Santa Clara Family Health Plan
Medi-Cal Formulary

# List of Prior Authorization Requirements

Last Update: 07/01/2020

# ABALOPARATIDE

**Products Affected**
TYMLOS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Woman with diagnosis of postmenopausal osteoporosis; **and**<br>2. Chart notes document high risk for fracture as defined by one of the following: **and**<br>a. History of osteoporotic (i.e., fragility, low trauma) fracture (s); **or**<br>b. 2 or more risk factors for fracture (e.g., history of multiple recent low trauma fractures, BMD T-score ≤2.5, long-term corticosteroid use, use of GnRH analogs, etc).<br>3. Bone mineral density test results are provided and dated within the last 2 years; **and**<br>4. Failure contraindication to, or clinically significant adverse effects(s) to oral bisphosphonates (e.g., alendronate, ibandronate, risedronate) **and**<br>5. Failure contraindication to, or clinically significant adverse effects(s) to Prolia (denosumab); **and**<br>6. Duration of treatment with parathyroid hormone analogs (e.g., Tymlos, Forteo) does not exceed 2 years in a patient's lifetime; **and**<br>7. Dose does not exceed 80 mcg once daily. |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# ADALIMUMAB

**Products Affected**
HUMIRA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Rheumatoid Arthritis (RA)**<br>1. Diagnosis of moderate to severe active rheumatoid arthritis; **and**<br>2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine; **and**<br>3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, JAK inhibitor, IL-1 inhibitor, IL-6 inhibitor, abatacept (Orencia), rituximab (Rituxan); **and**<br>4. Dose does not exceed 40 mg every week.<br><br>**Polyarticular Juvenile Idiopathic Arthritis (JIA)**<br>1. Diagnosis of moderate to severe active polyarticular juvenile idiopathic arthritis; **and**<br>2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, thalidomide, or cyclosporine; **and**<br>3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-6 inhibitor, abatacept (Orencia), rituximab (Rituxan); **and**<br>4. Patient's current weight is documented; **and**<br>5. Dose does not exceed the following based on weight:<br>a. 10 kg (22 lbs) to <15 kg (33 lbs): 10 mg every other week<br>b. 15 kg (33 lbs) to <30 kg (66 lbs): 20 mg every other week<br>c. ≥30 kg (66 lbs): 40 mg every other week.<br><br>**Plaque Psoriasis (PsO)**<br>1. Diagnosis of moderate to severe chronic plaque psoriasis; **and**<br>2. Plaque psoriasis involve at least 5% body surface area (BSA) or psoriatic lesions affecting the hands, feet, scalp, face, or genital area; **and**<br>3. Previous trial with one of the following conventional therapies: phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), |

topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine; **and**
4. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, IL-17 inhibitor, IL-23 inhibitor; **and**
5. Dose does not exceed 80 mg for initial dose, followed by 40 mg every other week starting one week after initial dose.

**Psoriatic Arthritis (PsA)**
1. Diagnosis of active psoriatic arthritis; **and**
2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, azathioprine, sulfasalazine, or cyclosporine; **and**
3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, IL-17 inhibitor, IL-23 inhibitor, JAK inhibitor, abatacept; **and**
4. Dose does not exceed 40 mg every other week.

**Ankylosing Spondylitis (AS)**
1. Diagnosis of active ankylosing spondylitis; **and**
2. Tried and failed one nonsteroidal anti-inflammatory drug (NSAID), e.g. ibuprofen, naproxen, meloxicam, celecoxib, diclofenac, nabumetone; **and**
3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-17 inhibitor, JAK inhibitor; **and**
4. Dose does not exceed 40 mg every other week.

**Crohn's Disease (CD)**
1. Diagnosis of moderate to severe active Crohn's disease; **and**
2. Previous trial with at least one of the following conventional agents: corticosteroids (i.e. budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine; **and**
3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, vedolizumab, natalizumab; **and**
4. Dose does not exceed the following based on age and weight:
    a. Adult:
        i. Initial dose (Day 1): 160 mg
        ii. Second dose two weeks later (Day 15): 80 mg
        iii. Third (Day 29) and subsequent doses: 40 mg every other week
    b. Pediatric:
        i. 17 kg (37 lbs) to <40 kg (88 lbs):
            1. Initial dose (Day 1): 80 mg
            2. Second dose two weeks later (Day 15): 40 mg

3. Third (Day 29) and subsequent doses: 20 mg every other week.

ii. ≥40 kg (88 lbs):
1. Initial dose (Day 1): 160 mg
2. Second dose two weeks later (Day 15): 80 mg
3. Third (Day 29) and subsequent doses: 40 mg every other week.

**Ulcerative Colitis (UC)**

1. Diagnosis of moderate to severe active ulcerative colitis; **and**
2. Previous trial with at least one of the following conventional agents: corticosteroids (i.e. budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine; **and**
3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, JAK inhibitor, vedolizumab; **and**
4. Dose does not exceed the following based on age and weight:
   a. Adult:
      i. Initial dose (Day 1): 160 mg
      ii. Second dose two weeks later (Day 15): 80 mg
      iii. Two weeks later (Day 29): 40 mg every other week.

**Hidradenitis Suppurativa (HS)**

1. Diagnosis of moderate to severe hidradenitis suppurativa; **and**
2. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, IL-1 inhibitor; **and**
3. Dose does not exceed the following:
   a. Initial dose (Day 1): 160 mg
   b. Second dose two weeks later (Day 15): 80 mg
   c. Third (Day 29) and subsequent doses: 40 mg every week.

**Uveitis (UV)**

1. Diagnosis of non-infectious intermediate, posterior and panuveitis; **and**
2. Patient will not be on concurrent therapy with another TNF-α inhibitor; **and**
3. Dose does not exceed the following bsed on age and weight:
   a. Adult:
      i. Initial dose (Day 1): 80 mg
      ii. Second dose one week later (Day 8): 40 mg every other week
   b. Pediatric:
      i. 10 kg (22 lbs) to <15 kg (33 lbs): 10 mg every other week
      ii. 15 kg (33 lbs) to <30 kg (66 lbs): 20 mg every other week
      iii. ≥30 kg (66 lbs): 40 mg every other week.

