Santa Clara Family Health Plan
Medi-Cal Plan Formulary

List of Prior Authorization Requirements

Effective: 01/01/2022

40610.2022.01E

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** 2. Chart notes document high risk for fracture as defined by one of the following: **and** a. History of osteoporotic (i.e., fragility, low trauma) fracture (s); **or** 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). 3. Bone mineral density test results are provided and dated within the last 2 years; **and** 4. Failure contraindication to, or clinically significant adverse effects(s) to oral bisphosphonates (e.g., alendronate, ibandronate, risedronate) **and** 5. Failure contraindication to, or clinically significant adverse effects(s) to Prolia (denosumab); **and** 6. Duration of treatment with parathyroid hormone analogs (e.g., Tymlos, Forteo) does not exceed 2 years in a patient's lifetime; **and** 7. Dose does not exceed 80 mcg once daily.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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)** 1. Diagnosis of moderate to severe active rheumatoid arthritis; **and** 2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine; **and** 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** 4. Dose does not exceed 40 mg every week or 80 mg every other week in patients not taking methotrexate. **Polyarticular Juvenile Idiopathic Arthritis (JIA)** 1. Diagnosis of moderate to severe active polyarticular juvenile idiopathic arthritis; **and** 2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, thalidomide, 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-6 inhibitor, abatacept (Orencia), rituximab (Rituxan); **and** 4. Patient's current weight is documented; **and** 5. Dose does not exceed the following based on weight: a. 10 kg (22 lbs) to <15 kg (33 lbs): 10 mg every other week b. 15 kg (33 lbs) to <30 kg (66 lbs): 20 mg every other week c. ≥30 kg (66 lbs): 40 mg every other week. **Plaque Psoriasis (PsO)** 1. Diagnosis of moderate to severe chronic plaque psoriasis; **and** 2. Plaque psoriasis involve at least 5% body surface area (BSA) or psoriatic lesions affecting the hands, feet, scalp, face, or genital area; **and** 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 (Orencia); **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 (Entyvio), natalizumab (Tysabri); **and**
4. Dose does not exceed the following based on age and weight:
    a. Adult:
        i. Initial dose: 160 mg on Day 1 or split and given over 2 consecutive days
        ii. Second dose two weeks later (Day 15): 80 mg
        iii. Maintenance dose (starting on Day 29): 40 mg every other week
    b. Pediatric (≥ 6 years of age and adolescents):
        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. Maintenance dose (starting on Day 29): 20 mg every other week.

ii. ≥40 kg (88 lbs):
1. Initial dose: 160 mg on Day 1 or split and given over 2 consecutive days
2. Second dose two weeks later (Day 15): 80 mg
3. Maintenance dose (starting on Day 29): 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 (Entyvio); **and**
4. Dose does not exceed the following based on age and weight:
   a. Adult:
      i. Initial dose: 160 mg on Day 1 *or* split and given over 2 consecutive days
      ii. Second dose two weeks later (Day 15): 80 mg
      ii. Maintenance dose (starting on Day 29): 40 mg every other week.
   b Pediatric (≥ 5 years of age and adolescents):
      i. 20 kg (44 lbs) to <40 kg (88 lbs):
         1. Initial dose (Day 1) 80 mg
         2. Second and Third doses (Day 8 and Day 15): 40 mg
         3. Maintenance dose (starting on Day 29): 40 mg every other week or 20 mg every week
      ii. ≥ 40 kg (88 lbs):
         1. Initial dose: 160mg on Day 1 *or* split and given over 2 consecutive days
         2. Second and Third doses (Day 8 and Day 15): 80 mg
         3. Maintenance dose (starting on Day 29): 80 mg every other week or 40 mg every 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. Adult

	i. Initial dose: 160 mg on Day 1 *or* split and given over 2 consecutive days ii. Second dose two weeks later (Day 15): 80 mg iii. Maintenance dose (starting on Day 29): 40 mg every week or 80 mg every other week b. Pediatric (≥ 12 years of age and adolescents): i. 30 kg (66 lbs) to <60 kg (132 lbs): 1. Initial dose (Day 1): 80 mg 2. Maintenance dose (starting on Day 8): 40mg every other week ii. (≥ 60 kg (132 lbs): 1. Initial dose: 160 mg on Day 1 *or* split and given over 2 consecutive days 2. Second dose two weeks later (Day 15): 80 mg 3. Maintenance dose (starting on Day 29): 40 mg every week *or* 80 mg every other week **Uveitis (UV)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 based on age and weight: a. Adult: i. Initial dose (Day 1): 80 mg ii. Maintenance dose (starting on Day 8): 40 mg every other week b. Pediatric (≥ 2 years of age and adolescents): 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.
Age Restrictions	RHEUMATOID ARTHRITIS, PLAQUE PSORIASIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS: 18 YEARS OF AGE OR OLDER POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, UVEITIS: 2 YEARS OF AGE OR ORDER CROHN'S DISEASE: 6 YEARS OF AGE OR OLDER ULCERATIVE COLITIS: 5 YEARS OF AGE OR OLDER HIDRADENITIS SUPPURATIVA: 12 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST PLAQUE PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST

	PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST CROHN'S DISEASE, ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPTHALMOLOGIST, RHEUMATOLOGIST, OR INFECTIOUS DISEASE PHYSICIAN
Coverage Duration	INITIAL: 6 MONTHS 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** 2. Patient does not have idiopathic pulmonary fibrosis (IPF); **and** 3. Dose does not exceed the following: a. Initial dose: does not exceed 5mg daily for 4 weeks; **or** 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 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: a. Patient is receiving chemotherapy agent considered to be high emetic risk; **or** 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: EMEND TRIFOLD PACK: ONE PACK PER CHEMOTHERAPY CYCLE FOR 6 MONTHS OR LENGTH OF THERAPY (WHICHEVER IS LESS); OR ONE 125MCG EMEND CAPSULE AND TWO 80MG CAPSULES PER CHEMOTHERAPY CYCLE FOR 6 MONTHS OR LENGTH OF THERAPY (WHICHEVER IS LESS). SURGERY: 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** 1. Atovaquone-proguanil is recommended for the location of travel by the Centers for Disease Control and Prevention (CDC); **and** 2. Dose does not exceed 250-100 mg daily; **and** 3. Patient cannot use all of the following if recommended by CDC based on travel location: a. Doxycycline; b. Mefloquine; 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** 1. Diagnosis of plaque psoriasis; **and** 2. Failure or clinically significant adverse effect(s) to two high potency topical steroids (e.g. betamethasone, betamethasone-augmented, fluocinonide, clobetasol, desoximetasone, halobetasol). **Facial/Intertriginous affected areas** 1. Diagnosis of plaque psoriasis; **and** 2. Failure or clinically significant adverse effect(s) to one low potency topical steroid (e.g. alclometasone, hydrocortisone, desonide). **Around or on the eyelid** 1. Diagnosis of plaque psoriasis around or on the eyelids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 2. One of the following: **and** a. Tried and failed oral terbinafine; or b. Patient is younger than 18 years of age 3. Dose does not exceed 6.6 mL per month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS REAUTHORIZATION: 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 2. One of the following: a. Patient tried and failed both of the following: ofloxacin 0.3% otic drops, neomycin/polymycin B/hydrocortisone otic solution/suspension; **or** b. Patient has a perforated tympanic membrane; **or** 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** a. Chronic dermal ulcer; **or** b. Severely burned area(s) 2. Chart note documentation of wound width and wound length; **and** 3. Requested quantity does not exceed the manufacturer's dosing calculator.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 4 MONTHS REAUTHORIZATION: 12 MONTHS
Other Criteria	

CYCLOSPORINE OPHTHALMIC

Products Affected
RESTASIS
CEQUA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS
Exclusion Criteria	
Required Medical Information	**Sjogren's Syndrome or Ocular-related Transplant** 1. One of the following: a. Diagnosis of Sjogren's Syndrome; **or** b. Treated for ocular graft versus host disease; **or** c. Treated for corneal transplant rejection. **Dry Eyes** 1. One of the following diagnoses; **and** a. Chronic Dry Eye Syndrome b. Keratoconjunctivitis Sicca (KCS) c. Keratitis Sicca d. Xerophthalmia 2. Tried and failed artificial tears; **and** 3. Tried and failed ophthalmic lubricant ointment (generic Refresh PM).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 2. Tried and failed at least *two* of the following antimuscarinics; **and** a. Oxybutynin (immediate-release or extended-release); or b. Tolterodine (immediate-release or extended-release); or c. Solifenacin; or d. Trospium (immediate-release) 3. Dose does not exceed 15mg per day.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 1. Diagnosis of chronic iron overload; **and** 2. Serum ferritin level greater is than 1000 mcg/L; **and** 3. Creatinine clearance (CrCl) is greater or equal to 40 mL/min 4. Dose does not exceed 28 mg/kg/day **Chronic Iron Overload Resulting from Non-Transfusion Dependent Thalassemia (NTDT)** 1. Diagnosis of chronic iron overload resulting from non-transfusion dependent thalassemia; **and** 2. Serum ferritin level is greater than 300 mcg/L; **and** 3. Liver iron concentration (LIC) at least 5mg Fe/g dry weight or greater; **and** 4. Creatinine clearance (CrCl) is greater or equal to 40 mL/min; **and** 5. Dose does not exceed 14 mcg/kg/day
Age Restrictions	CHRONIC IRON OVERLOAD: 2 YEARS OF AGE AND OLDER 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 REAUTHORIZATION: 12 MONTHS
Other Criteria	RENEWAL CRITERIA **Chronic Iron Overload** 1. Serum ferritin level is greater than 500 mcg/L **Chronic Iron Overload in Non-Transfusion Dependent Thalassemia (NTDT)**

