndrome (IBS):</p> <ul style="list-style-type: none"> • Must have clinically documented moderate to severe IBS with diarrhea • Must have failed or was intolerant to one formulary antidepressant (tricyclic antidepressants) <p>Criteria for continuation of therapy: Hepatic Encephalopathy and IBS:</p> <ul style="list-style-type: none"> • A decrease in the clinical symptoms <p>Last reviewed 9/2025</p>
<p style="text-align: center;">PA</p>	<p style="text-align: center;">Roflumilast (Daliresp)</p>	<p>Bullet Points Below are all inclusive unless otherwise noted</p> <ul style="list-style-type: none"> • Clinically diagnosed with severe COPD associated with chronic bronchitis • History of exacerbations (1 in previous year) • Documented trial and failure or intolerance with a preferred inhaled LABA/LAMA combination, or LABA/LAMA/ICS combination for a minimum of 4 weeks of therapy in the previous 60 days • Documented continuation of therapy with LABA or LAMA <p>If the criteria are met, the request will be approved with up to a 12 month duration</p> <p>Last review 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Rufinamide (Banzel®)	<ul style="list-style-type: none"> • Diagnosis of Lennox-Gastaut syndrome. <p>Patient is currently receiving another anticonvulsant medication at a therapeutic dosage.</p> <p>Last review 6/2025</p>
PA	Ruxolitinib (Jakafi)	<p>Forward to CCHP for PA Review:</p> <p>CCHP Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> •The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient’s medical records. •Must be prescribed by a hematologist or oncologist •Must be clinically diagnosed with polycythemia vera, intermediate or high-risk primary myelofibrosis, postpolycythemia vera myelofibrosis, post-essential thrombocythemia myelofibrosis, chronic graft-versus-host disease, or steroid refractory acute graft-versus-host disease •For polycythemia vera, patient must have failed or been intolerant to hydroxyurea or interferon therapy • For steroid-refractory acute graft-versus-host-disease (GVHD), patient must be 12 years and older and disease is inadequately controlled on glucocorticoid treatment • For chronic graft-versus-host-disease (GVHD), the patient must have tried and failed one line of systemic therapy <p>Criteria for continuation of therapy:</p> <ul style="list-style-type: none"> •Patient must have a documented decrease in splenic volume or symptom Improvement <p>Last review 12/2025</p>

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APPROVAL CRITERIA-CCHP

<p>PA</p>	<p>Short-acting beta agonists: Levalbuterol (Xopenex®) inhaler, nebulizer solution Albuterol nebulizer solution 0.63mg/3ml, 1.25mg/3ml</p>	<p>Member has tried and failed or has contraindications to the use of albuterol HFA or formulary strengths of albuterol nebulizer solution.</p> <p>If the criteria are met, the request will be approved with up to a 12 month duration.</p> <p>Last review 12/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Sleep Medications	<p>FORMULARY STATUS Formulary, pays at POS with or without restriction (preferred 1st line agents)</p> <p>AMBIEN (zolpidem) Tablet: 5mg, 10mg (QL 30/30) AMBIEN CR (zolpidem extended-release) Tablet: 6.25mg, 12.5mg (QL 30/30) SONATA (zaleplon) Capsule: 5mg, 10mg LUNESTA (eszopiclone) Tablet: 1mg, 2mg, 3mg</p> <ul style="list-style-type: none"> • Maximum starting dose for zolpidem is 5mg in females per FDA. May approve 10mg strength if member has a history of tolerating 10mg tablets. • Maximum starting dose for zolpidem ER is 6.25mg in females per FDA. May approve zolpidem ER 12.5mg strength if member has history of tolerating 12.5mg tablets. <p>FORMULARY STATUS Formulary, requires prior authorization or non-formulary, requires prior authorization (2nd line agents)</p> <p>Doxepin (Silenor) Tablet: 3mg, 6mg ROZEREM (ramelteon) Tablet: 8mg BELSOMRA (suvorexant) Tablet: 5mg, 10mg, 15mg, 20mg DAYVIGO (lemborexant) Tablet: 5mg, 10mg QUVIVIQ (daridorexant) Tablet: 25mg, 50mg EDLUAR (zolpidem) SL Tablet: 5mg, 10 mg Zolpidem (Intermezzo) SL Tablet: 1.75, 3.5 mg</p> <ul style="list-style-type: none"> • Patient must have a diagnosis of insomnia. AND • Patient must have tried and failed at least 3 preferred 1st line agents for approval of PA request. Documented trial and failure of any agent is defined as at least 2 weeks of therapy. AND • For Silenor, patient must have trialed and failed or shown intolerance to doxepin 10mg/ml oral concentrate OR • For Belsomra, patient must have trialed and failed or shown intolerance to Dayvigo OR • For Quviviq, patient must have trialed and failed or shown intolerance to Dayvigo AND Belsomra • **For Rozerem, can be approved as a first line agent if there is a history of substance abuse or current chronic opioid use <p>NOTE: All formulary and non-formulary sedative hypnotics are limited to 30 days of dispensing per fill. If the above criteria is met, requests will be approved for a maximum duration of 12 months.</p> <p>Last review 6/2025</p>
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APPROVAL CRITERIA-CCHP

PA	Tapentadol (Nucynta®)/ Nucynta® ER)	<p>CCHP Criteria for use (bullet points below are all inclusive unless otherwise noted):</p> <ul style="list-style-type: none"> • The medication is being used for an FDA approved indication and dose • Must have failed or was intolerant to tramadol AND <ul style="list-style-type: none"> • If the indication is diabetic peripheral neuropathy, a trial and failure of tramadol is not required • Must have failed or been intolerant (GI side effects) to at least 1 other CCHP preferred opioid (Examples: morphine sulfate or fentanyl patches) <ul style="list-style-type: none"> • If the indication is diabetic peripheral neuropathy, a trial and failure of an opioid is not required <p>AND</p> <ul style="list-style-type: none"> • Must have failed or was intolerant to at least 2 non-opioid therapies such as: <ul style="list-style-type: none"> • APAP/NSAIDs/Cox-2 agent • Muscle relaxants • Corticosteroids • TCAs • SNRIs (duloxetine, desvenlafaxine, venlafaxine) • Gabapentinoids (gabapentin, pregabalin) • Sodium channel blockers (valproic acid) • Topical analgesics (i.e. capsaicin) <p>Last review 6/2025</p>
PA	Temazepam (Restoril®)	<p>7.5, 22.5mg brand requests: DEFER and fax back message, "Temazepam 15 mg and 30 mg are formulary. For further consideration, please reply with additional medical justification for not being able to use formulary strengths. Thank you."</p> <p>Last review 12/2025</p>
PA	Teriparatide (Forteo) 600mcg/2.4ml pen Teriparatide 620mcg/2.48ml	<p><u>For all requests:</u></p> <ul style="list-style-type: none"> • The member is taking calcium and vitamin D • The member has a documented (consistent with pharmacy claims) adequate trial of an oral bisphosphonate or has a medical reason (e.g. intolerance, hypersensitivity, contraindication, very high risk status or prior fracture etc.) for not using an oral bisphosphonate <p><u>If the diagnosis is osteoporosis:</u></p> <ul style="list-style-type: none"> • Documentation was submitted indicating member is postmenopausal woman or a male member over 50 years of age with a bone mineral density (BMD) value consistent with osteoporosis (T-score equal to or less than -2.5) OR has had an osteoporotic fracture OR member has a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability >3% or a 10 year major osteoporosis-related fracture probability >20%, based on the US-adapted WHO absolute fracture risk model • Trial and failure, intolerance, or medical reason not to use one injectable bisphosphonate or zoledronic acid (Reclast). OR • The member has VERY HIGH RISK/prior fractures osteoporosis (T-Score -3.5 or below, or T- Score of -2.5 or below plus a fragility fracture) <p><u>If the diagnosis is glucocorticoid-induced osteoporosis:</u></p> <ul style="list-style-type: none"> • For members ≥ 40 years of age on long-term glucocorticoid therapy: <ul style="list-style-type: none"> ○ Dosage of the glucocorticoid therapy is greater than 2.5 mg of prednisone daily or its equivalent for a minimum of 3 months ○ Member has a moderate to very high risk of fracture based on ONE of the following: <ul style="list-style-type: none"> ▪ History of osteoporotic fracture (very high risk)