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| **Age Restrictions** | 18 YEARS AND OLDER |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST<br>PLAQUE PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST<br>PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST<br>CROHN'S DISEASE, ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST<br>HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST<br>UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPTHALMOLOGIST, RHEUMATOLOGIST, OR INFECTIOUS DISEASE PHYSICIAN |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# AMBRISENTAN

**Products Affected**
LETAIRIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Chart notes document diagnosis of pulmonary arterial hypertension (PAH) (WHO Group I) confirmed by right heart catheterization; **and**<br>2. Patient does not have idiopathic pulmonary fibrosis (IPF); **and**<br>3. Dose does not exceed the following:<br>a. Initial dose: does not exceed 5mg daily for 4 weeks; **or**<br>b. Maintenance dose: does not exceed 10mg daily. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# APREPITANT

**Products Affected**
EMEND

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Request is for any of the following:<br>a. Patient is receiving chemotherapy agent considered to be high emetic risk; **or**<br>b. Patient is undergoing surgery with a high risk of postoperative nausea and vomiting (i.e., intra-abdominal procedures, major gynecologic surgery, orthopedic surgery, ear-nose-throat surgery, laparoscopic surgery, adenotonsillectomy or strabismus surgery). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | CHEMOTHERAPY:<br>EMEND TRIFOLD PACK: ONE PACK PER CHEMOTHERAPY CYCLE FOR 6 MONTHS OR LENGTH OF THERAPY (WHICHEVER IS LESS); OR<br>ONE 125MCG EMEND CAPSULE AND TWO 80MG CAPSULES PER CHEMOTHERAPY CYCLE FOR 6 MONTHS OR LENGTH OF THERAPY (WHICHEVER IS LESS).<br>SURGERY:<br>APPROVE EMEND 40MG #1 CAPSULE FOR 1 FILL. |
| **Other Criteria** | |

# ATOVAQUONE-PROGUANIL HCL

**Products Affected**
MALARONE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Prevention or treatment of Malaria**<br>1. Atovaquone-proguanil is recommended for the location of travel by the Centers for Disease Control and Prevention (CDC); **and**<br>2. Dose does not exceed 250-100 mg daily; **and**<br>3. Patient cannot use all of the following if recommended by CDC based on travel location:<br>a. Doxycycline;<br>b. Mefloquine;<br>c. Chloroquine. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: FOR DURATION OF TRAVEL PLUS 9 DAYS (2 DAYS PRIOR AND 7 DAYS AFTER LEAVING AREA) |
| **Other Criteria** | |

# CALCIPOTRIENE

**Products Affected**
DOVONEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Nonfacial/Nonintertriginous affected areas**<br>1. Diagnosis of plaque psoriasis; **and**<br>2. Failure or clinically significant adverse effect(s) to two high potency topical steroids (e.g. betamethasone, betamethasone-augmented, fluocinonide, clobetasol, desoximetasone, halobetasol).<br><br>**Facial/Intertriginous affected areas**<br>1. Diagnosis of plaque psoriasis; **and**<br>2. Failure or clinically significant adverse effect(s) to one low potency topical steroid (e.g. alclometasone, hydrocortisone, desonide).<br><br>**Around or on the eyelid**<br>1. Diagnosis of plaque psoriasis around or on the eyelids. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# CICLOPIROX 8%

**Products Affected**
PENLAC
CICLODAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of onychomycosis or tinea unguium of fingernail(s) or toenail(s); **and**<br>2. Failure, clinically significant adverse effect(s), or contraindication(s) to oral terbinafine; **and**<br>3. Dose does not exceed 6.6 mL per month. |
| **Age Restrictions** | 12 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | **Reauthorization Criteria:**<br>1. Updated clinical chart notes; **and**<br>2. Total duration of treatment does not exceed 12 months. |

# CIPROFLOXACIN-DEXAMETHASONE OTIC

**Products Affected**
CIPRODEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of acute otitis media or acute otitis externa; and<br>2. One of the following:<br>a. Patient tried and failed both of the following: ofloxacin 0.3% otic drops, neomycin/polymycin B/hydrocortisone otic solution/suspension; **or**<br>b. Patient has a perforated tympanic membrane; **or**<br>c. Patient has tympanostomy tube (s). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 3 MONTHS |
| **Other Criteria** | |

# COLLAGENASE CLOSTRIDIUM HISTOLYTICUM

**Products Affected**
SANTYL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of one of the following: **and**<br>a. Chronic dermal ulcer; **or**<br>b. Severely burned area(s)<br>2. Chart note documentation of wound width and wound length; **and**<br>3. Requested quantity does not exceed the manufacturer's dosing calculator. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 4 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# CYCLOSPORINE 0.05% OPTHALMIC

**Products Affected**
RESTASIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Sjogren's Syndrome or Ocular-related Transplant**<br>1. One of the following:<br>a. Diagnosis of Sjogren's Syndrome; **or**<br>b. Treated for ocular graft versus host disease; **or**<br>c. Treated for corneal transplant rejection.<br><br>**Dry Eyes**<br>1. One of the following diagnoses; **and**<br>a. Chronic Dry Eye Syndrome<br>b. Keratoconjunctivitis Sicca (KCS)<br>c. Keratitis Sicca<br>d. Xerophthalmia<br>2. Tried and failed artificial tears; **and**<br>3. Tried and failed ophthalmic lubricant ointment (generic Refresh PM). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# DARIFENACIN

**Products Affected**
ENABLEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and urinary frequency; **and**<br><br>2. Tried and failed at least *two* of the following antimuscarinics; **and**<br>a. Oxybutynin (immediate-release or extended-release); or<br>b. Tolterodine (immediate-release or extended-release); or<br>c. Trospium (immediate-release)<br><br>3. Dose does not exceed 15mg per day. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# DEFERASIROX