	Meet ONE of the following criteria: a. Serum ferritin level is greater than 300 mcg/L; **or** 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)

DIMETHYL FUMARATE

Products Affected
TECFIDERA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS
Exclusion Criteria	
Required Medical Information	1. Diagnosis of relapsing form of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; **and** 2. Patient will not be on concurrent therapy with another disease-modifying agent; **and** 3. Does not exceed 480 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 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** 1. Treatment is for anorexia associated with weight loss; **and** 2. Chart note documentation of acquired immunodeficiency syndrome (AIDS); **and** 3. Dose does not exceed 20mg daily. **Nausea and vomiting associated with cancer chemotherapy** 1. Patient is currently undergoing chemotherapy; **and** 2. Chemotherapy regimen is classified as high or moderate emetic risk per NCCN guidelines; **and** 3. Failure or clinically significant adverse effect(s) to a neurokinin-1 (NK1) antagonist (e.g. aprepitant, fosaprepitant, rolapitant); **and** 4. Failure or clinically significant adverse effect(s) to a selective 5-HT3 receptor antagonist (e.g. alosetron, dolasetron, granisetron, ondansetron, palonosetron); **and** 5. Failure or clinically significant adverse effect(s) to a steroid (e.g. dexamethasone); **and** 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 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)** 1. Hemoglobin (Hgb) level is less than 10g/dL. **Anemia due to the effect of concomitantly administered cancer chemotherapy** 1. Hemoglobin (Hgb) level is less than 10g/dL; **and** 2. Minimum of two additional months of planned chemotherapy. **Anemia related to zidovudine (AZT) therapy** 1. Hemoglobin (Hgb) level is less than 10g/dL. **Anemia due to concurrent hepatitis C treatment** 1. Hep C treatment is one of the following: a. Ribavirin and interferon alfa combination; **or** b. Ribavirin and peginterferon alfa combination; **and** 2. Hemoglobin (Hgb) level is less than 10g/dL; **and** 3. Patient has had a trial or contraindication to ribavirin dose reduction. **Reduction of allogenic blood transfusions due to undergoing elective, noncardiac, nonvascular surgery** 1. Preoperative hemoglobin (Hgb) level is greater than 10g/dL; **and** 2. Preoperative hemoglobin (Hgb) level is less than or equal to 13g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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)** 1. Diagnosis of moderate to severe active rheumatoid arthritis; **and** 2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine; **and** 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** 4. Dose does not exceed 50 mg once weekly. **Polyarticular Juvenile Idiopathic Arthritis (JIA)** 1. Diagnosis of moderate to severe active polyarticular juvenile idiopathic arthritis; **and** 2. Previous trial with at least one of the following disease-modifying antirheumatic drugs (DMARDs): methotrexate, leflunomide, 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-6 inhibitor, abatacept, rituximab; **and** 4. Dose does not exceed 50 mg once weekly. **Plaque Psoriasis (PsO)** 1. Diagnosis of moderate to severe chronic plaque psoriasis; **and** 2. Plaque psoriasis involve at least 5% body surface area (BSA) or psoriatic lesions affecting the hands, feet, scalp, face, or genital area; **and** 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 the following: a. Adult: i. 50mg twice weekly for first 3 months, followed by 50mg once weekly b. Pediatric: i. 50mg once weekly **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 50 mg once weekly. **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 50 mg once weekly.
Age Restrictions	RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS: 18 YEARS OF AGE OR OLDER PLAQUE PSORIASIS: 4 YEARS OF AGE OR OLDER 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 PLAQUE PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST
Coverage Duration	INITIAL: 6 MONTHS 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** 1. Patient meets the definition of opioid tolerance; **and** 2. Request is for only one strength of transdermal fentanyl; **and** 3. The medication will not be used on as "as needed" or "PRN" basis. **48-Hour Dosing Frequency** 1. Patient has tried every 72 hours dosing; **and** 2. Patient meets the definition of opioid tolerance; **and** 3. Request is for only one strength of transdermal fentanyl; **and** 4. The medication will not be used on as "as needed" or "PRN" basis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 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** b. Prevention of febrile neutropenia in patients with acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy treatment; **or** 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** d. Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; **or** e. Symptomatic congenital neutropenia; **or** f. Symptomatic cyclic neutropenia; **or** g. Symptomatic idiopathic neutropenia. 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 REAUTHORIZATION: 12 MONTHS
Other Criteria	