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APPROVAL CRITERIA-CCHP

		<ul style="list-style-type: none"> ▪ BMD less than or equal to -1 at the hip or spine (moderate to very high risk) ▪ FRAX® (GC-Adjusted) 10-year risk of major osteoporotic fracture (MOF) ≥30% or hip ≥4.5% (very high risk) ▪ FRAX® (GC-Adjusted) 10-year risk of MOF ≥20% but <30% or hip ≥3% but <4.5% (high risk) ▪ FRAX® (GC-Adjusted) 10-year risk of MOF ≥10 and <20%, hip >1 and <3% (moderate risk) ○ Trial and failure, intolerance, or medical reason not to use one injectable bisphosphonate or zoledronic acid infusion • For adult members (all ages) receiving HIGH dose glucocorticoid therapy: <ul style="list-style-type: none"> ○ Member has a moderate to very high risk of fracture based on ONE of the following: <ul style="list-style-type: none"> ▪ Has a history of prior fracture(s) (very high risk) ▪ Glucocorticoid ≥30mg/day or cumulative ≥5grams/year (very high risk) ▪ Continuing glucocorticoid treatment ≥7.5mg/day for ≥6 months AND BMD Z score < -3 OR significant BMD loss (> least significant change of DXA) (moderate risk) ○ Trial and failure, intolerance, or medical reason not to use one injectable bisphosphonate or zoledronic acid infusion <p>For all requests, in addition to meeting all criteria above, approval of brand Forteo requires trial and failure of, contraindication to, or inability to use brand Teriparatide 620mcg/2.48ml</p> <p>Contraindications: hypersensitivity to teriparatide or to any of its excipients.</p> <p>Not indicated if:</p> <ul style="list-style-type: none"> • Patient has risk for osteosarcoma • Patient has Paget's disease • Patient has unexplained elevations of alkaline phosphatase • Child • Growing adults • Patient has had prior bone radiation • Patient has bone metastases or a history of skeletal malignancies • Patient has metabolic bone diseases other than osteoporosis • Patient has high levels of calcium • Patient has used product for 24 months <p>Last review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

<p style="text-align: center;">PA</p>	<p style="text-align: center;">Testosterone products</p> <p style="text-align: center;"><u>Formulary</u> Testosterone cypionate Testosterone enanthate</p> <p style="text-align: center;"><u>T3-PA/Non-Formulary</u> Androgel 1% packet (25mg/2.5g; 50mg/5g) Androgel Pump 20.25mg/actu 1.62% (75g) Vogelxo 1% topical gel in pump (12.5mg/1.25g) Testosterone (Axiron) 30 mg/1.5ml pump Vogelxo/Testim packets 1% (50mg/5gram) topical gel</p>	<p>FORMULARY STATUS preferred 1st line agents, pays at POS Testosterone cypionate: Intramuscular Oil 200mg/ml (with quantity limit) Testosterone enanthate: Intramuscular Oil 200mg/ml</p> <p>FORMULARY STATUS requires PA (2nd line agent) ANDROGEL Pump 1.62%: 20.25mg/act VOGELXO Pump 1% topical gel: 12.5mg/1.25g Testosterone (Axiron) 30 mg/1.5ml pump</p> <ul style="list-style-type: none"> • Patient must have tried and failed or found to be intolerant to 1st line agents for approval of PA request <p>FORMULARY STATUS requires PA (3rd line agent) VOGELXO/TESTIM packets 1% (50mg/5gram) topical gel ANDROGEL 1% packet: 25mg/2.5g; 50mg/5g</p> <ul style="list-style-type: none"> • Patient must have tried and failed a preferred 1st line agent AND a 2nd line agent for approval of PA request <p>FORMULARY STATUS Non-Formulary, requires PA (4th line agent) Any other non-formulary testosterone product</p> <ul style="list-style-type: none"> • Patient must have tried and failed a preferred 1st line agent AND a 2nd line agent AND a 3rd line agent for approval of PA request <p>Last review 12/2025</p>
<p style="text-align: center;">PA</p>	<p>Tranexamic acid (Lysteda)</p>	<ul style="list-style-type: none"> • Member has diagnosis of heavy menstrual bleeding <p>AND</p> <ul style="list-style-type: none"> • The medication is used at the FDA-approved dose of 1,300 mg 3 times daily (3,900 mg/day) for a maximum of 5 days during monthly menstruation <p>AND</p> <ul style="list-style-type: none"> • Documented trial and failure, intolerance or contraindication to formulary hormonal therapy or the provider indicates clinical inappropriateness of hormonal therapy (hormonal therapy includes: oral contraceptives/hormone replacement products, IUDs, hormonal injections) <p>If the above conditions are met, the request will be approved for a 12 month duration</p> <p>Last review 3/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Tretinoin (Retin A®)	<p>Status: Formulary <= 30 years old. Formulary for CCHP County dermatology network** without age limits.</p> <p>Covered for Acne Vulgaris only. Not a covered benefit for cosmetic uses (wrinkles).</p> <p>Qty Limits: Unless PA indicates treatment area includes back – Limit to 1 tube/30 days (up to 90-days supply)</p> <p>For Members >30 years of age</p> <ul style="list-style-type: none"> • Diagnosis of acne • Documentation of trial and failure, intolerance, contraindication or inability to use the following formulary alternative: adapalene (Differin) 0.1% gel OTC OR topical antibiotics OR • For severe or comedonal acne, member must only try and fail one of the following: topical benzoyl peroxide, a topical antimicrobial, or topical adapalene <p>**Note – Community dermatologists will not be added to the specialty list. Dermatology network includes dermatologists at the county clinic only, currently the following: Lee, John, DEA- AL5306798 Leong, Rudy, DEA- AL9534187 Mbanugo, Ogo, DEA- BM1406912 Paige, Thomas, DEA- AP4466290 Shaw, Howard, DEA- MS0491390 Corser, Nancy DEA- MC0497556</p> <p>Last reviewed 12/2025</p>
PA	Tretinoin Microsphere (Retin A Micro®)	<p>Status: Formulary <= 30 years old. Formulary for CCHP County dermatology network** without age limits.</p> <p>Covered for Acne Vulgaris only. Not a covered benefit for cosmetic uses (wrinkles).</p> <p>Qty Limits: Unless PA indicates treatment area includes back – Limit to 1 tube/30 days (up to 90-days supply)</p> <p>Dx: Adult Acne: APPROVE x 1 year if patient has tried/failed (or using in combination with) benzoyl peroxide, topical antimicrobials, AND tretinoin topical non-microsphere formulations. Approvable if medical justification provided for why formulary agents cannot be used (ex. allergy to erythromycin).</p> <p>**Note – Community dermatologists will not be added to the specialty list. Dermatology network includes dermatologists at the county clinic only, currently the following: Lee, John, DEA- AL5306798 Leong, Rudy, DEA- AL9534187 Mbanugo, Ogo, DEA- BM1406912 Paige, Thomas, DEA- AP4466290 Shaw, Howard, DEA- MS0491390 Corser, Nancy DEA- MC0497556</p> <p>Last review: 12/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Triptans	<p>FORMULARY STATUS Preferred 1st line agents, pay at POS within quantity limits: <u>IMITREX</u> (sumatriptan) Tablet: 25mg, 50mg, 100mg <u>MAXALT</u> (rizatriptan) Tablet: 5mg, 10mg; MLT Tablet: 5mg, 10mg</p> <p>FORMULARY STATUS Preferred 2nd line agent, requires ST with either 1st line agent: <u>AMERGE</u> (naratriptan) Tablet: 1mg, 2.5mg</p> <p>FORMULARY STATUS Non-Preferred, Requires PA: <u>IMITREX</u> (sumatriptan) Nasal Spray: 5mg, 20mg <u>IMITREX</u> (sumatriptan) Subcutaneous Injection: 4mg/0.5mL, 6mg/0.5mL <u>ZEMBRACE SymTouch</u> (sumatriptan) Subcutaneous Injection: 3mg/0.5mL <u>AXERT</u> (almotriptan) Tablet: 6.25mg, 12.5mg <u>FROVA</u> (frovatriptan) Tablet: 2.5mg <u>RELPAK</u> (eletriptan) Tablet: 20mg, 40mg <u>TREXIMET</u> (sumatriptan/naproxen) Tablet: 85mg/500mg <u>ZOMIG</u> (zolmitriptan) Tablet: 2.5mg, 5mg <u>ZOMIG-ZMT</u> (zolmitriptan) Orally Disintegrating Tablet: 2.5mg, 5mg Sumatriptan (Imitrex STATdose) SQ cartridge, pen injector, vial Zomig (Zolmitriptan) nasal spray: 2.5mg, 5mg Onzetra Xsail (sumatriptan) nose piece: 11mg Tosymra (sumatriptan) nasal spray: 10mg/act</p> <p><u>PA CRITERIA FOR APPROVAL:</u></p> <p><u>Preferred 1st line Agents:</u></p> <ul style="list-style-type: none"> • Diagnosis of migraine headaches. • Note: An automatic approval at the point-of-sale will occur if the quantities prescribed do not exceed #12 tablets per 30 days. (#18 tablets per 30 days for sumatriptan 50mg and 100mg) <p><u>Preferred 2nd line Agent:</u></p> <ul style="list-style-type: none"> • Documented trial and failure of either preferred 1st line agent (sumatriptan or rizatriptan) <p><u>Non-Preferred Agents (excluding Treximet):</u></p> <ul style="list-style-type: none"> • Diagnosis of migraine headaches (or cluster headache for sumatriptan injection). • Documented trial and failure of either preferred 1st line agent (sumatriptan or rizatriptan). • Documented trial and failure of preferred 2nd line agent naratriptan. <p>If above conditions are met, the request will be approved with a 12 month duration for a quantity not to exceed 12 tablets (or dosage formulation-dependent equivalent) per 30 days</p> <p><u>Treximet:</u></p> <ul style="list-style-type: none"> • Requests for Treximet should be directed to using the two individual agents (sumatriptan and naproxen). <p><u>Quantities Greater than Allowed per 30 days if Prior Authorization Criteria Met:</u> If patient requires doses greater than the set limits above after meeting approval, request will be evaluated by CCHP clinical staff for review</p> <p>Last review 6/2025</p>
PA	Urea 40% cream	<p>Must have tried and failed Urea 20% cream</p> <p>Last review 12/2025</p>