**Products Affected**
JADENU

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Chronic Iron Overload**<br>1. Diagnosis of chronic iron overload; **and**<br>2. Serum ferritin level greater is than 1000 mcg/L; **and**<br>3. Creatinine clearance (CrCl) is greater or equal to 40 mL/min<br>4. Dose does not exceed 28 mg/kg/day<br><br>**Chronic Iron Overload Resulting from Non-Transfusion Dependent Thalassemia (NTDT)**<br>1. Diagnosis of chronic iron overload resulting from non-transfusion dependent thalassemia; **and**<br>2. Serum ferritin level is greater than 300 mcg/L; **and**<br>3. Liver iron concentration (LIC) at least 5mg Fe/g dry weight or greater; **and**<br>4. Creatinine clearance (CrCl) is greater or equal to 40 mL/min; **and**<br>5. Dose does not exceed 14 mcg/kg/day |
| **Age Restrictions** | CHRONIC IRON OVERLOAD: 2 YEARS OF AGE AND OLDER<br>CHRONIC IRON OVERLOAD RESULTING FROM NON-TRANSFUSION DEPENDENT THALASSEMIA: 10 YEARS OF AGE AND OLDER. |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | RENEWAL CRITERIA<br>**Chronic Iron Overload**<br>1. Serum ferritin level is greater than 500 mcg/L<br><br>**Chronic Iron Overload in Non-Transfusion Dependent Thalassemia (NTDT)** |

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| | Meet ONE of the following criteria:<br>a. Serum ferritin level is greater than 300 mcg/L; **or**<br>b. Liver iron concentration (LIC) is at least 3mg Fe/g dry weight or greater (Liver iron concentration supersedes serum ferritin level when both measurements are available) |

# DIROXIMEL FUMARATE

**Products Affected**
VUMERITY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of a relapsing form of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; **and**<br>2. Tried and failed one disease-modifying agent (e.g.,glatiramer acetate, Avonex, Plegridy, Rebif, Betaseron, Extavia, Tysabri, Aubagio, Lemtrada, Zinbryta, Tecfidera, Novantrone, Ocrevus, Mavenclad, Mayzent); **and**<br>3. Patient will not be on concurrent therapy with another disease modifying agent; **and**<br>4. Dose does not exceed 924 mg per day. |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# DRONABINOL

**Products Affected**
MARINOL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Anorexia associated with weight loss in patients with AIDS**<br>1. Treatment is for anorexia associated with weight loss; **and**<br>2. Chart note documentation of acquired immunodeficiency syndrome (AIDS); **and**<br>3. Dose does not exceed 20mg daily.<br><br>**Nausea and vomiting associated with cancer chemotherapy**<br>1. Patient is currently undergoing chemotherapy; **and**<br>2. Chemotherapy regimen is classified as high or moderate emetic risk per NCCN guidelines; **and**<br>3. Failure or clinically significant adverse effect(s) to a neurokinin-1 (NK1) antagonist (e.g. aprepitant, fosaprepitant, rolapitant); **and**<br>4. Failure or clinically significant adverse effect(s) to a selective 5-HT3 receptor antagonist (e.g. alosetron, dolasetron, granisetron, ondansetron, palonosetron); **and**<br>5. Failure or clinically significant adverse effect(s) to a steroid (e.g. dexamethasone); **and**<br>6. Dose does not exceed 15mg/$m^2$ per dose. |
| **Age Restrictions** | ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS: 18 YEARS AND OLDER |
| **Prescriber Restrictions** | NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# EPOETIN ALFA-EPBX

**Products Affected**
RETACRIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Anemia associated with chronic renal failure (on dialysis or not on dialysis)**<br>1. Hemoglobin (Hgb) level is less than 10g/dL.<br><br>**Anemia due to the effect of concomitantly administered cancer chemotherapy**<br>1. Hemoglobin (Hgb) level is less than 10g/dL; **and**<br>2. Minimum of two additional months of planned chemotherapy.<br><br>**Anemia related to zidovudine (AZT) therapy**<br>1. Hemoglobin (Hgb) level is less than 10g/dL.<br><br>**Anemia due to concurrent hepatitis C treatment**<br>1. Hep C treatment is one of the following:<br>a. Ribavirin and interferon alfa combination; **or**<br>b. Ribavirin and peginterferon alfa combination; **and**<br>2. Hemoglobin (Hgb) level is less than 10g/dL; **and**<br>3. Patient has had a trial or contraindication to ribavirin dose reduction.<br><br>**Reduction of allogenic blood transfusions due to undergoing elective, noncardiac, nonvascular surgery**<br>1. Preoperative hemoglobin (Hgb) level is greater than 10g/dL; **and**<br>2. Preoperative hemoglobin (Hgb) level is less than or equal to 13g/dL. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# ETANERCEPT

Products Affected
ENBREL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Rheumatoid Arthritis (RA)**<br>1. Diagnosis of moderate to severe active rheumatoid arthritis; **and**<br>2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine; **and**<br>3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, JAK inhibitor, IL-1 inhibitor, IL-6 inhibitor, abatacept, rituximab; **and**<br>4. Dose does not exceed 50 mg once weekly.<br><br>**Polyarticular Juvenile Idiopathic Arthritis (JIA)**<br>1. Diagnosis of moderate to severe active polyarticular juvenile idiopathic arthritis; **and**<br>2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, or cyclosporine; **and**<br>3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-6 inhibitor, abatacept, rituximab; **and**<br>4. Dose does not exceed 50 mg once weekly.<br><br>**Plaque Psoriasis (PsO)**<br>1. Diagnosis of moderate to severe chronic plaque psoriasis; **and**<br>2. Plaque psoriasis involve at least 5% body surface area (BSA) or psoriatic lesions affecting the hands, feet, scalp, face, or genital area; **and**<br>3. Previous trial with one of the following conventional therapies: phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine; **and**<br>4. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, IL-17 inhibitor, IL-23 inhibitor; **and** |