FINGOLIMOD

Products Affected
GILENYA

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** 2. Patient will not be on concurrent therapy with another disease-modifying agent; **and** 3. 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 REAUTHORIZATION: 12 MONTHS
Other Criteria	

GLATIRAMER ACETATE

Products Affected
COPAXONE
GLATOPA

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** 2. Patient will not be on concurrent therapy with another disease-modifying agent; **and** 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 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:** 1. Diagnosis of treatment-naïve Hepatitis C; **and** 2. No cirrhosis or compensated cirrhosis; **and** Hepatitis C viral load (HCV RNA Quantitative) within past 12 months; **and** 3. Patient is >12 years of age or weights at least 45kg; **and** 4. No documentation of life expectancy <12 months; **and** 5. Documentation that sofosbuvir/velpatasvir (Epclusa) cannot be used; **and** 6. Requested duration does not exceed 8 weeks. **Treatment-Experienced, decompensated Cirrhosis, Post-liver Transplant, Renal Impairment, or Post-kidney Transplant** 1. Reviewed by a clinical pharmacist or medical director; and 2. Meets SCFHP Hepatitis C policy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TREATMENT-NAÏVE: 8 WEEKS 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** 2. Chart notes document one of the following: a. Difficulty swallowing oral tablets/capsules; **or** b. Contraindication to oral tablets/capsules; **or** c. Upcoming bariatric surgery 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 REAUTHORIZATION-12 MONTHS 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** 2. Currently pregnant with a singleton; **and** 3. Treatment to be started between 16 weeks and 21 weeks of gestation; **and** 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** 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** 3. Patient will not be on concurrent therapy with another disease-modifying agent; **and** 4. Requested dose does not exceed: a. Avonex: 30mcg once per week b. Rebif: 44 mcg three times per week
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST
Coverage Duration	INITIAL: 6 MONTHS 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** 1. Supported by National Comprehensive Cancer Network (NCCN) guidelines; **and** 2. Reviewed by a clinical pharmacist or medical director. **Condylomata Acuminata** 1. Patient tried and failed both podofilox 0.5% topical solution and imiquimod 5% topical cream; **and** 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. **Chronic Hepatitis B** 1. Patient has compensated liver disease; **and** 2. Patient has serum HBsAg positive for at least 6 months; **and** 3. Patient has evidence of HBV replication (serum HBeAg positive) with elevated serum ALT; **and** 4. Reviewed by a clinical pharmacist or medical director; **and** 5. Dose does not exceed the following: a. Adult: i. 5 million IU daily or 10 million IU three times a week for 16 weeks b. Pediatric: i. 10 million IU three times a week for 16 to 24 weeks **Chronic Hepatitis C** 1. Refer to SCFHP Hepatitis C Policy; **and** 2. Reviewed by a clinical pharmacist or medical director.
Age Restrictions	CONDYLOMATA ACUMINATA: 18 YEARS OF AGE OR OLDER CHRONIC HEPATITIS B: 1 YEAR OF AGE OR OLDER

Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS 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** 1. Dose does not exceed 600mg per day. **Coccidioidomycosis, Cryptococcosis, or Oropharyngeal/Esophageal candidiasis** 1. Tried and failed fluconazole; **and** 2. Dose does not exceed 600mg per day. **Coccidioidomycosis of bone or joint infections in HIV patients** 1. Dose does not exceed 600mg per day. **Onychomycosis of toenail or fingernail** 1. Confirmed diagnosis by potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy; **and** 2. Tried and failed oral terbinafine; **and** 3. Dose does not exceed 400mg per day for 3 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS REAUTHORIZATION: 12 MONTHS
Other Criteria	