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APPROVAL CRITERIA-CCHP

PA	<p>Urinary Antispasmodics</p> <p><u>Formulary</u> Oxybutynin IR tablet Oxybutynin ER tablet Solifenacin (Vesicare) tablet Tolterodine (Detrol) tablet Tolterodine (Detrol LA) capsule</p> <p><u>Prior Authorization Required</u> Oxytrol (oxybutynin) 3.9 mg/24 hr patch Gelnique (oxybutynin) 10% transdermal gel packet Flavoxate (Urispas) tablet Darifenacin (Enablex) tablet Vesicare LS (solifenacin) 1 mg/mL oral suspension Trospium (Sanctura) tablet Trospium (Sanctura XR) capsule Fesoterodine (Toviaz) ER tablet Mirabegron (Myrbetriq) ER tablet Myrbetriq (mirabegron) 8 mg/mL oral suspension, extended release Gemtesa (vibegron) 75 mg tablet</p>	<p>PA CRITERIA FOR APPROVAL for Prior Authorization required medications :</p> <ul style="list-style-type: none"> • Diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency and urinary frequency Drug is being requested for an FDA-approved dose and indication. <p>AND</p> <ul style="list-style-type: none"> • Documented trial and failure, intolerance, or inability to use two formulary agents <p>Exception: Members >65 years old are not required to try and fail oxybutynin and tolterodine</p> <p>Last review: 12/2025</p>
PA	Vaccines	<ul style="list-style-type: none"> • Travel related vaccines are a covered pharmacy benefit but must match CDC recommendation. <p>Last review 3/2025</p>
PA	<p style="text-align: center;">Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors</p> <p>Ingrezza (valbenazine) Austedo/Austedo XR (deutetrabenazine) tetrabenazine (Xenazine)</p>	<p>Initial Authorization:</p> <ul style="list-style-type: none"> • Dose is within FDA-approved limits • Prescribed by a psychiatrist or neurologist • Prescriber attests patient will not be receiving treatment with any other VMAT2 inhibitor <p>For approval for use in Tardive Dyskinesia (TD):</p> <ul style="list-style-type: none"> • Member must have clinical diagnosis of tardive dyskinesia that has persisted for the last 90 days, with documented baseline evaluation (e.g., Abnormal Involuntary Movement Scale (AIMS), the Tardive Dyskinesia Rating Scale (TDRS), etc.) • For members on antipsychotics, the antipsychotic dose(s) must have been stable for a continuous 90 day period at some point prior to the request • Prescriber has attempted at least ONE of the following strategies to manage the patient's condition, or has provided a clinical reason why NONE of the following are possible: <ul style="list-style-type: none"> ○ Reducing the dose of the drug responsible for causing dyskinesia ○ Discontinuing the drug responsible for causing dyskinesia ○ For members on first generation antipsychotics, switching to a second generation antipsychotic ○ Trial of benzodiazepines • For VMAT2 inhibitors other than tetrabenazine, member has a documented medical reason (e.g., treatment failure, intolerance, hypersensitivity, contraindication) for not using tetrabenazine AND <ul style="list-style-type: none"> ○ For Austedo requests: <ul style="list-style-type: none"> ▪ Prescriber attests patient has no signs of hepatic impairment ▪ For patients at risk for QT prolongation, prescriber attests a baseline ECG has been obtained ○ For Ingrezza requests: <ul style="list-style-type: none"> ▪ Must be dosed at one capsule per day <p>For approval for use in chorea associated with Huntington's Disease (HD):</p> <ul style="list-style-type: none"> • Patient must have diagnosis of moderate to severe Huntington's with chorea, with documented baseline Total Maximal Chorea (TMC) score provided

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APPROVAL CRITERIA-CCHP

		<ul style="list-style-type: none"> • For VMAT2 inhibitors other than tetrabenazine, member has a documented medical reason (e.g., treatment failure, intolerance, hypersensitivity, contraindication) for not using tetrabenazine AND <ul style="list-style-type: none"> ○ For Austedo requests: <ul style="list-style-type: none"> ▪ Prescriber attests patient has no signs of hepatic impairment ▪ For patients at risk for QT prolongation, prescriber attests a baseline ECG has been obtained ○ For Ingrezza requests: <ul style="list-style-type: none"> ▪ Must be dosed at one capsule per day <p>Re-Authorization:</p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (e.g., improvement from baseline in average scores on the previously submitted symptom rating scale, decrease in symptoms, etc.) • Medication is prescribed at an FDA approved dose <p>Last review 12/2025</p>
PA	Valganciclovir (Valcyte®)	<p>The medication request is consistent with a FDA-approved indication for use in patients with the treatment or prevention of cytomegalovirus (CMV) and is being recommended and prescribed at a FDA-approved dosage.</p> <p>Last review: 9/2025</p>
PA	Vilazodone (Viibryd)	<p>Criteria for Use (ALL of the following must be met):</p> <ul style="list-style-type: none"> • Clinically diagnosed with major depressive disorder and ordered by a psychiatrist • Requires trial and failure of at least two among three of the following classes: <ul style="list-style-type: none"> ○ Failed or intolerant to at least one preferred SSRI (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline) ○ Failed or intolerant to at least one SNRI (venlafaxine, duloxetine) ○ Failed or intolerant to at least one other anti-depressant from a different class (bupropion, trazodone, mirtazapine, nortriptyline) <p>Last review 6/2025</p>
PA	Voriconazole (Vfend®)	<p>Maximum BID dosing. MD = Infectious Disease: Approve as requested.</p> <p>DX Invasive Aspergillosis, Serious Fungal infection from Scedosporium or Fusarium: Approve as requested.</p> <p>For Transplant patients: Approve x 1 month (up to #60/30 days) and fax back "For additional therapy, fluconazole is available without a PA for transplant patients. If patient needs additional voriconazole, please provide justification for why other antifungals such as fluconazole or itraconazole cannot be used.</p> <p>For candidemia and other candida infections or esophageal candidiasis Documented trial and failure, contraindication, culture and sensitivity resistance, or inability to use at least one formulary antifungal medication</p> <p>For any diagnosis, if the liquid formulation is requested, inability to swallow or other reason not to use the tablet formulation must be provided.</p> <p>Last review: 9/2025</p>

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APPROVAL CRITERIA-CCHP

PA	Vortioxetine (Trintellix)	<p>Criteria for Use (ALL of the following must be met):</p> <ul style="list-style-type: none"> • Clinically diagnosed with major depressive disorder • Requires trial and failure of at least two among three of the following classes: <ul style="list-style-type: none"> ○ Failed or intolerant to at least one preferred SSRI (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline) ○ Failed or intolerant to at least one SNRI (venlafaxine, duloxetine) ○ Failed or intolerant to at least one other anti-depressant from a different class (bupropion, trazodone, mirtazapine, nortriptyline) <p>Last review: 6/2025</p>
	Vyalev (foscarbidopa and foselevodopa)	<p><u>Initial Authorization:</u></p> <ul style="list-style-type: none"> • Prescriber must be a neurologist or in consultation with a neurologist • Diagnosis of advanced Parkinson’s Disease • Prescriber attestation or documentation that the patient is experiencing persistent motor fluctuations despite optimized carbidopa/levodopa therapy (including a minimum of 2.5 hours of “off” time per day) • Patient is taking ≥400 mg of levodopa/day • Documented trial and failure (or contraindication) to at least two of the following adjunctive medication classes: <ul style="list-style-type: none"> ○ COMT-inhibitors (e.g., entacapone) ○ Dopamine agonists (e.g., ropinirole, pramipexole) ○ MAO-B inhibitors (e.g., rasagiline, selegiline) • Medication is prescribed at an FDA approved dose <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (i.e. increase in “on” time without troublesome dyskinesia, decreased “off” time) • Medication is prescribed at an FDA approved dose <p><u>Exclusion:</u> Concurrent use with a nonselective monoamine oxidase (MAO) inhibitor (such as phenelzine or tranylcypromine)</p> <p><u>Coverage Duration:</u> If all the criteria are met, the initial and reauthorization requests will be approved for 12 months</p> <p>Last review: 6/2025</p>