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| | 5. Dose does not exceed the following:<br>a. Adult:<br>i. 50mg twice weekly for first 3 months, followed by 50mg once weekly<br>b. Pediatric:<br>i. 50mg once weekly<br><br>**Psoriatic Arthritis (PsA)**<br>1. Diagnosis of active psoriatic arthritis; **and**<br>2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, azathioprine, sulfasalazine, or cyclosporine; **and**<br>3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, IL-17 inhibitor, IL-23 inhibitor, JAK inhibitor, abatacept; **and**<br>4. Dose does not exceed 50 mg once weekly.<br><br>**Ankylosing Spondylitis (AS)**<br>1. Diagnosis of active ankylosing spondylitis; **and**<br>2. Tried and failed one nonsteroidal anti-inflammatory drug (NSAID), e.g. ibuprofen, naproxen, meloxicam, celecoxib, diclofenac, nabumetone; **and**<br>3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-17 inhibitor, JAK inhibitor; **and**<br>4. Dose does not exceed 50 mg once weekly. |
| **Age Restrictions** | RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS: 18 YEARS OF AGE OR OLDER<br>PLAQUE PSORIASIS: 4 YEARS OF AGE OR OLDER<br>POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA): 2 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST<br>PLAQUE PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST<br>PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# FENTANYL TRANSDERMAL

**Products Affected**
DURAGESIC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **72-Hour Dosing Frequency**<br>1. Patient meets the definition of opioid tolerance; **and**<br>2. Request is for only one strength of transdermal fentanyl; **and**<br>3. The medication will not be used on as "as needed" or "PRN" basis.<br><br>**48-Hour Dosing Frequency**<br>1. Patient has tried every 72 hours dosing; **and**<br>2. Patient meets the definition of opioid tolerance; **and**<br>3. Request is for only one strength of transdermal fentanyl; **and**<br>4. The medication will not be used on as "as needed" or "PRN" basis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# FILGRASTIM-SNDZ

**Products Affected**

ZARXIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Request is for any one of the following diagnoses; **and**<br>a. Prevention of febrile neutropenia in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever; **or**<br>b. Prevention of febrile neutropenia in patients with acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy treatment; **or**<br>c. Prevention or treatment of febrile neutropenia and/or neutropenia-related clinical sequelae in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation; **or**<br>d. Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; **or**<br>e. Symptomatic congenital neutropenia; **or**<br>f. Symptomatic cyclic neutropenia; **or**<br>g. Symptomatic idiopathic neutropenia.<br>2. Requested dose does not exceed 24 mcg/kg/day. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR A HEMATOLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# FINGOLIMOD

**Products Affected**
GILENYA
VUMERITY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of a relapsing form of multiple sclerosis; **and**<br>2. Tried and failed one disease-modifying agent (e.g., glatiramer acetate, Avonex, Plegridy, Rebif, Betaseron, Extavia, Tysabri, Aubagio, Lemtrada, Zinbryta, Tecfidera, Vumerity, Novantrone, Ocrevus, Mavenclad, Mayzent); **and**<br>3. Patient will not be on concurrent therapy with another disease-modifying agent; **and**<br>4. Requested dose does not exceed 0.5 mg per day. |
| **Age Restrictions** | 10 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# GLATIRAMER ACETATE

**Products Affected**
COPAXONE
GLATOPA
VUMERITY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of a relapsing form of multiple sclerosis; **and**<br>2. Patient will not be on concurrent therapy with another disease-modifying agent (e.g., Avonex, Plegridy, Rebif, Betaseron, Extavia, Tysabri, Vumerity,Aubagio, Lemtrada, Zinbryta, Tecfidera, Gilenya, Novantrone, Ocrevus, Mavenclad, Mayzent); **and**<br>3. Requested dose does not exceed 40 mg/ml 3 times per week. |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# GLECAPREVIR-PIBRENTASVIR

**Products Affected**
MAVYRET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Treatment-Naïve:**<br>1. Diagnosis of treatment-naïve Hepatitis C; **and**<br>2. No cirrhosis or compensated cirrhosis; **and**<br>Hepatitis C viral load (HCV RNA Quantitative) within past 12 months; **and**<br>3. Patient is >12 years of age or weights at least 45kg; **and**<br>4. No documentation of life expectancy <12 months; **and**<br>5. Documentation that sofosbuvir/velpatasvir (Epclusa) cannot be used; **and**<br>6. Requested duration does not exceed 8 weeks.<br><br>**Treatment-Experienced, decompensated Cirrhosis, Post-liver Transplant, Renal Impairment, or Post-kidney Transplant**<br>1. Reviewed by a clinical pharmacist or medical director; and<br>2. Meets SCFHP Hepatitis C policy. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | TREATMENT-NAÏVE: APPROVE FOR 84 TABLETS PER 28 DAYS FOR 8 WEEKS<br>TREATMENT-EXPERIENCED, DECOMPENSATED CIRRHOSIS, POST-LIVER TRANSPLANT, RENAL IMPAIRMENT, OR POST-KIDNEY TRANSPLANT: BASED ON SCFHP HEPATITIS C POLICY |
| **Other Criteria** | |

# HYDROCODONE-ACETAMINOPHEN

**Products Affected**
HYCET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of pain; **and**<br>2. Chart notes document one of the following:<br>a. Difficulty swallowing oral tablets/capsules; **or**<br>b. Contraindication to oral tablets/capsules; **or**<br>c. Upcoming bariatric surgery<br>3. Dose does not exceed 90 ml per day. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1. DIFFICULTY SWALLOWING OR CONTRAINDICATION TO TABLETS/CAPSULES: INITIAL-12 MONTHS RENEWAL-12 MONTHS<br>2. UPCOMING BARIATRIC SURGERY: UP TO 1 MONTH |
| **Other Criteria** | |

# HYDROXYPROGESTERONE CAPROATE

**Products Affected**
MAKENA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. History of singleton spontaneous preterm birth before 37 weeks gestation; **and**<br>2. Currently pregnant with a singleton; **and**<br>3. Treatment to be started between 16 weeks and 21 weeks of gestation; **and**<br>4. Dose does not exceed 250 mg once weekly. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: UNTIL WEEK 37 OF GESTATION |
| **Other Criteria** | |