IVERMECTIN

Products Affected
STROMECTOL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS
Exclusion Criteria	
Required Medical Information	**Onchocerciasis (River Blindness)** 1. Diagnosis of onchocerciasis (river blindness); **and** 2. Diagnosis confirmed by skin snip biopsy; **and** 3. Patient weighs ≥15 kg; **and** 4. Requested dose does not exceed 150 mcg/kg as a single dose (note: retreatment may be required every 3 to 12 months until asymptomatic). **Strongyloidiasis of the intestinal tract** 1. Diagnosis of strongyloidiasis of the intestinal tract; **and** 2. Diagnosis confirmed by stool and/or serologic testing; **and** 3. Patient weighs ≥15 kg; **and** 4. Requested dose does not exceed 200 mcg/kg/day for 1 to 2 days (per the Centers for Disease Control and Prevention (CDC).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approve for a one time fill.
Other Criteria	

IXEKIZUMAB

Products Affected
TALTZ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS
Exclusion Criteria	
Required Medical Information	**Plaque Psoriasis (PsO)** 1. Diagnosis of moderate to severe chronic plaque psoriasis; **and** 2. Plaque psoriasis involve at least 5% body surface area (BSA) or psoriatic lesions affecting the hands, feet, scalp, face, or genital area; **and** 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** 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 the following: a. Induction: i. 160 mg at Week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12. b. Maintenance: i. 80mg every 4 weeks. **Psoriatic Arthritis (PsA)** 1. Diagnosis of active psoriatic arthritis; **and** 2. Tried and failed 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 the following: a. Induction: i. 160 mg at Week 0 b. Maintenance: i. 80 mg every 4 weeks.

Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	PLAQUE PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST
Coverage Duration	INITIAL: 6 MONTHS 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** a. Open-angle glaucoma; **or** b. Ocular hypertension 2. One of the following: **and** a. Patient has tried and failed latanoprost; **or** b. Patient has sensitivity to or cannot tolerate ophthalmic preservatives (e.g. benzalkonium chloride) 3. Dose does not exceed one drop in the affected eye(s) once daily.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS 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** 2. Tried and failed a formulary antibiotic that the organism is susceptible to; **and** 3. Dose does not exceed 600 mg twice daily; **and** 4. Reviewed by a clinical pharmacist or medical director.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS 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)** 1. Diagnosis of chronic idiopathic constipation; **and** 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** 3. Not currently taking methadone; **and** 4. Dose does not exceed 24 mcg twice daily. **Irritable Bowel Syndrome with Constipation (IBS-C)** 1. Diagnosis of irritable bowel syndrome with constipation; **and** 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** 3. Not currently taking methadone; **and** 4. Dose does not exceed 8 mcg twice daily. **Opioid-Induced Constipation (OIC)** 1. Diagnosis of opioid-induced constipation; **and** 2. History of chronic use of an opioid medication in the past 30 days; **and** 3. Failure, clinically significant adverse effect(s), or contraindication(s) to Movantik (naloxegol); **and** 4. Not currently taking methadone; **and** 5. Dose does not exceed 24 mcg twice daily.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	

Coverage Duration	INITIAL: 12 MONTHS 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** 2. Tried and failed gabapentin up to 1,800 mg/day; **and** 3. Tried and failed duloxetine; **and** 4. Dose does not exceed 200mg twice daily.
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 2. Failure or clinically significant adverse effect(s) to two of the following antimuscarinics; **and** a. Oxybutynin (immediate-release or extended-release); **or** b. Tolterodine (immediate-release or extended-release); **or** c. Trospium (immediate-release); **or** d. Solifenacin; **or** 3. Dose does not exceed 50mg daily.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 1. Diagnosis of excessive sleepiness associated with narcolepsy; **and** 2. Narcolepsy confirmed by polysomnography/multiple sleep latency test; **and** 3. Dose does not exceed 200 mg per day. **Excessive sleepiness associated with Obstructive Sleep Apnea (OSA)** 1. Diagnosis of excessive sleepiness associated with OSA; **and** 2. OSA confirmed by polysomnography; **and** 3. Dose does not exceed 200 mg per day. **Excessive sleepiness associated with Shift Work Disorder (SWD)** 1. Diagnosis of excessive sleepiness associated with SWD; **and** 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** 3. Dose does not exceed 200 mg per day.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS REAUTHORIZATION: 12 MONTHS
Other Criteria	