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APPROVAL CRITERIA-CCHP

		<p>**Please Note: If the request is for Wegovy/Zepbound to reduce excess body weight and maintain weight reduction long term, refer to criteria for Anti-Obesity Medications***</p> <p><u>Initial Authorization for all requests:</u></p> <ul style="list-style-type: none"> • Requested dose is appropriate per labeling • Provider is or treatment is in consultation with: <ul style="list-style-type: none"> ○ Wegovy for MASH: hepatologist, gastroenterologist, endocrinologist, or a specialist in the treatment of liver disease ○ Zepbound for Obstructive Sleep Apnea: specialist or in consultation with a specialist in the treatment of sleep disorders <p><u>Wegovy Requests:</u></p> <p>For risk reduction of major adverse cardiovascular events in adults with established CV disease, the following must be met:</p> <ul style="list-style-type: none"> • Medication is prescribed for reducing the risk of adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease. Documentation demonstrates patient has history of one or more of the following: <ul style="list-style-type: none"> ▪ Prior myocardial infarction ▪ Prior stroke ▪ Symptomatic peripheral arterial disease, as evidenced by ≥1 of the following: <ul style="list-style-type: none"> • Intermittent claudication with ankle brachial index <0.85 (at rest) • Peripheral arterial revascularization procedure • Amputation due to atherosclerotic disease • Documentation is provided that patient is overweight or obese, defined as a body mass index (BMI) ≥ 27 kg/m² • Patient is receiving standard of care treatment of CVD, as appropriate/indicated, including an antiplatelet agent (ex. aspirin or P2Y12 inhibitor), lipid-lowering drug (ex. statin, otherwise ezetimibe, fibrate, and/or PCSK-9 inhibitor), antihypertensive (ex. beta blocker, ACE-I, ARB) • Patient does not have personal history of Type 1 or Type 2 diabetes • Documentation is provided patient's Hb A1c ≤ 6.5% • Member must be ≥ 45 years of age <p>For the treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults, all of the following must be met:</p> <ul style="list-style-type: none"> • Diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis • Documentation of stage F2 to F3 fibrosis confirmed by biopsy or a noninvasive test (NIT) • Prescriber attestation to providing lifestyle counseling on nutrition and exercise • Prescriber attestation that member avoids excess alcohol intake <p><u>Zepbound Requests:</u></p> <p>For treatment of moderate to severe obstructive sleep apnea in adults, the following must be met:</p> <ul style="list-style-type: none"> • Patient's body mass index (BMI) is provided and is ≥30 kg/m² • Documentation of current diagnosis of moderate to severe obstructive sleep apnea
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APPROVAL CRITERIA-CCHP

		<ul style="list-style-type: none"> • Documentation of trial and failure regarding lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity) to reach a BMI < 30 kg/m2 • One of the following: <ul style="list-style-type: none"> ○ Results of sleep testing showing patient's apnea hypopnea index (AHI) ≥ 15 while currently on PAP therapy ○ Results of sleep testing showing patient's apnea hypopnea index (AHI) ≥ 15 and patient had a previous trial and failure of PAP therapy, or a medical reason is provided why the patient is not able to use PAP therapy • Patient is not pregnant <p><u>Exclusion:</u></p> <ul style="list-style-type: none"> • Requests for a diagnosis of weight reduction and maintenance for overweight or obesity • Concurrent use of any glucagon-like-peptide-1 receptor agonist • Personal or family history of medullary thyroid carcinoma • Multiple Endocrine Neoplasia syndrome type 2 <p><u>Reauthorization</u></p> <p><u>Wegovy Requests:</u> For risk reduction of major adverse cardiovascular events in adults with established CV disease, the following must be met:</p> <ul style="list-style-type: none"> • Patient is receiving standard of care treatment of CVD, as appropriate/indicated, including an antiplatelet agent (ex. aspirin or P2Y12 inhibitor), lipid-lowering drug (ex. statin, otherwise ezetimibe, fibrate, and/or PCSK-9 inhibitor), antihypertensive (ex. beta blocker, ACE-I, ARB) • Patient continues to not have Type 1 or Type 2 diabetes • Patient is adherent to therapy, as evidenced by claims records demonstrating ≥80% fill rate <p>For the treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults, all of the following must be met:</p> <ul style="list-style-type: none"> • The member continues to have a fibrosis stage of ≤3 • Patient is adherent to therapy as evidenced by claims records demonstrating ≥80% fill rate <p><u>Zepbound Requests:</u> For the treatment of moderate to severe obstructive sleep apnea in adults, the following must be met:</p> <ul style="list-style-type: none"> • Documentation of positive clinical response to therapy (i.e. improvement in patient's AHI, improvement in daytime sleepiness, sleep arousals, snoring) • Patient is adherent to therapy, as evidenced by claims records demonstrating ≥80% fill rate <p>If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.</p> <p>Last review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

	<p>XDEMVY (lotilaner) ophthalmic solution</p>	<p>Prescriber is an ophthalmologist, optometrist, or a healthcare provider who specializes in the treatment of eye conditions</p> <p>Patient is ≥ 18 years old</p> <p>Diagnosis of Demodex blepharitis</p> <p>The patient presents with clinical signs consistent with collarettes, characterized by waxy cylindrical dandruff or “sleeves” on the eyelashes, crusty formations on the eyelid, eyelash misdirection, or loss of eyelashes.</p> <ul style="list-style-type: none"> ▪ Additional symptoms may include redness and inflammation, blurry vision, discomfort/irritation, itchiness, and stinging or burning sensation. <p>Last review: 9/2025</p>
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APPROVAL CRITERIA-CCHP

	<p><u>Xolair for Asthma, Urticaria, and IgE-Mediated Food Allergy</u></p>	<p>**For nasal polyposis, please refer to the “Biologic Agents for Nasal Polyposis” policy**</p> <p>Prescriber must be an allergist, pulmonologist, immunologist, or dermatologist</p> <p>Initial Authorization for Xolair for asthma:</p> <ul style="list-style-type: none"> • Member has at least a 6 month history of moderate to severe asthma • The drug is being prescribed at an FDA approved dose and according to member’s weight and IgE level • Member is taking maximal tolerated dose of inhaled corticosteroid/long-acting beta agonist (ICS/LABA) combination WITH add-on therapy of a LAMA (e.g. tiotropium) for a minimum of 3 months; or there is a documented medical reason why the member is unable to take these medications • Member’s asthma is uncontrolled as defined by having at least ONE of the following: <ul style="list-style-type: none"> ○ Frequent severe exacerbations requiring two or more bursts of systemic glucocorticoids (more than three days each) in the previous year ○ History of serious exacerbation: at least one hospitalization, intensive care unit stay, or mechanical ventilation in the previous year ○ Airflow limitation defined as an FEV1 less than 80% of predicted ○ Poor symptom control including at least THREE of the following: <ul style="list-style-type: none"> ▪ Asthma Control Questionnaire (ACQ) consistently >1.5 or Asthma Control Test (ACT) <20 ▪ Daytime asthma symptoms more than twice per week ▪ Use of an inhaled short acting beta2 agonist to relieve asthma symptoms more than twice per week (not including use prior to exercise) ▪ Limited physical activity due to asthma symptoms ▪ Nighttime awakening due to asthma • The member has a positive documented immediate response on RAST test and/or skin prick test to at least 1 common allergen (e.g. dermatophagoides farinae, dermatop hagoides pteronyssinus, dog, cat, or cockroach) which is an asthma trigger (copy of results required). • Pre-treatment serum IgE levels must be greater than or equal to 30 IU/mL
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APPROVAL CRITERIA-CCHP

