denotes change in current criteria
denotes new criteria

Celecoxib (removal of PA)

Current criteria:

~~COX-II Selective agents require thirty (30) day trials of each preferred Non-Selective Oral NSAID,~~ ~~**UNLESS**~~ ~~the following criteria are met:~~

~~Patient has a history or risk of a serious GI complication;~~ ~~**OR**~~
~~Agent is requested for treatment of a chronic condition~~ ~~**and**~~

1. ~~Patient is seventy (70) years of age or older,~~ ~~**or**~~
   ~~Patient is currently on anticoagulation therapy.~~

denotes change in current criteria
denotes new criteria

Seglentis (celecoxib/tramadol)

Seglentis requires medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents.

ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]

CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.
NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age. Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.

APAP/codeine butalbital/APAP/caffeine/codeine 50-325-30 mg codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydromorphone tablets meperidine oral solution morphine NUCYNTA (tapentadol) oxycodone capsule, tablets, solution oxycodone/APAP oxycodone/ASA tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine 50-300-30 mg butalbital/ASA/caffeine/codeine butorphanol DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) LORTAB SOLUTION (hydrocodone/acetaminophen) meperidine tablet morphine rectal suppository NORCO (hydrocodone/APAP) oxycodone concentrate oxycodone/ibuprofen oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) QDOLO SOLUTION (tramadol)	Fentanyl buccal, nasal and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. These dosage forms will not be authorized for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days. *Seglentis requires medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents.

	ROXICODONE (oxycodone) SEGLENTIS (celecoxib/tramadol)* ULTRACET (tramadol/APAP) VICOPROFEN (hydrocodone/ibuprofen)	

denotes change in current criteria
denotes new criteria

Rinvoq (upadacitinib)

Rinvoq (upadacitinib) is a Janus kinase (JAK) inhibitor indicated for the treatment of:

Adults with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: Use of RINVOQ in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Adults with active psoriatic arthritis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: Use of RINVOQ in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Adults and pediatric patients 12 years of age and older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies are inadvisable.
Limitations of Use: RINVOQ is not recommended for use in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants.

Adults with moderately to severely active ulcerative colitis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: RINVOQ is not recommended for use in combination with other JAK inhibitors, biological therapies for ulcerative colitis, or with other potent immunosuppressants such as azathioprine and cyclosporine.

Adults with active ankylosing spondylitis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: Use of RINVOQ in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

CRITERIA FOR APPROVAL for Atopic Dermatitis*:

1. Prescribed by or in consultation with an allergist, immunologist or dermatologist; **AND**

2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected BSA, areas of involvement and severity of symptoms; **AND**

3. The patient must be within the age range as recommended by the FDA label and indication; **AND**

4. Affected body surface area is greater than or equal to 10%; **AND**

5. Patient has failed to find relief of symptoms after a minimum of 30-day trials of two agents from the following list in the last 12 months:

a. Medium to High potency topical corticosteroid**
b. Elidel

denotes change in current criteria
denotes new criteria

c. Eucrisa
d. Tacrolimus; **AND**

6. The patient has a had a documented intolerance, allergy, or treatment failure after ninety (90) days with Adbry or Dupixent (unless contraindicated).

*For other Rinvoq indications, refer to criteria for Cytokine and CAM Antagonists

**Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds or genitals. However, a trial of two other agents among the list above, are still required prior to Rinvoq approval.

Approval Duration: Initial approval will be for 3 months.

Criteria for reauthorization:

1. Demonstrate continued documented compliance; **AND**
2. Documentation of satisfactory patient response (including current affected BSA and severity of symptoms) has been provided.

Continuation of therapy will be granted for 12 months.

denotes change in current criteria
denotes new criteria

Cibinqo (abrocitinib)

Cibinqo (abrocitinib) is a Janus kinase (JAK) inhibitor indicated for the treatment of adults with refractory, moderate-to-severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.

CRITERIA FOR APPROVAL:

1. Prescribed by or in consultation with an allergist, immunologist or dermatologist; **AND**

2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected BSA, areas of involvement and severity of symptoms; **AND**

3. The patient must be within the age range as recommended by the FDA label and indication; **AND**

4. Affected body surface area is greater than or equal to 10%; **AND**

5. Patient has failed to find relief of symptoms after a minimum of 30-day trials of two agents from the following list in the last 12 months:

a. Medium to High potency topical corticosteroid*
b. Elidel
c. Eucrisa
d. Tacrolimus; **AND**

6. The patient has a had a documented intolerance, allergy, or treatment failure after ninety (90) days with Adbry or Dupixent (unless contraindicated) **AND** the patient has a had a documented intolerance, allergy, or treatment failure after ninety (90) days with Rinvoq (unless contraindicated).

*Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds or genitals. However, a trial of two other agents among the list above, are still required prior to Cibinqo approval.

Approval Duration: Initial approval will be for 3 months.

Criteria for reauthorization:

1. Demonstrate continued documented compliance; **AND**
2. Documentation of satisfactory patient response (including current affected BSA and severity of symptoms) has been provided.

Continuation of therapy will be granted for 12 months.

denotes change in current criteria
denotes new criteria

Fleqsuvy/oral baclofen solution

Fleqsuvy (baclofen suspension) and oral baclofen solution may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.

MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
baclofen tizanidine tablets	baclofen solution* DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen)* tizanidine capsules ZANAFLEX (tizanidine)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. *Fleqsuvy (baclofen suspension) and oral baclofen solution may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.

denotes change in current criteria
denotes new criteria

Voxzogo (vosoritide)

Voxzogo (vosoritide) is a C-type natriuretic peptide (CNP) analog indicated to increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

CRITERIA FOR APPROVAL:

1. The patient must be within the age range as recommended by the FDA label and indication; **AND**
2. The patient must have a documented diagnosis of achondroplasia confirmed with genetic testing; **AND**
3. Voxzogo must be prescribed by a pediatric endocrinologist; **AND**
4. There is confirmation of non-closure of epiphyseal plates (x-ray determining bone age) must be provided for females > age 12 and males >14; **AND**
5. The height, body weight, growth velocity, and physical development of the patient will be measured at baseline and will also be monitored and assessed throughout therapy; **AND**
6. Patient has not had (within the previous 18 months) nor will they receive limb-lengthening surgery during treatment with Voxzogo; **AND**
7. Voxzogo will not be used in combination with any human growth hormone products.

Approval Duration: Initial approval will be for 3 months.

Criteria for reauthorization:

1. Demonstrate continued documented compliance; **AND**
2. The patient does not have closure of epiphyses; **AND**
3. Documentation of improvement in growth velocity compared to pre-treatment baseline has been provided.

Continuation of therapy will be granted for 12 months.

denotes change in current criteria
denotes new criteria

Ibsrela

Ibsrela requires thirty (30) day trials of each preferred agent for IBS-C, however for males, a trial of Amitiza is not required.

IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS [CL]		
CLASS PA CRITERIA: All agents are approvable only for patients age eighteen (18) and older. **See below for additional sub-class criteria.**		
CONSTIPATION		
AMITIZA (lubiprostone) LINZESS 145 and 290 mcg (linaclotide) MOVANTIK (naloxegol)	IBSRELA (tenapanor) LINZESS 72 mcg (linaclotide) lubiprostone capsule MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLET (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide)	All agents in this subclass require documentation of the current diagnosis and evidence that the patient has failed to find relief with dietary modification and a fourteen (14) day trial of an osmotic laxative. No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least 90-days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use.
		Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria shall also apply, unless one (1) of the exceptions on the PA form is present: **Ibsrela** requires thirty (30) day trials of each preferred agent for IBS-C, however for males, a trial of Amitiza is not required. **Linzess 72mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145mcg dose. **Lubiprostone** may only be authorized with a documented allergy or intolerance to Amitiza. **Motegrity** requires a 30-day trial of both Amitiza and Linzess. **Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza. **Trulance** requires thirty (30) day trials of both Amitiza and Linzess, however for the indication of IBS-C in males, a trial of Amitiza is not required. **Zelnorm** is indicated for females < 65 years of age diagnosed with irritable bowel syndrome with constipation (IBS-C) AND requires thirty (30) day trials of Amitiza and Linzess.

denotes change in current criteria
denotes new criteria

Norliqva (amlodipine oral solution)

*Katerzia and Norliqva may be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. In addition, Norliqva may only be authorized for patients who have a documented allergy or are unable to tolerate Katerzia.

CALCIUM CHANNEL BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
LONG-ACTING		
amlodipine diltiazem ER/CD felodipine ER nifedipine ER verapamil ER	CALAN SR (verapamil) CARDIZEM CD, LA (diltiazem) diltiazem LA KATERZIA SUSPENSION (amlodipine)* MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) NORLIQVA (amlodipine)* PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	*Katerzia and Norliqva may be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. In addition, Norliqva may only be authorized for patients who have a documented allergy or are unable to tolerate Katerzia.

denotes change in current criteria
denotes new criteria

Vaginal ring contraceptives

CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent.

VAGINAL RING CONTRACEPTIVES		
CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent		
NUVARING (etonogestrel/ethinyl estradiol)	ANNOVERA (segesterone/ethinyl estradiol) ELURYNG (etonogestrel/ethinyl estradiol) etonogestrel/ethinyl estradiol vaginal rings	

denotes change in current criteria
denotes new criteria

Testosterone Injectable vial (cypionate & enanthate)- removal of criteria - - - Add this criteria for the entire category (Androderm & Androgel being the other preferred agents)

Prior authorization requests for testosterone injection may be approved if the following criteria are met:

1. Patient has two (2) morning pre-treatment total testosterone levels below the lower limit of the normal total testosterone reference range of the individual laboratory used (please attach lab results).

Requests for erectile dysfunction or infertility will not be approved, unless testicular failure is due to one of the following:

a) Cryptorchidism

b) Bilateral torsion

c) Orchitis

d) Vanishing testes syndrome

e) Orchiectomy

f) Klinefelter's syndrome

g) Chemotherapy

h) Toxic damage from alcohol or heavy metals

If criteria for coverage are met, initial authorization will be given for 3 months.

Requests for continuation of therapy will require an updated total testosterone level between 400 and 600, and documented improvement of symptoms. (Please attach lab result).