NALOXEGOL OXALATE

Products Affected
MOVANTIK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS
Exclusion Criteria	
Required Medical Information	1. Diagnosis of opioid-induced constipation; **and** 2. History of chronic use of an opioid medication in the past 30 days; **and** 3. Failure, clinically significant adverse effect(s), or contraindication(s) to two of the following laxatives: bisacodyl (Dulcolax), docusate calcium (Kao-Tin), docusate sodium (Colace), glycerin suppositories (Fleet), lactulose (Kristalose), magnesium citrate (Citroma), magnesium hydroxide (Milk of Magnesia), methylcellulose fiber (Citrucel), polyethylene glycol 3350 (Miralax), psyllium fiber (Metamucil), sennosides (Sennokot); **and** 4. Dose does not exceed 25 mg per day.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** a. Open-angle glaucoma; **or** b. Ocular hypertension 2. Tried and failed at least two of the following drug classes: **and** a. Prostaglandin analogs (bimatoprost, latanoprost, latanoprostene bunod, tafluprost, travoprost, Xelpros) b. Beta-adrenergic blocking agents (betaxolol, carteolol, levobunolol, metipranolol, timolol) c. Carbonic anhydrase inhibitors (dorzolamide, brinzolamide) d. Alpha-2 adrenergic agonists (apraclonidine, brimonidine) e. Direct acting miotics (carbachol, pilocarpine) 3. Dose does not exceed one drop in the affected eye(s) once daily.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 2. Failure or clinically significant adverse effect(s) to one of the following: a. Nicotine gum; **or** b. Nicotine lozenge.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 2. Labs are provided and show baseline triglyceride level ≥ 500 mg/dL; **and** 3. Failure or clinically significant adverse effect(s) to OTC fish oil 1 gram per day; **and** 4. Failure or clinically significant adverse effect(s) to one of the following: **and** a. Fenofibrate; **or** b. Gemfibrozil; **or** c. Niacin ER. 5. Dose does not exceed 4 grams per day.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS 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** 2. Will not be used on an "as needed" or "PRN" basis; **and** 3. Dosing frequency does not exceed every 12 hours (twice daily); **and** 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: a. Diagnosis of active cancer; **or** b. Diagnosis of sickle cell disease; **or** c. In hospice care; **or** d. Receiving palliative or end of life care; **or** e. Is a resident of a long-term care facility.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS REAUTHORIZATION: 12 MONTHS
Other Criteria	

OZANIMOD

Products Affected
ZEPOSIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS
Exclusion Criteria	
Required Medical Information	**Multiple Sclerosis** 1. Diagnosis of a relapsing form of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; **and** 2. Tried and failed Gilenya (fingolimod); **and** 3. Patient will not be on concurrent therapy with another disease-modifying agent; **and** 4. Requested dose does not exceed 0.92 mg per day. **Ulcerative Colitis (UC)** 1. Diagnosis of moderate to severe active ulcerative colitis (UC); **and** 2. Tried and failed Humira (adalimumab); **and** 3. Patient will not be on concurrent therapy with another biologic agent used to treat ulcerative colitis; **and** 4. Requested dose does not exceed 0.92mg per day.
Age Restrictions	MULTIPLE SCLEROSIS: 18 YEARS OF AGE OR OLDER ULCERATIVE COLITIS: 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	MULTIPLE SCLEROSIS: PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULATION WITH GASTROENTEROLOGIST
Coverage Duration	INITIAL: 6 MONTHS 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** 2. Patient is HIV-infected; **and** 3. Chart notes documenting patient failed a trial or contraindication to trimethoprim-sulfamethoxazole; **and** 4. Chart notes documenting patient failed a trial or contraindication to dapsone; **and** 5. Dose does not exceed 300 mg every 4 weeks; **and** 6. Chart notes documenting one of the following: a. History of one or more episodes of PCP; **or** b. CD4 count less than or equal to 200/mm^3.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS REAUTHORIZATION: 6 MONTHS
Other Criteria	**Reauthorization Criteria**: 1. Request is for continued PCP prophylaxis; **and** 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** 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 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** 2. Previous trial all of the following agents, unless contraindicated: a. One insulin agent (any duration type) b. Metformin 2,000 mg/day or maximum dose tolerated c. One sulfonylurea or meglitinide analog d. One DPP-4 inhibitor or SGLT-2 inhibitor e. One GLP-1 receptor agonist
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 1. Tried and failed one bisphosphonate (alendronate, ibandronate); 2. Dose does not exceed 60 mg per day. **Reduction in risk of invasive breast cancer in postmenopausal osteoporosis** 1. Dose does not exceed 60 mg per day. **Reduction in risk of invasive breast cancer in high risk postmenopausal invasive breast cancer.** 1. Dose does not exceed 60 mg per day.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 1. Diagnosis of HIV; **and** 2. CD4 count less than 50 cells/mm3; **and** 3. Tried and failed one of the following preferred regimens: **and** a. Azithromycin; **or** b. Clarithromycin 4. Dose does not exceed 300 mg daily. **Chronic Maintenance Therapy (Secondary Prophylaxis) of disseminated Mycobacterium avium complex (MAC) disease in HIV-infected patients** 1. Diagnosis of HIV; **and** 2. Documentation of MAC infection; **and** 3. Chart notes indicating need for rifabutin in addition to one of the following regimens: **and** a. Clarithromycin/ethambutol; **or** b. Azithromycin/ethambutol: **or** c. Ethambutol 4. Dose does not exceed 300 mg daily. **Treatment of Mycobacterium avium complex (MAC) disease** 1. Documentation of MAC infection; **and** 2. Chart notes indicating need for rifabutin in addition to one of the following regimens: **and** a. Clarithromycin with ethambutol; **or** b. Azithromycin with ethambutol; **or** c. Ethambutol (cannot use clarithromycin or azithromycin) 3. Dose does not exceed 450 mg daily. **Treatment of latent Mycobacterium tuberculosis infection (LTBI)** 1. Documentation of latent tuberculosis infection (LTBI); **and**