		<p>(continuation of Xolair criteria)</p> <p><u>Initial Authorization for Xolair for urticaria:</u></p> <ul style="list-style-type: none"> • The drug is being prescribed at an FDA approved dose • The member has a documented history of urticaria for at least 6 weeks • The member requires oral corticosteroids to control symptoms • The member remains symptomatic despite a minimum two week trial of a formulary second generation H1 antihistamine at the maximum tolerated dose; or has a medical reason for not utilizing a second generation antihistamine <p><u>Initial Authorization for Xolair for IgE-mediated food allergy:</u></p> <ul style="list-style-type: none"> • Diagnosis of IgE-mediated food allergy with documented allergy to one or more of the following foods: <ul style="list-style-type: none"> ○ Peanut, milk, egg, wheat, cashew, hazelnut, or walnut • Attestation Xolair will be used in conjunction with food allergen avoidance • The drug is being prescribed at an FDA approved dose according to the member's weight and IgE level <p><u>Exclusion:</u></p> <ul style="list-style-type: none"> • Use of Xolair concomitantly with Palforzia • Use of Xolair for emergency treatment of allergic reactions, including anaphylaxis • When used in combination with another pulmonary biologic (e.g., Cinqair, Fasentra, Nucala, Dupixent, or Tezspire) <p><u>Reauthorization:</u></p> <ul style="list-style-type: none"> • The drug is being prescribed at an approved dose • The member has clinically benefited from medication (e.g. decreased exacerbations, reduction in use of oral steroids, decrease in skin manifestations or severe itching, improvement in pulmonary function tests, etc.) <p>If the above conditions are met, the initial request will be approved with a 4 month duration. All subsequent requests will be approved with a 12 month duration.</p> <p>Last review: 9/2025</p>
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APPROVAL CRITERIA-CCHP

	<p>Zoryve (roflumilast) 0.15%, 0.3% cream (60g), 0.3% foam (60g)</p>	<p><u>Initial Authorization:</u> All claims: quantity limit of one 60g tube per 30 days Medication is prescribed for an FDA approved age</p> <p>For diagnosis of plaque psoriasis:</p> <ul style="list-style-type: none"> • Request is for 0.3% cream or 0.3% foam • Diagnosis of plaque psoriasis • Documented trial and failure (minimum duration of 4 weeks), contraindication, or intolerance to a topical corticosteroid (e.g. betamethasone, clobetasol, fluocinonide, desonide) AND • Trial and failure or inability to use topical corticosteroid in combination with one of the following topical agents: <ul style="list-style-type: none"> ○ Vitamin D analogs (e.g. calcitriol, calcipotriene) ○ Tazarotene ○ Calcineurin inhibitors (e.g. tacrolimus, pimecrolimus) <p>For diagnosis of atopic dermatitis:</p> <ul style="list-style-type: none"> • Request is for 0.15% cream • Diagnosis of mild to moderate atopic dermatitis • Documented trial and failure of, intolerance, or inability to use, one formulary topical corticosteroid AND • Trial and failure of, intolerance, or inability to use topical tacrolimus or pimecrolimus <p>For diagnosis of seborrheic dermatitis:</p> <ul style="list-style-type: none"> • Request is for 0.3% foam • Diagnosis of seborrheic dermatitis • Documented trial and failure of, intolerance, or inability to use, one formulary topical antifungal (e.g. ciclopirox, ketoconazole) AND • Trial and failure of, intolerance, or inability to use, one formulary topical corticosteroid <p><u>Re-Authorization:</u></p> <ul style="list-style-type: none"> • Documentation or provider attestation of positive clinical response (e.g. clearing of the skin, reduction in itching) <p><u>Coverage Duration:</u> If the criteria are met, the initial request will be approved for 2 month duration, and reauthorization request for up to a 12 month duration.</p> <p>Last review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

<p>Step Therapy Exception Criteria</p> <p>Requests for drugs on the plan's formulary with a step therapy restriction which do not meet step therapy requirements</p>	<p>Requests for drugs on the plan's formulary with a step therapy restriction which do not meet step therapy requirements will be considered when the provider verbally or in writing has submitted a medical reason why:</p> <ul style="list-style-type: none"> • Required step therapy drug(s) have previously or have the potential to cause an adverse reaction, physical or mental harm, or deterioration of the member's condition, or; • Required step therapy drug(s) would be ineffective, or; • Required step therapy drug(s) have been previously discontinued due to lack of efficacy, diminished effect, or an adverse reaction, or; • Required step therapy drug(s) are not clinically appropriate (i.e., would worsen a comorbid condition, decrease the members ADLs, pose a significant barrier to adherence with the member's drug regimen, or the member is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration while covered by their current or previous health coverage or Medicaid), or; • The requested drug would be superior to the required prerequisite trial(s) with preferred drug(s). <p>Covered Uses: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</p> <p>Last review: 3/2025</p>
<p>Off-label uses</p> <p>Formulary, Formulary PA required, Formulary, ST required, or Non-formulary medications with off-label uses</p>	<p>Initial criteria for approval:</p> <ul style="list-style-type: none"> • One of the following: <ul style="list-style-type: none"> • Patient has had a documented trial and or intolerance with up to two preferred medications used to treat the documented diagnosis, or for medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. • No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia <p>AND</p> <ul style="list-style-type: none"> • One of the following: <ul style="list-style-type: none"> • Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Covered Uses section) • Requested use can be supported by at least two published peer reviewed clinical studies <p>AND</p> <ul style="list-style-type: none"> • Medication is being requested at an appropriate dose per literature <p>Reauthorization criteria for approval:</p> <ul style="list-style-type: none"> • Patient is stable and continuing the medication AND • Medication is used for appropriate indication and at appropriate dose

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APPROVAL CRITERIA-CCHP

	<p>Covered Uses: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</p> <p>Last reviewed: 9/2025</p>
<p>Oncology Drugs/Therapies</p> <p>Oncology Medications and Oncology Gene Therapies (specialty or non-specialty) without product specific criteria when requested for an oncology diagnosis</p>	<p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • Prescriber is an oncologist, or specialist in type of cancer being treated • Requested use must be a labeled indication or be supported by NCCN Category 1 or 2A level of evidence. If the request is for an off-label use supported by NCCN as Category 2B recommendation then medical documentation has been provided as to why member is unable to utilize a treatment regimen with a higher level of evidence (e.g. allergic reaction, contraindication) • Documentation has been provided of the results of all required genetic testing where required per drug package insert • Documentation has been provided of the results of all required laboratory values and patient specific information (e.g. weight, ALT/AST, Creatine Kinase, etc.) necessary to ensure the patient has no contraindications to therapy per drug package insert • The product is being prescribed at a dose that is within FDA approved/NCCN guidelines. • If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available, documentation of one of the following: <ul style="list-style-type: none"> ○ The provider has verbally or in writing submitted a member specific reason why the reference biologic is required based on the member's condition or treatment history; AND if the member had side effects or a reaction to the biosimilar or interchangeable biologic, the provider has completed and submitted an FDA MedWatch form to justify the member's need to avoid these drugs. The MedWatch form must be included with the prior authorization request ○ The currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested <p style="text-align: center;"><u>Form FDA 3500 – Voluntary Reporting</u></p> <ul style="list-style-type: none"> • If the request is for abiraterone (Zytiga) 500 mg tablet, a documented medical reason why two tablets of generic abiraterone acetate 250 mg cannot be used <p>If the criteria are met, the request will be approved for up to 6 month duration</p> <p>Covered Uses: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI) , and the Drug Package Insert, and/or per the National Comprehensive Cancer Network (NCCN)</p> <p>Last reviewed: 9/2025</p>

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APPROVAL CRITERIA-CCHP

<p>Specialty Biologic Agents</p> <p><u>Step 1: Preferred (pays at point-of-sale)</u> Hadlima (adalimumab-bwwd) Adalimumab-fkjp (Hulio) Adalimumab-aaty (Yuflyma) Simlandi (adalimumab-ryvk)</p> <p><u>Step 2: Preferred (PA required)</u> Enbrel (etanercept) Simponi, Simponi Aria (golimumab) Infliximab Inflectra (infliximab-dyyb) Avsola (infliximab-axxq) Renflexis (infliximab-abda) Orencia (abatacept) Xeljanz, Xeljanz XR (tofacitinib) Kineret (anakinra) Otezla (Apremilast) Siliq (brodalumab) Kevzara (sarilumab) Tyenne (tocilizumab-aazg) Tofidence (tocilizumab-bavi) Avtozma (tocilizumab-anoh) Olumiant (baricitinib) Otulfi (ustekinumab-aaaz) Yesintek (ustekinumab-kfce) Selarsdi (ustekinumab-aekn) Imuldosa (ustekinumab-srlf)</p> <p><u>Step 3: Non-Preferred (PA required)</u> Humira (adalimumab) Stelara (ustekinumab) Skyrizi (risankizumab) Actemra (tocilizumab) Arcalyst (rilonacept) Ilaris (canakinumab) Tremfya (guselkumab) Remicade (infliximab) Cosentyx (secukinumab) Zeposia (ozanimod) Taltz (ixekizumab) Tysabri (natalizumab) Tyruko (natalizumab-sztn) Cimzia (certolizumab) Rinvoq (upadacitinib) Ilumya (tildrakizumab-asmn) Sotyktu (deucravacitinib) Bimzelx (bimekizumab) Omvoh (mirikizumab) Zymfentra (infliximab)</p>	<p>Note: ** For Non-FDA approved (i.e. off-label) uses; refer to the “Off-Label Use” policy**</p> <ul style="list-style-type: none"> The drug is being requested for an appropriate indication and dose (per the references outlined in covered uses) The prescriber is a specialist in the field to treat the member’s respective medical condition If the request is for a preferred Step 2 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use a preferred Step 1 agent appropriate for the requested use (per the references outlined in “Covered Uses”) If the request is for a non-preferred Step 3 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use one preferred step 1 agent and one preferred step 2 agent appropriate for the requested use (per the references outlined in covered uses) <p>AND:</p> <ul style="list-style-type: none"> If the request is for a reference biologic drug with a biosimilar or interchangeable biologic drug (ex. Humira, Remicade, Actemra, Stelara), documentation of one of the following: <ul style="list-style-type: none"> The provider has verbally, or in writing, submitted a member-specific reason why the reference biologic is required based on the member’s condition or treatment history; AND if the member had side effects or a reaction to the biosimilar or interchangeable biologic, the provider has completed and submitted an FDA MedWatch form to justify the member’s need to avoid these drugs. MedWatch form must also be included with the prior authorization request. Form FDA 3500 – Voluntary Reporting The currently available biosimilar product does not have the same appropriate use (per the references outlined in “Covered Uses”) as the reference biologic drug being requested <p>*NOTE:</p> <ul style="list-style-type: none"> Requests for Humira 10 mg/0.1 mL in pediatric patients may be approved without a trial of a step 1 or step 2 agent, when requested for an appropriate use (per the references outlined in “Covered Uses”) <p>Reauthorization:</p> <ul style="list-style-type: none"> Documentation submitted indicates that the member has obtained clinical benefit from the medication. The drug is being requested for an appropriate use and dose <p>Initial approval and reauthorization: 12 months</p> <p>Covered Uses: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.</p> <p>Last review: 12/2025</p>
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APPROVAL CRITERIA-CCHP