# INTERFERON BETA-1A, INTERFERON BETA-1A/ALBUMIN

**Products Affected**
AVONEX, AVONEX PEN (INTRAMUSCULAR).
AVONEX, REBIF REBIDOSE, REBIF (SUBCUTANEOUS)

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of a relapsing form of multiple sclerosis; **and**<br>2. Tried and failed one disease-modifying agent (e.g., glatiramer acetate, Plegridy, Betaseron, Extavia, Tysabri, Aubagio, Lemtrada, Zinbryta, Tecfidera,Vumerity, Novantrone, Ocrevus, Mavenclad, Mayzent); **and**<br>3. Patient will not be on concurrent therapy with another disease-modifying agent; **and**<br>4. Requested dose does not exceed:<br>a. Avonex: 30mcg once per week<br>b. Rebif: 44 mcg three times per week |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# INTERFERON ALFA-2B

**Products Affected**
INTRON A

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Hairy Cell Leukemia, Malignant Melanoma, Follicular Non-Hodgkin's Lymphoma, or AIDS-related Kaposi's Sarcoma**<br>1. Supported by National Comprehensive Cancer Network (NCCN) guidelines; **and**<br>2. Reviewed by a clinical pharmacist or medical director.<br><br>**Condylomata Acuminata**<br>1. Patient tried and failed both podofilox 0.5% topical solution and imiquimod 5% topical cream; **and**<br>2. Dose does not exceed 1 million international units (IU) per lesion in a maximum of 5 lesions in a single course 3 times weekly on alternate days for 3 weeks.<br><br>**Chronic Hepatitis B**<br>1. Patient has compensated liver disease; **and**<br>2. Patient has serum HBsAg positive for at least 6 months; **and**<br>3. Patient has evidence of HBV replication (serum HBeAg positive) with elevated serum ALT; **and**<br>4. Reviewed by a clinical pharmacist or medical director; **and**<br>5. Dose does not exceed the following:<br>a. Adult:<br>i. 5 million IU daily or 10 million IU three times a week for 16 weeks<br>b. Pediatric:<br>i. 10 million IU three times a week for 16 to 24 weeks<br><br>**Chronic Hepatitis C**<br>1. Refer to SCFHP Hepatitis C Policy; **and**<br>2. Reviewed by a clinical pharmacist or medical director. |
| **Age Restrictions** | CONDYLOMATA ACUMINATA: 18 YEARS OF AGE OR OLDER<br>CHRONIC HEPATITIS B: 1 YEAR OF AGE OR OLDER |

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|---|---|
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# ITRACONAZOLE

**Products Affected**
SPORANOX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Blastomycosis, Histoplasmosis, or Aspergillosis**<br>1. Dose does not exceed 600mg per day.<br><br>**Coccidioidomycosis, Cryptococcosis, or Oropharyngeal/Esophageal candidiasis**<br>1. Tried and failed fluconazole; **and**<br>2. Dose does not exceed 600mg per day.<br><br>**Coccidioidomycosis of bone or joint infections in HIV patients**<br>1. Dose does not exceed 600mg per day.<br><br>**Onychomycosis of toenail or fingernail**<br>1. Confirmed diagnosis by potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy; **and**<br>2. Tried and failed oral terbinafine; **and**<br>3. Dose does not exceed 400mg per day for 3 months. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# IXEKIZUMAB

**Products Affected**
TALTZ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Plaque Psoriasis (PsO)**<br>1. Diagnosis of moderate to severe chronic plaque psoriasis; **and**<br>2. Plaque psoriasis involve at least 5% body surface area (BSA) or psoriatic lesions affecting the hands, feet, scalp, face, or genital area; **and**<br>3. Tried and failed one of the following conventional therapies: phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine; **and**<br>4. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, IL-17 inhibitor, IL-23 inhibitor; **and**<br>5. Dose does not exceed the following:<br>a. Induction:<br>i. 160 mg at Week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12.<br>b. Maintenance:<br>i. 80mg every 4 weeks.<br><br>**Psoriatic Arthritis (PsA)**<br>1. Diagnosis of active psoriatic arthritis; **and**<br>2. Tried and failed at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, azathioprine, sulfasalazine, or cyclosporine; **and**<br>3. Patient will not be on concurrent therapy with any of the following drugs for the same indication: TNF-α inhibitor, IL-12/IL-23 inhibitor, IL-17 inhibitor, IL-23 inhibitor, JAK inhibitor, abatacept; **and**<br>4. Dose does not exceed the following:<br>a. Induction:<br>i. 160 mg at Week 0<br>b. Maintenance:<br>i. 80 mg every 4 weeks. |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |

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| **Prescriber Restrictions** | PLAQUE PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST<br>PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# LATANOPROST

**Products Affected**
XELPROS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of one of the following: **and**<br>a. Open-angle glaucoma; **or**<br>b. Ocular hypertension<br>2. One of the following: **and**<br>a. Patient has tried and failed latanoprost; **or**<br>b. Patient has sensitivity to or cannot tolerate ophthalmic preservatives (e.g. benzalkonium chloride)<br>3. Dose does not exceed one drop in the affected eye(s) once daily. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# LINEZOLID

**Products Affected**
ZYVOX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Prescribed for an FDA approved indication or supported by nationally recognized compendia and/or evidence-based practice guidelines (e.g., Infectious Diseases Society of America (IDSA)); **and**<br>2. Tried and failed a formulary antibiotic that the organism is susceptible to; **and**<br>3. Dose does not exceed 600 mg twice daily; **and**<br>4. Reviewed by a clinical pharmacist or medical director. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# LUBIPROSTONE