	2. Tried and failed or contraindication to isoniazid and rifampin; **and** 3. Dose does not exceed 300 mg daily. **Tuberculosis prophylaxis** 1. Documentation of close contact with a person with infectious tuberculosis; **and** 2. Tried and failed or contraindication to isoniazid and rifampin; **and** 3. Dose does not exceed 300 mg daily. **Treatment of active tuberculosis** 1. Documentation of active tuberculosis; **and** 2. Tried and failed or contraindication to rifampin; **and** 3. Dose does not exceed 300 mg daily.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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)** 1. Request is for Parkinson's disease dementia (no chart notes required). **Mild to moderate Alzheimer's disease** 1. Failure or clinically significant adverse effect(s) to donepezil; **and** 2. Dose does not exceed 12 mg/day.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS 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** 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 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:** 1. Diagnosis of treatment-naïve Hepatitis C; **and** 2. No cirrhosis or compensated cirrhosis; **and** 3. Hepatitis C viral load (HCV RNA Quantitative) within past 12 months; **and** 4. No documentation of life expectancy <12 months; **and** 5. Requested duration does not exceed the following: a. No cirrhosis: 12 weeks; **or** b. Compensated cirrhosis: 12 weeks. **Decompensated cirrhosis or treatment experienced:** 1. Reviewed by a Medical Director or Clinical Pharmacist; **and** 2. Meets SCFHP Hepatitis C Policy.
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	NO CIRRHOSIS OR COMPENSATED CIRRHOSIS: 12 WEEKS 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** 1. Chart notes document diagnosis of pediatric GHD, Noonan syndrome, or Turner syndrome; **and** 2. Confirmation of open epiphyses (growth plates) in patients more than 12 years of age; **and** 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. **Prader-Willi syndrome (PWS)** 1. Chart notes document disgnosis of Prader-Willi syndrome; **and** 2. Document of growth failure. **Short stature born small for gestational age (SGA)** 1. Chart notes document diagnosis of small stature born small for SGA; **and** 2. Confirmation of open epiphyses (growth plates) in patients more than 12 years of age; **and** 3. Patient has no catch-up growth by age 2 to 4 years; **and** 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. **Adult onset growth hormone deficiency (GHD)** 1. Chart notes document diagnosis of GHD; **and** 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** 3. Labs provided show low IGF-1 level.