<p>All adalimumab biosimilar agents not listed in step 1 (ex. Amjevita, Cyltezo, Hyrimoz, Yuflyma, etc.) Litfulo (ritlecinib) All Stelara biosimilars not listed in step 2 (ex. Steqeyma, Wezlana, etc.) Or any newly marketed agent</p>	
<p>Specialty Biological Agents for Rheumatoid Arthritis</p> <p><u>Step 1: Preferred (pays at point-of-sale)</u> Hadlima (adalimumab-bwwd) Adalimumab-fkjp (Hulio) Adalimumab-aaty (Yuflyma) Simlandi (adalimumab-ryvk)</p> <p><u>Step 2: Preferred (PA required)</u> Enbrel (etanercept) Simponi, Simponi Aria (golimumab) Infliximab Inflixtra (infliximab-dyyb) Avsola (infliximab-axxq) Renflexis (infliximab-abda) Orencia (abatacept) SQ, IV Xeljanz, Xeljanz XR (tofacitinib) PO Kineret (anakinra) SQ Kevzara (sarilumab) SQ Tyenne (tocilizumab-aazg) SQ Tofidence (tocilizumab-bavi) SQ Olumiant (baricitinib) PO</p> <p><u>Step 3: Non-Preferred (PA required)</u> Humira (adalimumab) Actemra (tocilizumab) Remicade (infliximab) Cimzia (certolizumab) Rinvoq (upadacitinib) Zymfentra (infliximab) All adalimumab biosimilar agents not listed in step 1 (ex. Amjevita, Cyltezo, Hyrimoz, Yuflyma, etc.) Litfulo (ritlecinib) Or any newly marketed agent</p>	<p><u>PA CRITERIA FOR APPROVAL FOR RHEUMATOID ARTHRITIS:</u></p> <ul style="list-style-type: none"> • Prescriber is a rheumatologist • The member has a diagnosis of rheumatoid arthritis. • Member has documented (consistent with pharmacy claims/medical record data/chart notes/physician attestation) adequate trial of, or has a documented medical reason (e.g. allergy, intolerance, contraindication), for not taking one other disease modifying anti-rheumatic drug (DMARD) (e.g. methotrexate, leflunomide, sulfasalazine or hydroxychloroquine) to manage their condition. • The medication requested is being prescribed at an FDA-approved dosage for age and weight. • If the request is for a preferred Step 2 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use a preferred Step 1 agent appropriate for the requested use (per the references outlined in "Covered Uses") • If the request is for a non-preferred Step 3 agent, documentation has been provided that the member has tried and failed or has a medical reason why (e.g. intolerance, contraindication) they cannot use one preferred step 1 agent and one preferred step 2 agent appropriate for the requested use (per the references outlined in covered uses) <p><u>PA CRITERIA FOR RE-AUTHORIZATION FOR RHEUMATOID ARTHRITIS:</u></p> <ul style="list-style-type: none"> • The member has been receiving the medication and documentation was provided that a rheumatologist has evaluated the member and recommends continuation of therapy. • Documentation submitted indicates that the member has obtained clinical benefit from the medication. • For members who require dose increases to Humira 40 mg weekly or 80mg every other week, documentation must be submitted indicating that the member is not on concomitant methotrexate and has a medical reason (e.g. intolerance, hypersensitivity, contraindication) for not receiving concomitant methotrexate • The medication is being prescribed at an FDA-approved dosage. <p>Last review: 3/2025</p>
<p>Agents for Atopic Dermatitis</p> <p><u>T1-QL (30/30):</u> Tacrolimus (Protopic)</p>	<p><u>Initial Authorization:</u></p> <p>Prescribed by or in consultation with a dermatologist, allergist, or immunologist</p>

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APPROVAL CRITERIA-CCHP

Formulary, Prior

Authorization Required:

Pimecrolimus (Elidel)
Dupixent (dupilumab)

Non-formulary:

Eucrisa (crisaborol)
Opzelura (ruxolitinib)
Adbry (tralokinumab-ldrm)
Cibinqo (abrocitinib)
Rinvoq (upadacitinib)
Ebglyss (lebrikizumab-lbkz)
Nemluvio (nemolizumab-ilto)
Vtama (tapinarof)

Any other newly marketed agent for atopic dermatitis

Criteria for approval for pimecrolimus (Elidel)

- Diagnosis of mild to moderate atopic dermatitis (AD)
- For mild AD: trial and failure of, intolerance, or inability to use, one formulary medium to high potency topical corticosteroid
- For moderate AD: trial and failure of, intolerance, or inability to use, one formulary medium to high potency topical corticosteroid AND topical tacrolimus

Criteria for approval for Eucrisa, Opzelura, Vtama:

- Diagnosis of AD
- Trial and failure of, intolerance, or inability to use, one formulary medium to high potency topical corticosteroid
- Trial and failure of, intolerance, or inability to use topical tacrolimus or pimecrolimus
- All claims: quantity limit of 1 large tube every 30 days.

Criteria for approval for Dupixent:

- Diagnosis of moderate to severe AD
- Trial and failure of ONE of the following:
 - One formulary topical corticosteroid
 - Topical tacrolimus or pimecrolimus
 - Eucrisa (crisaborole)

Criteria for approval for Adbry or Nemluvio:

- Diagnosis of moderate to severe AD
- Trial and failure of, or contraindication/intolerance to, ONE of the following:
 - Eucrisa
 - Opzelura
 - Vtama
 - Zoryve

Criteria for approval for Ebglyss:

- Diagnosis of moderate to severe AD
- Trial and failure of, or contraindication/intolerance to, ONE of the following:
 - Dupixent
 - Adbry
 - Nemluvio

Criteria for approval for Cibinqo or Rinvoq:

- Diagnosis of refractory, moderate to severe, AD
- Trial and failure of, intolerance to, or contraindication to, another systemic drug product for AD

Reauthorization:

Prescriber attests that the member has experienced improvement in symptoms (e.g. significant clearing of the skin, reduction in itching)

Coverage Duration:

If the criteria are met, the requests for Opzelura and Vtama will be approved with up to an 8 week duration and all reauthorization requests will be approved for up to a 6 month duration. For all others: the request will be approved with up to a 6 month duration.