**Products Affected**
AMITIZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Chronic Idiopathic Constipation (CIC)**<br>1. Diagnosis of chronic idiopathic constipation; **and**<br>2. Failure, clinically significant adverse effect(s), or contraindication(s) to two of the following laxatives: bisacodyl, docusate calcium, docusate sodium, glycerin suppositories, lactulose, magnesium citrate, magnesium hydroxide, methylcellulose fiber, polyethylene glycol 3350, psyllium fiber, sennosides; **and**<br>3. Not currently taking methadone; **and**<br>4. Dose does not exceed 24 mcg twice daily.<br><br>**Irritable Bowel Syndrome with Constipation (IBS-C)**<br>1. Diagnosis of irritable bowel syndrome with constipation; **and**<br>2. Failure, clinically significant adverse effect(s), or contraindication(s) to two of the following laxatives: bisacodyl, docusate calcium, docusate sodium, glycerin suppositories, lactulose, magnesium citrate, magnesium hydroxide methylcellulose fiber, polyethylene glycol 3350, psyllium fiber, sennosides; **and**<br>3. Not currently taking methadone; **and**<br>4. Dose does not exceed 8 mcg twice daily.<br><br>**Opioid-Induced Constipation (OIC)**<br>1. Diagnosis of opioid-induced constipation; **and**<br>2. History of chronic use of an opioid medication in the past 30 days; **and**<br>3. Failure, clinically significant adverse effect(s), or contraindication(s) to two of the following laxatives: bisacodyl, docusate calcium, docusate sodium, glycerin suppositories, lactulose, magnesium citrate, magnesium hydroxide, methylcellulose fiber, polyethylene glycol 3350, psyllium fiber, sennosides; **and**<br>4. Not currently taking methadone; **and**<br>5. Dose does not exceed 24 mcg twice daily. |

| | |
|---|---|
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# MILNACIPRAN HCL

**Products Affected**
SAVELLA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of fibromyalgia; **and**<br>2. Tried and failed gabapentin up to 1,800 mg/day; **and**<br>3. Tried and failed duloxetine; **and**<br>4. Dose does not exceed 200mg twice daily. |
| **Age Restrictions** | 18 YEARS OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# MIRABEGRON

**Products Affected**
MYRBETRIQ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and urinary frequency; **and**<br>2. Failure or clinically significant adverse effect(s) to two of the following antimuscarinics; **and**<br>a. Oxybutynin (immediate-release or extended-release); **or**<br>b. Tolterodine (immediate-release or extended-release); **or**<br>c. Trospium (immediate-release); **or**<br>d. Solifenacin; **or**<br>e. Darifenacin; **or**<br>f. Fesoterodine.<br>3. Dose does not exceed 50mg daily. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# MODAFINIL

**Products Affected**
PROVIGIL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Excessive sleepiness associated with Narcolepsy**<br>1. Diagnosis of excessive sleepiness associated with narcolepsy; **and**<br>2. Narcolepsy confirmed by polysomnography/multiple sleep latency test; **and**<br>3. Dose does not exceed 200 mg per day.<br><br>**Excessive sleepiness associated with Obstructive Sleep Apnea (OSA)**<br>1. Diagnosis of excessive sleepiness associated with OSA; **and**<br>2. OSA confirmed by polysomnography; **and**<br>3. Dose does not exceed 200 mg per day.<br><br>**Excessive sleepiness associated with Shift Work Disorder (SWD)**<br>1. Diagnosis of excessive sleepiness associated with SWD; **and**<br>2. Chart note documents insomnia or excessive sleepiness for at least 1 month that is associated with a work schedule that overlaps the usual sleep period (e.g., night shift work schedule, rotating shift work schedule); **and**<br>3. Dose does not exceed 200 mg per day. |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# NETARSUDIL

**Products Affected**
RHOPRESSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of one of the following: **and**<br>a. Open-angle glaucoma; **or**<br>b. Ocular hypertension<br>2. Tried and failed at least two of the following drug classes: **and**<br>a. Prostaglandin analogs (bimatoprost, latanoprost, latanoprostene bunod, tafluprost, travoprost, Xelpros)<br>b. Beta-adrenergic blocking agents (betaxolol, carteolol, levobunolol, metipranolol, timolol)<br>c. Carbonic anhydrase inhibitors (dorzolamide, brinzolamide)<br>d. Alpha-2 adrenergic agonists (apraclonidine, brimonidine)<br>e. Direct acting miotics (carbachol, pilocarpine)<br>3. Dose does not exceed one drop in the affected eye(s) once daily. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# NICOTINE

**Products Affected**
NICOTROL
NICOTROL NS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Failure or clinically significant adverse effect(s) to nicotine transdermal patch; **and**<br>2. Failure or clinically significant adverse effect(s) to one of the following:<br>a. Nicotine gum; **or**<br>b. Nicotine lozenge. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# OMEGA-3 ACID ETHYL ESTERS

**Products Affected**
LOVAZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of hypertriglyceridemia; **and**<br>2. Labs are provided and show baseline triglyceride level ≥ 500 mg/dL; **and**<br>3. Failure or clinically significant adverse effect(s) to OTC fish oil 1 gram per day; **and**<br>4. Failure or clinically significant adverse effect(s) to one of the following: **and**<br>a. Fenofibrate; **or**<br>b. Gemfibrozil; **or**<br>c. Niacin ER.<br>5. Dose does not exceed 4 grams per day. |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# OXYCODONE ER

**Products Affected**
OXYCONTIN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Patient has tried and failed extended-release morphine; **and**<br>2. Will not be used on an "as needed" or "PRN" basis; **and**<br>3. Dosing frequency does not exceed every 12 hours (twice daily); **and**<br>4. History of naloxone prescription within the last 2 years if cumulative opioid dose ≥ 90 morphine milligram equivalents per day, **except** if patient meets one of the following:<br>a. Diagnosis of active cancer; **or**<br>b. Diagnosis of sickle cell disease; **or**<br>c. In hospice care; **or**<br>d. Receiving palliative or end of life care; **or**<br>e. Is a resident of a long-term care facility. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# PENTAMIDINE