	Adult onset growth hormone deficiency (GHD) due to hypopituitarism 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** 2. Labs provided show low IGF-1 level. **Childhood onset growth hormone deficiency (GHD) continuing into adulthood** 1. Chart notes document diagnosis of childhood onset GHD continuing into adulthood; **and** 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 REAUTHORIZATION: 12 MONTHS
Other Criteria	REAUTHORIZATION CRITERIA **Pediatric GHD, Noonan syndrome, Turner syndrome, or short stature born SGA** 1. Chart notes document one of the following: a. Growth velocity of >2cm over the previous year of treatment; **or** b. Patient has not reached 50th percentile for target height following growth hormone therapy. **Prader-Willi syndrome** 1. Chart notes document a positive response to therapy. **Adult onset growth hormone deficiency (GHD)** 1. Chart notes and labs document improvement or stabilization of IGF-1 level. **Childhood onset growth hormone deficiency (GHD) continuing into adulthood** 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** 1. Diagnosis of atopic dermatitis/eczema; **and** 2. Tried and failed two medium or high potency topical steroids; **and** 3. One of the following: a. Tacrolimus 0.1% ointment: 16 years of age or older; **or** b. Tacrolimus 0.03% ointment: no age limit **Facial/Intertriginous affected areas (excluding around eyes)** 1. Diagnosis of atopic dermatitis/eczema; **and** 2. Tried and failed one low potency topical steroid; **and** 3. One of the following: a. Tacrolimus 0.1%: 16 years of age or older; **or** b. Tacrolimus 0.03% ointment: no age limit **Around or on the eyelids** 1. Diagnosis of atopic dermatitis/eczema around or on the eyelids. 2. Quantity requested does not exceed 30 grams per month; **and** 3. One of the following: a. Tacrolimus 0.1% ointment: 16 years of age or older; **or** b. Tacrolimus 0.03% ointment: no age limit
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS REAUTHORIZATION: 12 MONTHS
Other Criteria	

TADALAFIL

Products Affected
ADCIRCA

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** 2. Does not exceed 40 mg daily.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL: 6 MONTHS 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** 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** 2. Failure or clinically significant adverse effect(s) to injectable testosterone (testosterone cypionate or testosterone enanthate); **and** 3. Patient is of male gender; **and** 4. Dose does not exceed the following: a. Fortesta (GPID 98317): 70 mg per day b. Vogelxo, Androgel, Testim (GPID 23141, 47851, 47852): 100 mg per day. **Gender dysphoria** 1. Patient is undergoing a female-to-male transition; **and** 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 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** 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 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** 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 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** a. Herpes simplex keratoconjunctivitis; **or** b. Herpes simplex epithelial keratitis. 2. Total treatment duration does not exceed 21 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 21 DAYS
Other Criteria	

VORICONAZOLE

Products Affected
VFEND

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS
Exclusion Criteria	
Required Medical Information	**Invasive Aspergillosis, Scedosporiosis, or Fusariosis** 1. Diagnosis of **one** of the following: **and** a. Invasive aspergillosis b. Infection caused by *Scedosporium apiospermum* c. Infection caused by *Fusarium* species 2. Dose does not exceed 400 mg twice daily for 2 doses, then 200-300 mg twice daily (supported by Infectious Diseases Society of America); **and** 3. Reviewed by a clinical pharmacist or medical director. **Candidemia in Non-Neutropenic Patients, Other Deep Tissue *Candida* Infections, or Esophageal Candidiasis** 1. Diagnosis of **one** of the following: **and** a. Candidemia in a non-neutropenic patient b. Deep tissue *Candida* infection (i.e., disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds) c. Esophageal candidiasis 2. Dose does not exceed 400 mg twice daily for 2 doses, then 200-300 mg twice daily (supported by Infectious Diseases Society of America); **and** 3. Reviewed by a clinical pharmacist or medical director.
Age Restrictions	2 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULATION WITH AN INFECTIOUS DISEASE SPECIALIST
Coverage Duration	1. ESOPHAGEL CANDIDIASIS: 1 MONTH 2. ALL OTHER INDICATIONS: 6 MONTHS
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** 2. Tried one selective serotonin reuptake inhibitor (e.g., citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline); **and** 3. Tried one serotonin norepinephrine reuptake inhibitor (e.g., venlafaxine, duloxetine); **and** 4. Tried one other antidepressant from one of the following classes: **and** a. Norepinephrine dopamine reuptake inhibitor (e.g., bupropion) b. Norepiphrine serotonin modulator (e.g., mirtazapine) c. Tricyclics (e.g., amitriptyline, nortriptyline, desipramine, doxepin, imipramine) 5. Dose does not exceed 20 mg per day.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS REAUTHORIZATION: 12 MONTHS
Other Criteria	