Last review date: 3/2025

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APPROVAL CRITERIA-CCHP

<p><u>Pulmonary Biologics for Respiratory and Eosinophilic Conditions</u></p> <p>Nucala (mepolizumab)</p> <p>Fasenra (benralizumab)</p> <p>Cinqair (reslizumab)</p> <p>Dupixent (dupilumab)</p> <p>Tezspire (tezepelumab)</p> <p>Or any newly marketed agents</p>	<p><u>Initial Authorization:</u> Prescribed by or in consultation with an allergist, pulmonologist, immunologist, rheumatologist, gastroenterologist, dermatologist, or other provider who specializes in the treatment of respiratory or eosinophilic conditions</p> <p><u>Asthma:</u></p> <ul style="list-style-type: none"> • Confirmed diagnosis of one of the following: <ul style="list-style-type: none"> ○ Nucala, Fasenra, and Cinqair: Severe Eosinophilic Asthma ○ Dupixent: Moderate-to-Severe eosinophilic asthma ○ Tezspire: Severe Asthma • Documentation has been provided of blood eosinophil count within ONE of the following ranges: <ul style="list-style-type: none"> ○ Nucala and Dupixent: ≥ 150 cells/mcL (within 6 weeks of request) OR ≥ 300 cells/mcL (within the past 12 months) ○ Fasenra: ≥ 150 cells/mcL (within the past 12 months) ○ Cinqair: ≥ 400 cells/mcL (within the past 12 months) ○ Tezspire: No baseline blood eosinophil counts are required • The member has a documented baseline FEV₁ < 80% of predicted with evidence of reversibility by bronchodilator response. <ul style="list-style-type: none"> ○ Tezspire ONLY: If age is < 18 years, the member has a documented baseline FEV₁ < 90% of predicted with evidence of reversibility by bronchodilator response • Documentation has been provided indicating that that the member continues to experience significant symptoms while compliant on a maximally tolerated inhaled corticosteroid with long-acting beta2 agonist (ICS/LABA) AND long-acting muscarinic antagonist (LAMA) (or a documented medical reason must be provided why the member is unable to use these therapies) and ONE of the following: <ul style="list-style-type: none"> ○ Nucala: ≥ 2 exacerbations in the past 12 months ○ Fasenra: ≥ 1 exacerbation in the past 12 months ○ Cinqair: ≥ 1 exacerbation in the past 12 months requiring systemic corticosteroids ○ Dupixent: ≥ 1 exacerbation in the past 12 months requiring systemic corticosteroids or hospitalization ○ Tezspire: ≥ 2 exacerbations requiring systemic corticosteroids OR ≥ 1 exacerbation in the past 12 months requiring hospitalization • The prescribed dose is within FDA approved dosing guidelines <p><u>Chronic Obstructive Pulmonary Disease (COPD) (Dupixent only):</u></p> <ul style="list-style-type: none"> • Confirmed diagnosis of COPD • Documentation has been provided of blood eosinophil count ≥ 300 cells/mcL • The member has a documented post-bronchodilator FEV₁/FVC ratio < 0.7 and post-bronchodilator FEV₁ of 30% to 70% predicted • Documentation has been provided indicating that that the member continues to experience significant symptoms (i.e., chronic productive cough) while compliant on maintenance triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta2 agonist (LABA), and inhaled corticosteroid (ICS) (or a documented medical reason must be provided why the member is unable to use these therapies) and ONE of the following: <ul style="list-style-type: none"> ○ ≥ 2 exacerbations in the past 12 months, where systemic corticosteroids were required for at least one of them ○ ≥ 1 exacerbation in the past 12 months requiring hospitalization • The prescribed dose is within FDA approved dosing guidelines
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APPROVAL CRITERIA-CCHP

Oral Corticosteroid Dependent Asthma: (*Dupixent only*)

- Confirmed diagnosis of oral corticosteroid (OCS) dependent asthma with at least 5 mg oral prednisone or equivalent per day for at least 4 weeks within the last 3 months
- The patient has a documented baseline FEV₁ < 80% of predicted with evidence of reversibility by bronchodilator response.
- Documentation has been provided indicating patient still is having significant symptoms with ≥ 1 exacerbations in the previous 12 months requiring additional medical treatment, (emergency room visits, hospital admissions) while compliant on a high-dose inhaled corticosteroid with a long-acting B₂ agonist (ICS/LABA) AND a long-acting muscarinic antagonist (LAMA).. If the patient has not utilized these therapies, a documented medical reason must be provided why patient is unable to do so.
- The prescribed dose is within FDA approved dosing guidelines

Eosinophilic Esophagitis (EoE) (*Dupixent only*):

- Confirmed diagnosis of EoE by endoscopic biopsy indicating ≥15 intraepithelial eosinophils per high-power field (eos/hpf)
- Documentation of baseline esophageal intraepithelial eosinophil count and Dysphagia Symptom Questionnaire (DSQ) scores
- Member has a history of at least 2 episodes of dysphagia (with intakes of solids) per week in the last 4 weeks
- Documented trial and failure, intolerance, or contraindication to one proton pump inhibitor at a maximally tolerated dose for a minimum of 8 weeks
- Member has a documented weight greater than or equal to 40 kg
- The prescribed dose is within FDA approved dosing guidelines

Prurigo Nodularis (PN) (*Dupixent only*):

- Confirmed diagnosis of PN lasting for at least three months prior to request
- Member has a Worst-itch Numeric Rating Scale (WI-NRS) score of 7 or higher indicating severe or very severe itching
- Member has at least 20 PN lesions in total
- Documented trial and failure, intolerance, or contraindication to at least two of the following for a minimum of two weeks:
 - One medium to super-high potency topical corticosteroid
 - One topical calcineurin inhibitor
 - UVB phototherapy or psoralen plus UVA phototherapy
- The prescribed dose is within FDA approved dosing guidelines

Eosinophilic granulomatosis with polyangiitis (EGPA) (*Nucala and Fasenra only*):

- Confirmed diagnosis of EGPA and eosinophilic asthma lasting for ≥6 months
- Member has a history of relapsing disease defined as at least one EGPA relapse requiring additional corticosteroids or immunosuppressant or hospitalization within the past 2 years OR member has a history of refractory disease defined as failure to attain remission in the prior 6 months following induction treatment with standard therapy
- Member must be on a stable dose of oral corticosteroids for at least 4 weeks prior to request
- Member has a blood eosinophil count ≥1,000 cells/mcL OR > 10% of total leukocyte count

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APPROVAL CRITERIA-CCHP

- Documented trial and failure, intolerance, or contraindication to cyclophosphamide, rituximab, azathioprine, methotrexate, OR mycophenolate mofetil
- If the request is for Nucala, member must also have documented trial and failure, intolerance, or contraindication to Fasenra
- The prescribed dose is within FDA approved dosing guidelines

Hypereosinophilic Syndrome (HES) (Nucala only):

- Confirmed diagnosis of FIP1 like 1-platelet derived growth factor receptor alpha (FIP1L1-PDGFRA)-negative HES lasting for ≥ 6 months without an identifiable non-hematologic secondary cause
- Member has a history of two or more HES flares (worsening of HES-related symptoms necessitating therapy escalation or ≥ 2 courses of rescue oral corticosteroids) within the past 12 months
- Member has a blood eosinophil count $\geq 1,000$ cells/mcL
- Documented trial and failure, intolerance, or contraindication to oral corticosteroids AND at least one second-line agent (e.g. hydroxyurea, interferon, imatinib, methotrexate, cyclophosphamide, cyclosporine, azathioprine) (member must be on stable dose of at least one agent for at least 4 weeks prior to request)

Re-Authorization:

- Documentation submitted indicates the member has clinically benefited from the medication (e.g. Asthma & COPD: improved FEV1, reduced exacerbations; HES: symptomatic improvement, reduced oral corticosteroid dose; EGPA: reduction in relapse frequency or severity, disease remission, symptomatic improvement, reduced oral corticosteroid dose; EoE: histological remission, improvement in DSQ scores; PN: improvement in WI-NRS score, symptomatic improvement.)
- The prescribed dose is within FDA approved dosing guidelines

Exclusion:

- When used in combination with another monoclonal antibody for the treatment of respiratory or eosinophilic conditions

If the above conditions are met, the initial request will be approved with a 4 month duration. All subsequent requests will be approved with a 6 month duration.

Last review 3/2025

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APPROVAL CRITERIA-CCHP

Table of common chemotherapy agents associated with emesis risk and corresponding preferred anti-emetic agents