**Products Affected**
NEBUPENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Used for pneumocystis jirovecii pneumonia (PCP) prophylaxis; **and**<br>2. Patient is HIV-infected; **and**<br>3. Chart notes documenting patient failed a trial or contraindication to trimethoprim-sulfamethoxazole; **and**<br>4. Chart notes documenting patient failed a trial or contraindication to dapsone; **and**<br>5. Dose does not exceed 300 mg every 4 weeks; **and**<br>6. Chart notes documenting one of the following:<br>a. History of one or more episodes of PCP; **or**<br>b. CD4 count less than or equal to 200/$mm^3$. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 6 MONTHS |
| **Other Criteria** | **Reauthorization Criteria**:<br>1. Request is for continued PCP prophylaxis; **and**<br>2. Labs documenting CD4 count less than or equal to 200/$mm^3$. |

# PENTOSAN POLYSULFATE SODIUM

**Products Affected**
ELMIRON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Chart notes are provided and document diagnosis of bladder pain or discomfort associated with interstitial cystitis; **and**<br>2. Dose does not exceed 300 mg per day. |
| **Age Restrictions** | 16 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A UROLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# PRAMLINTIDE

**Products Affected**
SYMLIN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Chart notes are provided and document diagnosis of Type 1 or Type 2 diabetes mellitus; **and**<br>2. Previous trial all of the following agents, unless contraindicated:<br>a. One insulin agent (any duration type)<br>b. Metformin 2,000 mg/day or maximum dose tolerated<br>c. One sulfonylurea or meglitinide analog<br>d. One DPP-4 inhibitor or SGLT-2 inhibitor<br>e. One GLP-1 receptor agonist |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORZATION: 12 MONTHS |
| **Other Criteria** | |

# RALOXIFENE

**Products Affected**
EVISTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Treatment and prevention of postmenopausal osteoporosis**<br>1. Tried and failed one bisphosphonate (alendronate, ibandronate);<br>2. Dose does not exceed 60 mg per day.<br><br>**Reduction in risk of invasive breast cancer in postmenopausal osteoporosis**<br>1. Dose does not exceed 60 mg per day.<br><br>**Reduction in risk of invasive breast cancer in high risk postmenopausal invasive breast cancer.**<br>1. Dose does not exceed 60 mg per day. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# RIFABUTIN

**Products Affected**
MYCOBUTIN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Prevention (Primary Prophylaxis) of disseminated Mycobacterium avium complex (MAC) disease in HIV-infected patients**<br>1. Diagnosis of HIV; **and**<br>2. CD4 count less than 50 cells/mm3; **and**<br>3. Tried and failed one of the following preferred regimens: **and**<br>a. Azithromycin; **or**<br>b. Clarithromycin<br>4. Dose does not exceed 300 mg daily.<br><br>**Chronic Maintenance Therapy (Secondary Prophylaxis) of disseminated Mycobacterium avium complex (MAC) disease in HIV-infected patients**<br>1. Diagnosis of HIV; **and**<br>2. Documentation of MAC infection; **and**<br>3. Chart notes indicating need for rifabutin in addition to one of the following regimens: **and**<br>a. Clarithromycin/ethambutol; **or**<br>b. Azithromycin/ethambutol: **or**<br>c. Ethambutol<br>4. Dose does not exceed 300 mg daily.<br><br>**Treatment of Mycobacterium avium complex (MAC) disease**<br>1. Documentation of MAC infection; **and**<br>2. Chart notes indicating need for rifabutin in addition to one of the following regimens: **and**<br>a. Clarithromycin with ethambutol; **or**<br>b. Azithromycin with ethambutol; **or**<br>c. Ethambutol (cannot use clarithromycin or azithromycin)<br>3. Dose does not exceed 450 mg daily.<br><br>**Treatment of latent Mycobacterium tuberculosis infection (LTBI)**<br>1. Documentation of latent tuberculosis infection (LTBI); **and** |

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| | 2. Tried and failed or contraindication to isoniazid and rifampin; **and**<br>3. Dose does not exceed 300 mg daily.<br><br>**Tuberculosis prophylaxis**<br>1. Documentation of close contact with a person with infectious tuberculosis; **and**<br>2. Tried and failed or contraindication to isoniazid and rifampin; **and**<br>3. Dose does not exceed 300 mg daily.<br><br>**Treatment of active tuberculosis**<br>1. Documentation of active tuberculosis; **and**<br>2. Tried and failed or contraindication to rifampin; **and**<br>3. Dose does not exceed 300 mg daily. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# RIVASTIGMINE

**Products Affected**
EXELON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Mild to moderate Parkinson's disease dementia (PDD)**<br>1. Request is for Parkinson's disease dementia (no chart notes required).<br><br>**Mild to moderate Alzheimer's disease**<br>1. Failure or clinically significant adverse effect(s) to donepezil; **and**<br>2. Dose does not exceed 12 mg/day. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# SILDENAFIL

**Products Affected**
REVATIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Chart notes document diagnosis of pulmonary arterial hypertension (PAH) (WHO Group I) confirmed by right heart catheterization; **and**<br>2. Dose does not exceed 20mg three times daily. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# SOFOSBUVIR/VELPATASVIR

**Products Affected**
EPCLUSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Treatment-Naïve:**<br>1. Diagnosis of treatment-naïve Hepatitis C; **and**<br>2. No cirrhosis or compensated cirrhosis; **and**<br>3. Hepatitis C viral load (HCV RNA Quantitative) within past 12 months; **and**<br>4. No documentation of life expectancy <12 months; **and**<br>5. Requested duration does not exceed the following:<br>a. No cirrhosis: 12 weeks; **or**<br>b. Compensated cirrhosis: 12 weeks.<br><br>**Decompensated cirrhosis or treatment experienced:**<br>1. Reviewed by a Medical Director or Clinical Pharmacist; **and**<br>2. Meets SCFHP Hepatitis C Policy. |
| **Age Restrictions** | 18 YEARS AND OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | NO CIRRHOSIS OR COMPENSATED CIRRHOSIS: 28 TABLETS PER 28 DAYS FOR 12 WEEKS<br>DECOMPENSATED OR TREATMENT-EXPERIENCED: APPROVE BASED ON SCFHP HEPATITIS C POLICY |
| **Other Criteria** | |