High Risk (>90% frequency without anti-emetics)		
<ul style="list-style-type: none"> • AC combination: Doxorubicin (Adriamycin) or Epirubicin (Ellence)+ Cyclophosphamide (Cytoxan, Neosar) • Altretamine (HMM, Hexalen) • Carmustine (BCNU, BICNU) >250mg/m² • Cisplatin (CDDP, Platinol, Platinol-AQ) >50mg/m² • Cyclophosphamide (CTX, Cytoxan, Neosar) >1,500mg/m² 	<ul style="list-style-type: none"> • Dacarbazine (DTIC, DTIC-Dome) • Doxorubicin (Adriamycin) >60mg/m² • Epirubicin (Ellence) >90mg/m² • Ifosfamide (Ifex) >10g/m² • Mechlorethamine (Mustargen) • Procarbazine (Matulane) oral • Streptozocin (Zanosar) 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Aprepitant PO 2. Dexamethasone PO 3. Ondansetron PO/IV 4. Prochlorperazine PO/PR and/or metoclopramide PO/IV
Moderate Risk (30–90% frequency without anti-emetics)		
<ul style="list-style-type: none"> • Aldesleukin (IL-2, Proleukin) >12–15 million units/m² • Amifostine (Ethylol) >300mg/m² • Arsenic trioxide (A3 O , Trisenox) • Azacitidine (Vidaza) • Bendamustine (Treanda) • Busulfan (Busulfex) IV, oral >4mg/d • Carboplatin (Paraplatin) • Carmustine (BCNU, BICNU) <250mg/m² • Cisplatin (CDDP, Platinol, Platinol-AQ) <50mg/m² • Clofarabine (Clolar) • Cyclophosphamide (CTX, Cytoxan, Neosar) <1,500mg/m² • Cyclophosphamide (CTX) oral >100mg/m²/day • Cytarabine (ARA-C, Cytosar-U) >200mg/m² 	<ul style="list-style-type: none"> • Dactinomycin (actinomycin D, Cosmegen) • Daunorubicin (Cerubidine, Daunomycin) • Doxorubicin (Adriamycin) <60mg/m² • Epirubicin (Ellence) <90mg/m² • Estramustine (Emcyt) • Etoposide (VP-16, VePesid) oral • Idarubicin (Idamycin) • Ifosfamide (Ifex) < 10g/m² • Interferon alpha (IFN-alfa, Intron A) >10 million units/m² • Irinotecan (CPT-11, Camptosar) • Lomustine (CCNU, CeeNU) • Melphalan (L-PAM, Alkeran) >50mg/m² IV • Methotrexate (MTX) >250mg/m² • Oxaliplatin (Eloxatin) >75mg/m² • Temozolomide (Temodar) oral >75mg/m²/day • Vinorelbine (Navelbine) oral 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Ondansetron PO/IV 2. Dexamethasone PO 3. Prochlorperazine PO/PR and/or metoclopramide PO/IV
Low Risk (10–30% frequency without anti-emetics)		
<ul style="list-style-type: none"> • Aldesleukin (IL-2, Proleukin) <12 million units/m² • Amifostine (Ethylol) <300mg • Bexarotene (Targretin) • Cabazitaxel (Jevtana) • Capecitabine (Xeloda) oral • Cetuximab (C225, Erbitux) • Cyclophosphamide (CTX) oral <100mg/m²/d 	<ul style="list-style-type: none"> • Cytarabine (ARA-C, Cytosar-U) 100–200mg/m² • Docetaxel (Taxotere) • Doxorubicin liposomal (Doxil) • Eribulin (Halaven) • Etoposide (VP-16, Etopophos, VePesid) IV • Floxuridine • Fludarabine (Fludara) oral • Fluorouracil (5-FU) 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Ondansetron PO/IV 2. Dexamethasone PO 3. Prochlorperazine PO/PR and/or metoclopramide PO/IV
Minimal Risk (<10% frequency without anti-emetics)		
<ul style="list-style-type: none"> • Alemtuzumab (Campath) • Asparaginase (Elspar) • Bevacizumab (Avastin) • Bleomycin (Blenoxane) • Bortezomib (Velcade) • Busulfan (Busulfex) oral 4mg/d • Cetuximab (Erbitux) • Chlorambucil (Leukeran) oral • Cladribine (2-CdA, Leustatin) • Cytarabine (ARA-C, Cytosar-U) <100mg/m² • Dasatinib (Sprycel) • Decitabine (Dacogen) • Denileukin diftitox (Ontak) • Dexrazoxane (Totect, Zinecard) • Erlotinib (Tarceva) • Everolimus (Afinitor, Zortress) • Fludarabine (Fludara) IV • Gefitinib (Iressa) • Hydroxyurea (Hydrea) oral • Imatinib (Gleevec) • Interferon alpha (IFN-alfa, Intron A) • Ipilimumab (Yervoy) • Lapatinib (Tykerb) • Lenalidomide (Revlimid) 	<ul style="list-style-type: none"> • Melphalan (L-PAM, Alkeran) low dose oral • Mercaptopurine (purinethol) • Methotrexate (MTX) _50mg/m² IV/oral • Nelarabine (Arranon) • Nilotinib (Tasigna) • Ofatumumab (Arzerra) • Panitumumab (Vectibix) • Pazopanib (Votrient) • Pegaspargase (Oncaspar) • PegInterferon • Rituximab (Rituxan) • Sorafenib (Nexavar) • Sunitinib (Sutent) • Temsirolimus (Torisel) • Temozolamide (Temodar) < 75mg/m²/day • Tretinoin (Vesanoid) • Thalidomide (Thalomid) • Thioguanine (6-TG,Tabloid) • Trastuzumab (Herceptin) • Valrubicin (Valstar) • Vandetanib (Caprelsa) • Vinblastine (VLB) • Vincristine (VCR) • Vinorelbine (Navelbine) IV • Vorinostat (Zolinza) 	<p>Preferred Agents:</p> <ol style="list-style-type: none"> 1. Prochlorperazine PO/PR and/or metoclopramide PO/IV

* QL: QUANTITY LIMIT

79

PA: REFERRING TO A NON-PREFERRED DRUG, REQUIRING A PRIOR AUTHORIZATION.

CI: CODE 1 RESTRICTION, REFERRING TO A NON-PREFERRED DRUG REQUIRING A CERTAIN CRITERIA WHICH COULD BE CITED ON THE PRESCRIPTION OR COMMUNICATED TO THE PHARMACIST. A PHARMACIST COULD ALSO OBTAIN THIS INFORMATION. NO PA FORM IS NECESSARY TO BE FILLED FOR THIS CONDITION.

* With a few exceptions, most PAs are approved for a period of one year. Some exceptions include but not limited to asthma preparations (i.e., one PA sufficient for life); OR 5HT1s (i.e., triptans) for migraine headaches (SEE individual agents for specific instructions on "frequency & maximum allowable quantity dispensed",.....).

APPROVAL CRITERIA-CCHP

Table of common chemotherapy regimens associated with risk of febrile neutropenia

Chemotherapy regimens associated with febrile neutropenia risk > 20%		
ABVD AC + docetaxel ACE BEACOPP BOP CEC (R-)CHOP-21 Capecitabine/docetaxel Cisplatin/vinorelbine/cetuximab Hyper CVAD + rituximab DCP DHAP Docetaxel Docetaxel/carboplatin	Docetaxel/cisplatin Docetaxel/irinotecan Docetaxel/doxorubicin Paclitaxel/doxorubicin ECF (R-)ESHAP Etoposide/cisplatin FC(R) (R-)ICE IGEV LVFU (-cisplatin/irinotecan) MAID MOPPED-VCAD MVAC	Paclitaxel Stanford V TAC TC(F) TIC Topotecan VICE VeIP Dose-dense FEC Dose-dense epirubicin/cyclophosphamide Dose-dense CAV -> PE Dose-dense VAPEC-B Dose-dense ACVBP
Chemotherapy regimens associated with febrile neutropenia risk 10-20%		
5-FU AC ACOD BEP Mega CHOP-R-Ara-C cyclophosphamide Cyclophosphamide/mitoxantrone CODE Doxorubicin/vinorelbine Epirubicin /cyclophosphamide	Etoposide/carboplatin Etoposide/cisplatin ECF ECX EOF EOX EPOCH Fludarabine/mitoxantrone GAV Gemcitabine/irinotecan	(R-)GemP (R-)GemOx FEC-D FEC-100 FOLFIRI Topotecan/cisplatin Tirapazamine/cisplatin/etoposide/irradiation VIG Vinorelbine/cisplatin
Chemotherapy regimens associated with febrile neutropenia risk < 10%		
Bevacizumab/paclitaxel/carboplatin CAV->PE CMF IV/oral Epirubicin/cyclophosphamide +/- lonidamine Gemcitabine/cisplatin	FEC-120 FAC-50 FOLFOX (-6) IFL	Irinotecan TAP TPF

Febrile neutropenia is defined as (bullet points below are all inclusive):

1. An absolute neutrophil count (ANC) of less than $0.5 \times 10^9/L$ (or less than $1 \times 10^9/L$ predicted to fall below $0.5 \times 10^9/L$ within 48 hours)
2. Fever or other clinical signs/symptoms of sepsis

* QL: QUANTITY LIMIT

80

PA: REFERRING TO A NON-PREFERRED DRUG, REQUIRING A PRIOR AUTHORIZATION.

C1: CODE 1 RESTRICTION, REFERRING TO A NON-PREFERRED DRUG REQUIRING A CERTAIN CRITERIA WHICH COULD BE CITED ON THE PRESCRIPTION OR COMMUNICATED TO THE PHARMACIST. A PHARMACIST COULD ALSO OBTAIN THIS INFORMATION. NO PA FORM IS NECESSARY TO BE FILLED FOR THIS CONDITION.

* With a few exceptions, most PAs are approved for a period of one year. Some exceptions include but not limited to asthma preparations (i.e., one PA sufficient for life); OR 5HT1s (i.e., triptans) for migraine headaches (SEE individual agents for specific instructions on "frequency & maximum allowable quantity dispensed",.....).