# SOMATROPIN

**Products Affected:**

NORDITROPIN FLEXPRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Pediatric growth hormone deficiency (GHD), Noonan syndrome, or Turner syndrome**<br>1. Chart notes document diagnosis of pediatric GHD, Noonan syndrome, or Turner syndrome; **and**<br>2. Confirmation of open epiphyses (growth plates) in patients more than 12 years of age; **and**<br>3. Patient's height is greater than or equal to 2 standard deviations (SD) below the mean height for normal children of the same age and gender.<br><br>**Prader-Willi syndrome (PWS)**<br>1. Chart notes document disgnosis of Prader-Willi syndrome; **and**<br>2. Document of growth failure.<br><br>**Short stature born small for gestational age (SGA)**<br>1. Chart notes document diagnosis of small stature born small for SGA; **and**<br>2. Confirmation of open epiphyses (growth plates) in patients more than 12 years of age; **and**<br>3. Patient has no catch-up growth by age 2 to 4 years; **and**<br>4. Patient's height is greater than or equal to 2 SD below the mean height for normal children of the same age and gender.<br><br>**Adult onset growth hormone deficiency (GHD)**<br>1. Chart notes document diagnosis of GHD; **and**<br>2. Confirmation of diagnosis with an appropriate growth hormone provocative test (i.e., insulin tolerance test (ITT), GHRH+arginine test (GHRH+ARG), arginine test (ARG), glucagon test); **and**<br>3. Labs provided show low IGF-1 level. |

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| | **Adult onset growth hormone deficiency (GHD) due to hypopituitarism**<br>1. Chart notes document diagnosis of GHD associated with multiple hormone deficiencies (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma; **and**<br>2. Labs provided show low IGF-1 level.<br><br>**Childhood onset growth hormone deficiency (GHD) continuing into adulthood**<br>1. Chart notes document diagnosis of childhood onset GHD continuing into adulthood; **and**<br>2. Re-confirmation of GH deficiency with an appropriate growth hormone provocative test (i.e., insulin tolerance test (ITT), GHRH+arginine test (GHRH+ARG), arginine test (ARG), glucagon test) after discontinuation of growth hormone treatment for at least 1 month. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR A PEDIATRIC ENDOCRINOLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | REAUTHORIZATION CRITERIA<br><br>**Pediatric GHD, Noonan syndrome, Turner syndrome, or short stature born SGA**<br>1. Chart notes document one of the following:<br>a. Growth velocity of >2cm over the previous year of treatment; **or**<br>b. Patient has not reached 50$^{th}$ percentile for target height following growth hormone therapy.<br><br>**Prader-Willi syndrome**<br>1. Chart notes document a positive response to therapy.<br><br>**Adult onset growth hormone deficiency (GHD)**<br>1. Chart notes and labs document improvement or stabilization of IGF-1 level.<br><br>**Childhood onset growth hormone deficiency (GHD) continuing into adulthood**<br>1. Chart notes document a positive response to therapy. |

# TACROLIMUS OINTMENT

**Products Affected**
PROTOPIC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Nonfacial/Nonintertriginous affected areas**<br>1. Diagnosis of atopic dermatitis/eczema; **and**<br>2. Tried and failed two medium or high potency topical steroids.<br><br>**Facial/Intertriginous affected areas (excluding around eyes)**<br>1. Diagnosis of atopic dermatitis/eczema; **and**<br>2. Tried and failed one low potency topical steroid.<br><br>**Around or on the eyelids**<br>1. Diagnosis of atopic dermatitis/eczema around or on the eyelids.<br>2. Quantity requested does not exceed 30 grams per month. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# TESTOSTERONE TOPICAL

**Products Affected**
FORTESTA, VOGELXO, ANDROGEL, TESTIM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | **Testosterone deficiency or low testosterone**<br>1. Labs show two pre-treatment serum total testosterone levels taken on different dates of <300 ng/dL or less than the reference range for the lab; **and**<br>2. Failure or clinically significant adverse effect(s) to injectable testosterone (testosterone cypionate or testosterone enanthate); **and**<br>3. Patient is of male gender; **and**<br>4. Dose does not exceed the following:<br>a. Fortesta (GPID 98317): 70 mg per day<br>b. Vogelxo, Androgel, Testim (GPID 23141, 47851, 47852): 100 mg per day.<br><br>**Gender dysphoria**<br>1. Patient is undergoing a female-to-male transition; **and**<br>2. Failure or clinically significant adverse effect(s) to injectable testosterone (testosterone cypionate or testosterone enanthate). |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | GENDER DYSPHORIA: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR TRANSGENDER SPECIALIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# TETRABENAZINE

**Products Affected**
XENAZINE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of chorea associated with Huntington's disease; **and**<br>2. Dose does not exceed 100 mg per day. |
| **Age Restrictions** | 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# TRANEXAMIC ACID

**Products Affected**
LYSTEDA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of cyclic heavy menstrual bleeding; **and**<br>2. Dose does not exceed 3,900 mg per day for 5 days per 30 days. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 12 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |

# TRIFLURIDINE

**Products Affected**
VIROPTIC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Chart notes are provided and document one of the following diagnoses; **and**<br>a. Herpes simplex keratoconjunctivitis; **or**<br>b. Herpes simplex epithelial keratitis.<br>2. Total treatment duration does not exceed 21 days. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 21 DAYS |
| **Other Criteria** | |

# VORTIOXETINE

**Products Affected**
TRINTELLIX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | ALL FDA APPROVED INDICATIONS |
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis of major depressive disorder; **and**<br>2. Tried one selective serotonin reuptake inhibitor (e.g., citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline); **and**<br>3. Tried one serotonin norepinephrine reuptake inhibitor (e.g., venlafaxine, duloxetine); **and**<br>4. Tried one other antidepressant from one of the following classes: **and**<br>a. Norepinephrine dopamine reuptake inhibitor (e.g., bupropion)<br>b. Norepiphrine serotonin modulator (e.g., mirtazapine)<br>c. Tricyclics (e.g., amitriptyline, nortriptyline, desipramine, doxepin, imipramine)<br>5. Dose does not exceed 20 mg per day. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS<br>REAUTHORIZATION: 12 MONTHS |
| **Other Criteria** | |